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Motivations for planned home birth: an exploratory descriptive study

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ABSTRACT

Aim: apprehend the motivations that led the couples to choose the planned home birth. **Method:** this is an exploratory descriptive study, using a qualitative approach, with eight couples who opted for home birth, indicated by the professionals who provided the delivery assistance between 2014 and 2016. The data were collected between July and August of 2016, through interviews recorded, transcribed in full and submitted to content analysis. **Results:** three categories emerged: "Fear of loss of autonomy in the hospital environment", "Feeling of security in home birth" and "Support and appreciation of the partner". **Conclusion:** the option for this place of birth is linked to the desire of the woman for natural childbirth when a gestation was found without intercurrences; however, the fear of the hospital environment promoted the search for home birth planned with the support of the partner. Female empowerment proved to be fundamental for couples to debate and firm their choices.

Descriptors: Home Childbirth; Natural Childbirth; Humanizing Delivery; Family Relations.

INTRODUCTION

Brazilian women seek a parto domiciliar planejado (PDP - Planned Home Birth) as an alternative to the current obstetric care scenario, which is highlighted by the excess of cesarean surgeries and hospital vaginal delivery accompanied by several interventions. The choice for this loco usually involves the whole family structure, because in the popular culture the PDP has not yet legitimized and there is little knowledge about it(1).

The model of obstetric care in Brazil is characterized by being hospital-centered, technicist and medicalized, which exposes mothers and babies to greater risks of morbidity and mortality and also unnecessarily increases health spending[2]. In 2016, about 98% of births in Brazil occurred in a hospital environment[3], which could be the scene of institutional violence and violation of the rights of women and children[2].

Contradicting this model, the PDP has been emerging for integrating more humanized practices to birth and delivery, respecting the physiology and choices of women. Countries such as the Netherlands, Canada, the United States, Denmark, Sweden, Ireland, New Zealand and Australia not only recognize this practice, but also encourage it. This is due to their conceptions, which seek to get rid of medicalization and obstetric technology that disregard the specificities of each woman, besides conferring less risk to adverse events when compared with the care performed in the hospital scope[4-6].

In this sense, delivery and birth are seen as events that change the lives of families and are usually at risk[2]. This perception encourages the choice of domicile for parturition, since the couples understand that this environment allows them greater autonomy, active participation of the family[4-5] and security, because, as this is a PDP, it has the integral and individualized support of professionals and, if necessary, backup support with a doctor and specialized referral service[5].

The focus of the discussions of this study is established in the questions about the PDP, directing it to the perceptions linked to the couple. In view of the above, it was established as an objective: to apprehend the motivations that led the couples to opt for the PDP.

METHOD

This is a descriptive and exploratory study, using a qualitative approach, carried out in a municipality in the southern region of Brazil, and which addresses the experience of eight couples who opted for the PDP between March 2014 and March 2016.

The PDP is performed by nurses in this municipality since 2012. Among these nurses, two are specialized in obstetrics and one in neonatology. It also includes a doctor who does not work at home but as a reference for cases of intercurrence. The work developed by this team involves follow-up throughout the prenatal care, with individualized care to the couple at home and in groups of pregnant women. It should be emphasized that this follow-up is parallel to that performed by the doctor of choice of the pregnant woman, with consultations and examinations.

During labor and delivery, the staff moves to the chosen home for delivery, with the necessary technical support, including materials for emergencies or intercurrences and for pain relief, such as a ball, a stool and a massager. During this period, family-centered physical and emotional support is provided. Home follow-up continues

in the immediate puerperium, both for women and for the newborn.

The informants were eight mothers and five parents intentionally located, indicating the nurses who perform this service or the participants themselves. It is emphasized that before the indication, the nurses contacted the couples to inform about the study and to verify their agreement to participate in the study. If agreed, the researchers made telephone contact to explain the purpose of the study, to request voluntary and anonymous participation and to schedule a day and place for a face-to-face meeting. Of the contacts made there was only one refusal, due to the change of city. Three teammates could not participate due to unavailability of time.

The data were collected in the months of July and August of 2016, through semi-structured interviews carried out in a place chosen by the participants, one in the university, the other in a cafeteria and the others in the households. They had an average duration of 50 minutes and were audiographed after consent and later transcribed in full. The interviews were carried out by two of the authors, both nurses. The main interviewer had experience in maternal and child health and was the trainer of the second one who was newly formed. One participant knew the main interviewer for her voluntary and sporadic participation in the groups of pregnant women.

To protect the identity of the deponents, each family received a number, which was assigned according to the order in which the interviews took place. Later, the speeches were edited to remove the vices of language and grammatical errors, in order to give a greater fluidity to the reading of the speeches, without, however, changing their meaning and content[7].

The statements were submitted to the analysis of content and thematic modality, following the operational phases based on: constitution of the corpus, floating reading, material exploration, composition of the units of record corresponding to the unit of signification (speech clipping), later classified for composing the categories according to semantic criterion, that is, the contents with similar meanings were grouped, which culminated in thematic categories[7]. The interviews originated 90 units of records. From the thematic grouping, 17 subcategories were formed and, finally, three categories emerged, according to Figure 1.

The study was developed in accordance with the guidelines disciplined by the National Health Council/Ministry of Health, through Resolution 466/12[8]. The research project was approved by the Standing Committee on Ethics in Research Involving Human Beings (COPEP) under opinion No. 1,636,468, on July 14, 2016.

RESULTS

Thirteen people participated in the study. Of these, eight were mothers and five were parents, all of them with complete higher education. The mean age of mothers and fathers was 30 and 33 years, respectively. Among the mothers, only one was primiparous, two had cesarean deliveries, two vaginal hospital deliveries, two home births and one had a hospital vaginal delivery and another at home.

After the strenuous reading of the material, three categories emerged, described below.

Fear of loss of autonomy in the hospital environment

The fear of losing autonomy over decisions about the calving process was present both in the speeches of women who had previous births and in those who did not have children. According to the deponents, the hospital en-

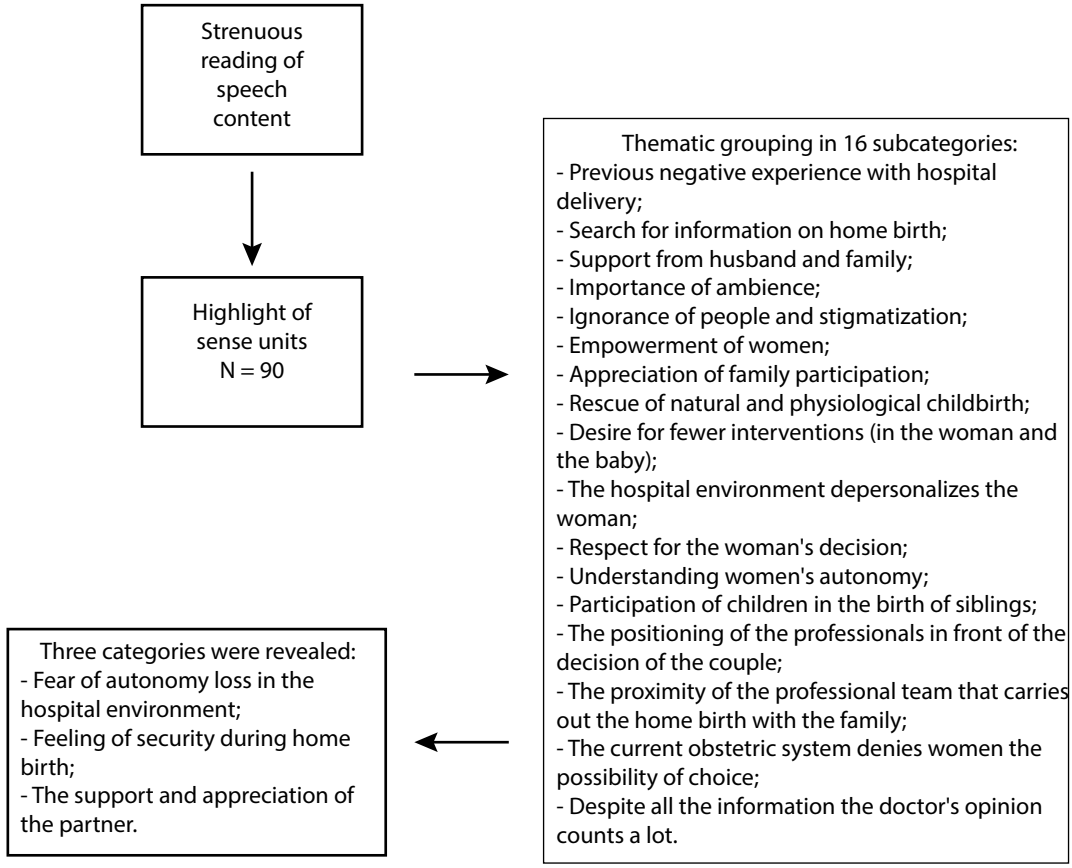

Figure 1. Explanatory organization chart on the process of defining thematic categories. Municipality of Southern Brazil, 2016

vironment was hostile, triggering anxiety and, especially, fear of not having enough freedom to make the choices regarding their own body and the birth of their child. Many were also worried about the lack of respect for the choices made, besides the imposition of hospital routines or obstetric interventions that did not coincide with the couples' desire.

In the hospital it was pretty bad. They didn't respect my will; I couldn't stay in the position I wanted. (Mother 01)

> They (professionals) tell us to lie on their belly up, which is the worst position in the world when you are having contractions. (Mother 02)

> I think the question of being a more hostile environment, of having so many interventions, an environment that doesn't bring confidence, in fact, is strange to say this, but it is so... I think this is the main justification. (Mother 05)

> The problem was that I didn't want any more interventions, even for what I wanted at home because I knew I would be more susceptible to them at the hospital because of the first experience. (Mother 08)

Professionals' unpreparedness in dealing with the couple in a moment full of expecta-

tions and emotions generates frustrations in the parents.

> There were a lot of wrong instructions; every time a different nurse came in, willing to examine me or telling me to use strength when I was not supposed to. (Mother 02)

> The professionals did not know how to offer me any kind of pain relief; I didn't have a ball or a shower I could get into. (Mother 03)

> I particularly don't like the nurses' influence on patients in the hospital; this thing is so cold and so impersonal, and it really affects me! (Mother 07)

It was identified that couples who have gone through the hospital experience demonstrated the importance of an adequate environment for delivery, because in their conceptions they did not have the opportunity to experiment. In reality, it was the opposite, some felt unprotected. Another intriguing aspect refers to the way the hospital depersonalizes women and performs routine and invasive treatments also on the newborn.

> By the time I entered the hospital the contractions stopped. I realized it was that environment, people asking many things, writing on forms and they even said I couldn't eat or drink! That made me nervous. I realized that for them (professionals) the normal birth was full of interventions, both on me and my son and I had already made my choices! (Mother 04)

> We were alone, unprepared, locked in a room and she (wife) in a lot of pain; I was very scared. For me it was traumatic. (Father 03)

> In fact, a bad experience is the hospital, where they treat you like meat and they don't give a darn! (Mother 01)

> I got to the hospital and they started: "Put on that little apron!". But would I stay in the hospital corridor with this little apron? I don't want that! There, we are treated like ETs (extraterrestrial)! (Mother 03)

> My son is not a chicken. I don't want him to be one more in this productive process. Because there will be no episiotomy, will they make other procedures on him (baby)? (Father 06)

Feeling safe at home birth

Among the motivations that led to the option of home delivery, the sense of security was fundamental. Confidence in the professionals, the existence of a gestation without intercurrences and the possibility of receiving support and affectionate care were highlighted in the speeches of couples. It is worth mentioning that through the initial desire to experience a more natural birth, the couples began to seek more information that could base and support their choices. In this sense, they started to participate in groups of alternative pregnant women, from the social network, to discuss possibilities, the pros and cons of this experience with friends and professionals, and in social media, which included videos, films and scientific articles.

> I researched and found information about humanized childbirth and it was then that I met the group of pregnant women and I started to learn about it. I joined the group and started researching. If you don't go deep and search, you will not succeed. (Mother 06)

> We studied a lot during pregnancy, read a lot of articles, and talked to a lot of people. It was not a passive choice, it was well studied! (Mother 04)

> I really started to wish for home birth when the movie Birth Reborn came out. (Mother 08)

> We searched the doula service here in the municipality, and through the girls we met the group of pregnant women, we started attending it and that's when we decided to give birth at home. (Mother 01)

Gestation occurs without adversity and the humanized professional care of quality and respect gave support to the option.

> It was a quiet gestation. I had nothing, no change, and no change of pressure, nothing that wouldn't lead to a quiet delivery. The doula and the obstetrician nurse were two sweethearts for me. (Mother 06)

> The hospital is not worthwhile for me. It would only be worth if there was any risk, that's my belief, but I wasn't at risk; indeed, there was nothing to go wrong, because my gestation was all right. (Mother 07)

> It was a low-risk pregnancy. (Mother 05)

> The staff supported me in everything, respecting all my requests that we had already discussed before, and it was wonderful! It was a birth with a lot of respect and lots of love. (Mother 01)

> What made all the difference was to the obstetric nurse, she was great! She's the one who stayed with us all the time. (Mother 02)

The desire and empowerment of women constituted a decisive factor in idealizing the realization of childbirth at home, while the support of the companion and other relatives was fundamental for the concretization of what was idealized.

> I always wanted to, because the decision is mine, after all! (Mother 01)

> It was my decision. From then on everyone supported it. (Mother 02)

> It's the woman who goes through the whole process. So, it's her wish, her dream; so, for me it was quiet. Do you want to do it at home? Let's do it at home. (Father 08)

> It was a natural thing for me; my mother had us in normal birth, my grandparents, everyone, so it was a natural thing to think about it. (Mother 05)

> We always wanted it in the most natural way possible. (Father 06)

> My wife is very involved in the issue of being born in the most natural way

possible and we realize that home birth was the most humanized manner. (Father 04)

The support and appreciation of the partner

Although the initial proposal came from the woman, the father played an important role throughout the process, from gestation to delivery.

> Their participation (family) was indispensable, especially that of my husband. Gosh, he supported me in everything: the form, the love, the respect, the support, all of it. (Mother 01)

> He (husband) was very calm. He had the sensitivity, both in my first delivery and in the second. He was indeed my support! He felt responsible for protecting me. (Mother 04)

> In humanized childbirth, in which the girls (the team that performs the home birth) came to my house, I participated in almost everything! I tried to accompany her throughout the prenatal care. We (men) must participate! (Father 03)

Couples expressed their joy at living this experience full of meanings, emotions and feelings. They attributed a sense of intense connection between the pairs to this moment. Moreover, they stated that, in the possibility of having future children, they would choose to give birth at home again.

> I told my wife that if we had a third child, it could only be this way, because everything went well. Her and my daughter's body did all the work. I think that even I could be the midwife! (laughs) (Father 04)

> The third child is not in our plans, but if it were, I would have it at home again! (Mother 03)

> I think everyone should go through this moment. Taking part in all this was unique to me! (Father 06)

DISCUSSION

The motivations that led the couples to choose PDP were singular and interrelated and involved, among other aspects, the fear of loss of autonomy in the hospital environment, the feeling of security in the home environment and the need for support from the partner. In this context, among the couples who had experienced a first delivery in the hospital, expressions predominated about the need to try something more natural, welcoming and respectful of the woman's body and the needs of the baby. The same desires were shared by those without previous experience. In both cases one can notice the influence of a lifestyle marked by healthier habits and a family history of (unplanned) childbirth at home. In this perspective, the environment and its characteristics can facilitate or disrupt the evolution of childbirth. However, over time, the birth went from a natural and physiological event that occurred at home, usually accompanied by relatives, to something pathological, full of medication and surgical interventions[4,9-10]. This context leads people to recognize the home as synonymous with warmth and security, and where the autonomy of women is respected and the evolution

of labor occurs naturally and is not threatened by external interruptions[4-5].

The need perceived by women is mainly due to previous experiences that have produced a sense of expropriation of one's own body, besides being based on a technical service, marked by the absence of human relationship, empathy, touch and affectivity. Such practice depersonalizes the parturient, who, at this moment, finds herself vulnerable, making her an object, incapable of exposing her wills and rights. Therefore, the couple's passive behavior, governed by professional norms and conditions imposed by the professionals, coupled with the practice of medicalization of childbirth, the impossibility of family participation, and even food restriction, generate traumatic references to childbirth in the hospital setting[1,11]. In this way, the negative effects of excessive use of technologies are immeasurable, since unjustified intervention triggers many others, whose results are not always favorable to the process of delivery and birth[4-5].

The hospital environment was defined by the interviewees as a "hostile place" in which a social relation that does not contemplate the needs of women in their process of giving birth predominates, making them feel excluded from something that naturally belongs to them[12]. Thus, the traumatic experience was one of the main justifications that stimulated the search for something that gave them another meaning about parturition. The fear related to the hospital environment was also identified in a study carried out in Sierra Leone, where it was found that among the population living in rural and low income areas, the fear of suffering humiliation and obstetric violence were the main reasons for choosing the delivery carried out by midwives at home[2,12].

In this sense, couples begin to search for information about a type of delivery that meets their needs and desires, especially regarding the principles of humanization and security for the mother-baby dyad[5], but also to support their choices. In this regard, their searches are effective, since there is evidence that in a gestation of habitual risk, giving birth at home represents less risks for the woman and the child[4-5].

The reports show that decision making was mediated by the search for information, in order to solve doubts and curiosities related to the paradigms surrounding home birth. Thus, access to consistent and scientifically based information, coupled with the reporting of positive experiences lived by others, even if unknown, and the opinion of professionals and trusted people, was essential for the couple to realize the option for this place of birth. This behavior corroborates what has been identified in the literature[12]. It is emphasized that when people have a more natural lifestyle and have socioeconomic conditions that allow them to bear the costs, the sharing of successful experiences is the driving force for the desire of a single and full delivery, besides providing major safety and well-being[4].

The desire to rescue the natural ability of the female body to perform natural childbirth, so desired and beneficial to the mother and the baby, was also the scope of the motivations for choosing this place of birth. Indeed, women yearn for respect to their specificities, their bodies and the physiology of delivery and birth, which is intrinsic in each[5]. In this aspect, it is worth noting that, although positive results are attributed to this model of attention to delivery, characteristics and attitudes of women, such as determination and culture, also play a relevant role. However, it is the empowerment that allows them to debate and firm their choices[2,13].

This empowerment is built even before gestation, as a woman takes responsibility for

ensuring her reproductive health, adopting responsible choices, demanding her rights and advocating for paradigm shifts in relation to her role in society[2]. These convictions make women more confident and well-prepared for the birth of their children, providing a sense of control over their destiny, as well as active participation in decision-making related to their experiences[2,9,14].

In this sense, it is up to health professionals to assist women in the decision-making process on the type of delivery, valuing their choices, respecting their rights, autonomy, culture and beliefs. It is also up to the professionals to promote a care centered on the needs of women in the puerperal pregnancy period, transcending contractual approaches in the professional--client relationship, rather than merely considering the legal standard of informed consent as an instrument of people's autonomy[9,12,15].

For the couples under study, the option for PDP was personified in the woman, and the partners agreed, supported and shared the decision. They related respect to the will of the partner, they understood that the autonomy over the female body belongs to the woman, and that the fundamental role of the partner, in these cases, is to offer support and security[16-17]. Furthermore, the support of the companion proved to be fundamental for the concretization of the birth in the family environment and contributed to the full experience of the feelings related to childbirth.

Such finding reveals the beginning of changes in the paradigms and roles developed by men and women in Brazilian society, because, in some countries, gender limits the right of women to choose the type and place of birth[2,12].

In this perspective, besides the benefits conferred to the health of the mother and the baby, the domicile allows the greater involvement not only of the father, but of the children and the other members of the family. In this aspect, the findings confirm the hypothesis that the domestic environment contributes to the strengthening of social relations, rescuing the protagonism of individuals during parturition[17-18]. It is possible for this loco to integrate components that refer to warmth, welcoming, familiarity and a sense of security, stimulating women to express their needs and to be authentic in their behavior. Thus, this environment induces the professionals to adapt the care to the family, making the health practices become increasingly humanized and holistic[10,11].

Another important but usually neglected aspect concerns the positive effect of this experience on future births, since, when experiencing childbirth in the home environment, women are able to plan, with greater propriety and safety, future births, reducing the possibility of unnecessary interventions[19].

Finally, the "act of giving birth" has become a rite of passage that, when it occurs at home, allows the woman and her family to have a unique experience, marked by the strengthening of family ties and the feeling of fullness and satisfaction with the success of the event. And for women with previous experience in the hospital environment, home birth allows for overcoming of disappointments and fears, as well as self-assertion about something that has been said to them that they would be unable to perform[18,11].

It is worth mentioning that the couples interviewed had similar sociodemographic characteristics, but distinct from the majority of the population, because they have high socioeconomic conditions and high schooling. This particularity favors the option for this assistance, since the cost of it is high and is not yet offered by the public health services

in Brazil. However, their results may contribute to the improvement of obstetric care, since they show that the desire for a home birth is triggered in part by dissatisfaction and frustration with previous hospital experience, marked by impersonality, disrespect for female autonomy and the imposition of interventions and routines.

CONCLUSION

The results of the study show that the motivations of the couples who opted for the PDP were initially related to the fear of women losing autonomy over their own bodies in the hospital environment - motivated or not by a traumatic experience and their desire to experience a unique and natural parturition. The initial desire is strengthened with the support of the partner and is consolidated from the access to information that shows the beneficial results of this experience, the verification of a gestation without intercurrences, confidence in the team that accompanies the couple in this trajectory and, finally, the female empowerment to make the choice. It is noteworthy that all families were satisfied with the experience.

The data also point out that it is necessary for health professionals, especially nurses to reproduce care, to attend to the specifics of the couple, respecting their autonomy, choices, culture and beliefs, so that they can dispense care that encompasses the real demands of these families, incorporating the holistic and humanized vision in the assistance provided during the reproduction process.

It is suggested that future research should approach health professionals so that beliefs, perspectives, fears and stigmas regarding the PDP can be better discussed and, thus, provide support to a differentiated obstetric action, and that this experience can be provided to a greater number of families.

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