

Being born at home is natural: care rituals for home birth

Natural nascer em casa: rituais de cuidado para o parto domiciliar

Natural nacer en casa: rituales de cuidado para el parto en casa

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ABSTRACT

Objective: To be aware of the care rituals developed by families when preparing for home birth during the gestational process. **Method:** Qualitative and ethnographic research developed with families during the gestational process. We adopted the observation-participation-reflection model, and the analysis was performed according to ethnonursing. **Results:** Care rituals are related to the choice of home as a place for childbirth, being characterized as a family's rite of separation to experience this process. Other care rituals involved the preparation of the family and the eldest child as well as the home, the body, and the mind of the pregnant woman, and the choice of destination of the placenta. **Final considerations:** We must understand the birth process beyond the biological perspective, considering women and their family as a whole, within a cultural context with their beliefs and values. **Descriptors:** Women's Health; Childbirth; Family; Culture; Ceremonial Behavior.

RESUMO

Objetivo: Conhecer os rituais de cuidado desenvolvidos pelas famílias na preparação para o parto domiciliar durante o processo gestacional. **Método:** Pesquisa qualitativa e etnográfica desenvolvida com famílias durante o processo gestacional. Foi adotado o modelo de observação-participação-reflexão, e a análise foi feita de acordo com a etnoenfermagem. **Resultados:** Os rituais de cuidado estão ligados à escolha do domicílio como local para o parto, caracterizando-se como um ritual de separação da família para a vivência desse processo. Outros rituais de cuidado envolveram a preparação da família e do filho mais velho, bem como do domicílio, do corpo e da mente da mulher, e a escolha do destino da placenta. **Considerações finais:** É preciso compreender o processo parturitivo além da perspectiva biológica, considerando a mulher e a família no seu todo, inseridos em um contexto cultural com suas crenças e valores.

Descritores: Saúde da Mulher; Parto; Família; Cultura; Comportamento Ritualístico.

RESUMEN

Objetivo: Conocer los rituales de cuidado desarrollados por las familias en la preparación para el parto en casa durante el proceso gestacional. **Método:** Investigación cualitativa y etnográfica desarrollada con familias durante el proceso gestacional. Ha sido adoptado el modelo de observación-participación-reflexión, y el análisis ha sido hecho de acuerdo con la etnoenfermería. **Resultados:** Los rituales de cuidado están vinculados a la decisión del domicilio como el sitio para el parto, caracterizándose como un ritual de separación de la familia para la vivencia de ese proceso. Otros rituales de cuidado han involucrado la preparación de la familia y del hijo mayor, así como del domicilio, del cuerpo y de la mente de la mujer, y la decisión del destino de la placenta. **Consideraciones finales:** Es necesario comprender el proceso parturitivo además de la perspectiva biológica, considerando la mujer y la familia en sus términos generales, insertados en un contexto cultural con sus creencias y valores.

Descriptores: Salud de la Mujer; Parto; Familia; Cultura; Conducta Ceremonial.

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INTRODUCTION

For a long time, childbirths occurred predominantly at home, which, overall, was regarded as natural by society. The childbirth process consisted of a rite of passage for women and their families⁽¹⁾, and not a medical act. From the World War II onwards, with the rise of institutionalized maternities, the childbirth process began to involve strict routines in hospital environments, in which the women's individuality was no longer considered. Before the institutionalization of labor, procedures such as episiotomy, shaving, enema, and childbirth induction began to be routinely adopted, without these practices being previously evaluated by scientific evidence⁽²⁻³⁾.

Such excess of interventions, in addition to the impersonality of health professionals and the high demand of work, attributed new meanings to obstetric care⁽⁴⁾, which quickly reverberated in the dehumanization of the care and in situations of obstetric violence⁽³⁾. Therefore, changes in the childbirth process have been sought through medicalization⁽⁵⁾.

Several efforts have been made to improve the current obstetric care model and to encourage less interventionist practices, but these initiatives aiming at humanization of labor and birth have been insufficient, since the care remains focused on the biomedical and technocratic model⁽⁶⁾.

Women and their families, in addition to many health professionals – with special emphasis on nurses –, have claimed the qualification of the care services to women during the childbirth process⁽⁴⁾. We infer that such qualification may improve maternal health and, consequently, achieve the fifth Millennium Development Goal (MDG): the reduction of maternal mortality and universal access to reproductive health⁽⁵⁾.

Women's dissatisfaction with the treatment received in obstetric care has been causing a movement of reconsidering childbirth as a physiological, female, familiar, and social event. Increasingly, women have claimed the right to childbirth as a pleasurable and human experience, trying to distance themselves from the fragmented care model, characterized by medicalization and iatrogenic interventions against the woman and the fetus⁽⁶⁾.

In addition to vaginal birth, we observe that women are increasingly opting for the experience of home birth, even though this is a new trend⁽⁷⁾. Propagation of information, mainly via the internet, actions from the public policies that advocate the humanization of labor and childbirth, and dissemination of studies based on scientific evidence on the obstetric field have favored the choice of home birth⁽³⁾. Regardless of the care model, we highlight the importance of surpassing the conception of labor as a biological event, also considering social, emotional, subjective⁽⁸⁾, familiar, and cultural aspects involved in this process. We developed our study based on theories of authors who study care rituals^(1,9-10) from the anthropological perspective⁽¹¹⁾. We present in this article results from a PhD dissertation, to which we directed the research question: "which are the care rituals developed by the family when preparing for home birth?".

OBJECTIVE

To be aware of the care rituals developed by families, during the gestational process, when preparing for home birth.

METHOD

Ethical aspects

During data production, the rigor criteria adopted were confirmability, recurring patterns, saturation, the meaning in context, and transferability⁽¹¹⁾, in addition to the Consolidated Criteria for Reporting Qualitative Studies (COREQ) checklist. Confirmability was obtained through data repetition or explanations provided by informants about certain information⁽¹¹⁾ and/or on their own care rituals. During production, when finding the informants, the researcher confirmed the interpretations, without disregarding the emic perspective.

Patterns, topics, and actions that repeated over time, that is, the recurring patterns, also attributed rigor to the study⁽¹¹⁾, since they reflected in care rituals standardized and verified in the focus of the study. On the other hand, saturation was a basis adopted for the interruption of production, since, considering the circularity of the data obtained with the informers, it was observed that there was no new rituals that could emerge from the analyzed speeches or situations⁽¹¹⁾.

Regarding "meaning in context," it is understood that it includes significant and relevant data for the informants in the context in which they live⁽¹¹⁾. Therefore, during the validation of results, we sought to ensure that information on the care rituals developed by the families, gathered by observations or interviews, would be interpreted considering the context in which such rituals were developed.

Finally, transferability is related to the possibility of applying the results of our survey to another context. It is considered that the totality of this ethnography cannot be transferred to other contexts, since care rituals are local and their meanings are not definitive, being influenced by the places and contexts in which individuals are inserted. However, our results can be used as theoretical reference for the care of families from the understanding of cultural meanings of care rituals.

The research was performed according to Resolution no. 466/2012 of the Brazilian Council of Health. The project was submitted to the Research with Human Beings Ethics Committee of the Federal University of Santa Maria and was approved on April 18, 2016. An Informed Consent Form was prepared by the authors and signed by the informants. The informants, throughout the research, were named with the letters "KI" (key informant) and "GI" (general informant), followed by a number.

Type of study

The study is classified as a qualitative and ethnographic research⁽¹¹⁾.

Study location

The study was carried out in a medium-sized city in the state of Rio Grande do Sul, Brazil, and comprised a general scope that involved a group of pregnant women. On the other

hand, the focused scopes were the homes of the families, the place in which the Baby Shower of one of the informants took place, and the doctor's office where two informants attended prenatal consultations.

Population, inclusion and exclusion criteria

The study was performed with three families during the gestational process, which were intentionally selected. There were eleven informants, of which six were key informants and five were general informants. Key informants were pregnant women and their partners, and general informants were four nurses (founders of a group of pregnant women) and an obstetrician (who accompanied two of the informants). Inclusion criteria were the families of pregnant women participating in the group of expecting mothers. No exclusion criteria were employed to select informants. It is noteworthy that, throughout data production, other families were invited to participate in the study, but they refused to.

Data collection and organization

The data production period lasted 9 months during 2016, with 94 hours of observation added to hours of interviews, which ranged from 1 to 2 hours with each family. The ethnographic study started from the contact established between the researcher, PhD student of the nursing program, and the founders of a group of pregnant women of a municipality in southern Brazil. They are nurses who, in addition to providing monthly meetings to pregnant women and their families, also provide care to home birth.

We adopted the observation-participation-reflection (OPR) model⁽¹¹⁾, which assisted the researcher to gradually penetrate and remain in the cultural context of the informants. The OPR model consists of four steps: 1) observation; 2) observation with some participation; 3) participation with some observation; and 4) reflective observation.

The first step⁽¹¹⁾ consisted in entering the field, where the researcher was informed about the cultural context in which the informants were inserted in order to have a broad, close, and objective vision of their culture through participation in meetings of the group. At this stage, she basically used face-to-face observation and listening, trying to establish contact with informants mainly from meetings and social networks. Gradually, she noted the most important details of the object of study, distant from the phenomenon, but attentive to the reports of families about their cultural context.

In the second step, after the invitation and acceptance of families, the researcher took part in the observed contexts. Hence, she began learning a little more about the home context and the routine of the family, distinguishing the most relevant issues to the study, at a time in which observation became more focused. The researcher participated in prenatal consultations, both at the doctor's office and at home, with the team of nurse-midwives. She was also at the Baby Shower of one of the informants who has invited her. Thus, the researcher started having a greater interaction with the informants and a more detailed observation about the care rituals developed by the family. Informants in the cultural context comprised the focus⁽¹¹⁾.

In the third stage, although maintaining observation, participation became more active. When asked, the researcher participated in the care rituals, contributing in the activities carried out and grasping the feelings and experiences of informants. Throughout the meetings, the informants approached the researcher for informal conversations in which they told personal information regarding pregnancy and shared their anxieties, joys, and doubts. She expressed and kept interaction with the informants, without losing focus on what took place in the cultural context regarding the care rituals. The approximation with the informants helped in understanding the studied phenomenon from the emic perspective. Thus, it was possible to recognize repeated patterns in the analyzed families as well as to identify unique and also random incidences. At this time, it was also possible to carry out face-to-face interviews, focusing on care rituals in their cultural context⁽¹¹⁾.

The last step was leaving the field; the researcher directed her attention to the events aiming to recap the experience with informants, reflecting on the whole process of data production and evaluating the findings. The focus of this stage was the analysis of the whole process. Such step was recorded in audio and consisted in the time the researcher retook pending questions and validated the results with the informants⁽¹¹⁾. Over the course of the meetings, the researcher informally introduced, during the conversation, some questions to confirm data and interpretations. These conversations were recorded in the field journal.

Data analysis

We performed the analysis according to ethnonursing⁽¹¹⁾. In the first step, we carried out data production and the description and documentation of observations of the field journal and the interviews, seeking to identify symbols and contextual meanings⁽¹¹⁾. Then, we read and reread all data to identify the care rituals found, resolve doubts with informants, and perform the final analysis. In this step, from the point of view of informants (emic perspective) and of the theoretical reference (etic perspective)⁽¹¹⁾, we sought to verify the symbols and contextual meanings related to the care rituals.

The second stage involved the identification and categorization of descriptors (emic and etic) and components to encode and classify data. Whereas the emic descriptors, which refer to how individuals express their experiences, were studied considering the context, similarities, and differences, the recurring components were examined considering their meanings, from the etic perspective⁽¹¹⁾. Information and interpretations of the researcher were confirmed with the key informants, seeking the emic perspective as basis. We considered the etic perspective to analyze and interpret the findings.

In the third stage, we performed the analysis of contexts and recurring patterns. Data were analyzed to identify the saturation of ideas and recurring patterns of meanings, in addition to interpretations or similar and divergent explanations of data⁽¹¹⁾ associated with care rituals. Recurring patterns involve topics and actions that are repeated, which enable us to perceive the standardized behaviors found in the study scope. On the other hand, saturation means that we can know or understand

everything related to the studied phenomenon. Grouping of the recurring patterns from their identification and contextual analysis allowed disclosing care rituals, the experiences of each informant, and the cultural approach of these situations.

The fourth step encompassed synthesis and interpretation. We synthesized and interpreted the main topics, research results, recommendations, and even new theoretical formulations⁽¹¹⁾. In this stage, from the synthesis, analysis, interpretation, and formulation, the researcher focused on the survey results, considering all previous steps.

RESULTS

The analytical process resulted in the identification of four cultural patterns: 1) "I've always wanted to have a natural childbirth": choice of delivery method; 2) "Her dream will be mine as well": family's nuances in the experience of home birth; 3) "Everything is planned, all the material that is required": rituals for preparing the home for childbirth; and 4) "There is always positive thinking": care rituals when preparing pregnant women to home birth.

The first pattern regards the choice of the delivery method, especially home birth assisted by nurse-midwives. The second involves the support of the family concerning home birth. The third comprises the home preparation for childbirth and the arrival of the baby. The fourth pattern includes the preparation of body and mind of the pregnant woman to the experience of home birth. From these cultural patterns, the theme of this article emerged: "Preparation for home birth: care rituals developed by families".

"I've always wanted to have a natural childbirth": choice of delivery method

The preparation for childbirth and the development of care rituals begin with the choice of delivery method, based on previous experiences, family reports and experiences, and knowledge shared throughout the life of each informant. In our study, we found that families initially craved for experiencing vaginal birth. During the sharing of experiences, in meetings with the group of pregnant women, they learned about home birth and the team of nurse-midwives who work in the municipality. Thus, they started idealizing such event.

I've always wanted to have a natural childbirth, always. [...] I'll have a child, I'll be a mother, I'll have a natural childbirth. [...] When the [first child] was born, he [partner] said: "the next one will be born at home," and I said: "But how? Where? There's no team, there's no way." (K13)

Key informant 1 details the birth of the first child. [...] She points out that the caesarean section was not a negative experience, but she has always craved for the childbirth experience, specifically the planned home birth. However, she thought it was something very far from her reality due to the absence of a team that could assist her. In the current pregnancy, with the support of the nurse-midwives team, she perceives the experience of home birth as something concrete. (Field journal)

The choice of vaginal birth and/or planned home birth as delivery method proved to be a woman's desire and, in some cases, a choice shared with her partner. Such decision derived from knowledge shared with the group of pregnant women and with other women, or from previous concerns and experiences. In this space, informants could expose their personal experiences within the pregnancy-puerperal cycle period and with the care of health professionals and institutions. During the meetings, they became aware of the group of nurse-midwives and started considering the possibility to experience childbirth in their own home.

I just wanted a natural childbirth and I talked to some professionals who I trusted. I was looking someone who were less interventionist. I talked to a doctor, to a pediatrician. [...] I talked to [a doctor] after the consultation only once to find out what I could take, because I had migraine crises during pregnancy. [...] My support network is composed mostly by the girls [team of nurse-midwives]. They answer my questions and dispel my fears. They calm me [...] because the gestation of my [firstborn] was very peaceful, I didn't give thought and now I guess I'm more rational. We think hard about problems and it happens [...] They [nurse-midwives] make me feel safe, we talk a lot. I look for them a lot for us to talk. (K11)

Craving for a less interventionist assistance, pregnant women seek recommendations of other women, talking to health care professionals or institutions in favor of the experience of the natural and physiological childbirth. In this context, they find the nurse-midwives who work in the municipality, who provide pregnant women and their families a new possibility of childbirth assistance, based on the protagonism and autonomy of individuals.

The informants justify their choice of vaginal birth based on the perception of this event as a natural physiological process. When referring to childbirth in hospitals, they express their dissatisfaction with the model provided in this scenario and stress home birth as a secure care model, focused on women's needs.

The idea itself is beautiful [the idea of home birth]. I think everyone likes the idea of having the child at home, a child born in your own home. This is a natural thing, it's not a mechanical thing, to push it out, to cut it. (K12)

According to the families of key informants 3 and 6, vaginal birth is the most common delivery method. They say that, in the past, vaginal birth was "the normal thing" [...] She points out that this was a strictly familiar experience, and that the doctor didn't participate and wasn't even aware of such experience. (Field journal)

I want home birth, because it make me feel safe. For me, it's very natural [...] I worry a lot about hospital routines. I mentioned to the girls [nurses of the team], in the last consultation, that it's more about the baby, because of the routine, the baby is taken away from us, we need to feed them NAN formulas without their [the hospital staff] knowledge. I think it's very "cold." I didn't want the [baby] to go through this. So, we are planning to stay at home, too, is more because of her, because, for me, my c-section [in previous pregnancy] was ok, it wasn't that traumatic, but it's more about the baby. (K11)

The informants reinforce their dissatisfaction with the care provided in health institutions, revealing that this environment prioritizes rules, procedures, and routines without considering the available scientific evidence on their real need or efficiency. They reinterpret past experiences, revealing situations they wish to avoid or to have experienced in more intimate and familiar way. Hence, the hospital environment starts leading to frustrations, and the home becomes an option consistent with the desire of these families.

“Her dream will be mine as well”: family’s nuances in the experience of home birth

The partner’s support emerged as an important aspect for the choice of home birth. Informants mention how such choice was told to the family and their reaction about it.

She’s always wanted natural childbirth, it was her wish. [...] I’ve always tried to support her and not to be against it [...] If it’s her dream, it will be my dream as well. [...] It’s a once-in-a-lifetime moment, we know that today few people are able to get through this, to be in your own home, with people you want to be there, people you trust to be there for the baby’s arrival. (K14)

He really trusts in me and I know that he also trusts in our team. [...] That’s what reassures me the most. [...] My support is knowing that he understands everything and I always say that [...] if anything happens, he knows that it was my choice, our choice, and that’s what is best for us. There’s no one to blame. (K11)

In a conversation, key informants 2 and 5 highlight that the choice of home birth was made by the couple, in common agreement. They report that their families know about the decision and claimed that there was no resistance, only surprise of some family members. (Field journal)

However, we identified some confrontations experienced by informants on the revelation of the desire by home birth. They highlight the perceptions of society and of health professionals, in particular the obstetrician’s, regarding the choice of home birth.

At first the idea of giving birth at home is kind of weird, for everyone. We explain that all the required material is part of the process. It’s still a new thing. (K11)

I say I’m going to try home birth and people imagine a pair of scissors, a candle, and towels. (K12)

Key informant 2 reports that, during a prenatal consultation with an obstetrician, she mentioned that she has decided the delivery method and that, in addition to vaginal birth, she would like to give birth in her own home. On the occasion, the obstetrician emphasized the risks of this decision and stated that she could die. She points out that he tried to scare her, he wondered if her partner and the rest of the family were aware of her choice and asked her about their opinion. While questioning her, she claims that he tried to convey the idea that the decision about her body and the

delivery method was not exclusively hers, but that it should be discussed with her parents and/or her partner. She mentions that he tried to argue a few times and to persuade her to undertake a cesarean section, always highlighting the risks of home birth. (Field journal)

Home birth encounters a resistance that a c-section would never do, it would never be questioned. If you want to do it differently you have to know what you’re up against. You’ll only be sure that you made the right decision after it’s all over. (K15)

Despite confrontations and impositions, the informants were convinced of their decision. Women, in particular, remained confident about their ability to give birth, whether in the institutional environment or not. Due to negative perceptions and conflicts, informants have opted for the preparation of some family members and friends in such a way they could become allies in the process.

*Key informant 2 mentions that, on a weekend, she watched the documentary *O renascimento do parto* [The rebirth of childbirth] with her father, her stepmother, and her best friend. She has been talking with them about humanized childbirth and home birth. (Field journal)*

In addition, rituals for preparing the eldest child to the experience of home birth were also discussed. Among the multiparous families, there was a concern with the reaction of this child during the labor process.

Throughout pregnancy, key informants 1 and 4 have talked with their eldest child about the childbirth, especially about the home birth. They talk about the videos and reports of childbirth, detailing how this process occurs. Key informant 1 states that her son has never questioned the reason for the choice of home birth. However, she still fears for his reaction, especially when seeing her with pain during labor [...] She talks with her child about the delivery methods. [...] She remembers that, initially, he said that she should go to the hospital, and the idea of home birth was confusing to him. However, today, he has a different understanding. (Field journal)

It’s a healthy thing. Actually, we’ve lost it [the idea of home birth]. Although, in the past, kids wouldn’t join the labor room, they experienced this preparation for childbirth. [...] So, I think it can be a very good experience, by reading reports on the internet, the brothers are together, because of the family bond, you know. (K11)

The first surprise was when I showed him the home birth video, because sometimes we have this prejudice with blood, pain, yelling. It’s ugly, it’s scary, but he reacted very well [...] I really want him [the eldest son] to see her [the baby] being born, because I think this understanding will be much easier than if he gets at home and there’s a baby. (K13)

The families used films and reports as rituals for preparing the eldest child for home birth, because they understand the need to familiarize them with the labor process. Families highlight the importance to include the eldest children, because

they understand their participation may collaborate to create a bond with the baby.

**“Everything is planned, all the material that is required”:
rituals for preparing the home for childbirth**

It is possible to identify care rituals to help the woman and her baby during the labor process. Among these, preparing the materials to be used during childbirth assistance is highlighted.

Everything is planned, all the material you need. [...] Who knows what we'll want when the time comes? (K11)

Among the materials selected for the labor, key informant 1 reports she bought lavender oil, because she believes it stimulates contractions. Furthermore, she thinks that low light and music therapy may help her to remain calm during labor. She points out she will not use color therapy and that she's not used to listening to music, but she thinks that some music can calm her, especially in the expulsion stage. (Field journal)

Key informant 2 key will control the lights through window shutters and the lamp in the living room. She also highlights that she selected a few songs she'd like to listen [...] and that the swimming pool will be placed in the living room. In the room, there will be a couch so she can lie down if she wants, and a desk, in which the material required by the team will be placed. (Field journal)

Key informant 3 wants to decrease the lights of the house, especially in the room where she will give birth. She plans to use a lamp which she uses overnight in her room. The swimming pool will be assembled in the room to have more privacy and so that she can feel more comfortable. (Field journal)

Although acknowledging that preparations for home birth could be nothing more than plans or assumptions, the families have outlined some care rituals involving materials and methods that the informants considered helpful in the labor process such as the lavender oil, low light, and music therapy. These rituals seem to be intensified in the days preceding childbirth. Among these, one of the informants is concerned about cleaning the place, in order to ensure a “clean” environment for the baby's arrival.

Cleaning the house is something that I've been doing every day [...] For two, three weeks, it seems that you have to do it today, because if she is born tomorrow I won't be able to do what I have to do. (K12)

Another care ritual mentioned in the conversations with key informants regarded the proper nutrition for the labor day, as well as for the following days, in which the family is focused primarily on the care of the puerpera and the newborn. Each family has developed a ritual in relation to food to be consumed during this period.

In the fridge of key informant 1 there was a soup, because she believes that this food will be needed in the postpartum period, since it is an “energetic” food. (Field journal)

I asked [the best friend] to make coffee or tea, we must have something to dish out to people. [...] I'm very worried about food, what I'll be willing to eat at the day, it looks like it's a party [laughs]. (K12)

Key informant 3 reinforces that she stored snacks, cookies, cereal and chocolate bars in the kitchen for childbirth. In the freezer, she stored cheese bread and soup. (Field journal)

These and other care rituals were mentioned by informants in the birth plan. This document was requested by the nurse-midwives team so that families could express their desires and expectations regarding the childbirth.

With 39 weeks of gestation, general informants 1 and 2 asked key informant 1 about her birth plan. She acknowledges that the ideal was preparing two plans, one for home birth and another for hospital birth. She states that she has not elaborated any of the plans yet. She claims that the nurses know how she wants the home birth to be conducted. (Field journal)

n the prenatal consultation, general informant 3 asked the couple about the elaboration of the birth plan. Key informant 2 states that she and her partner have practically concluded the birth plan. [...] She highlights some scientific terms or care practices that raised doubts. [...] General informant 3 clarifies the couple. [...] Key informant 2 says that she read the birth plan to her father, her stepmother, and her best friend in such a way they were aware of her wishes and her partner's in relation to childbirth. (Field journal. K12, K15, G13)

During this rite of separation and passage, key informants chose the individuals who could participate in the childbirth experience. This information was in the birth plan, but it has also been communicated to the team of nurses, family members, and friends.

Key informant 3 points out that, after the childbirth, she aims to share the news with family and friends. However, during the labor process, she does not want anyone, besides the team, to be informed, in order to avoid personal, telephone, and/or virtual interferences. (Field journal)

Key informant 2 reads the home birth plan and the hospital birth plan, which she called “plan B.” In the reading, she indicates people who can participate. [...] Below the names of these people, she reads the detailed job of each person during the labor. (Field journal)

People still think it's weird, but my family knows that I'm not going to call anyone, that the plan is to be only me, my partner, my son, and the nurses that will assist me. (K11)

Another care ritual planned by the families involved the destination of the placenta, after its expulsion. For one of the families, the placenta did not have a special meaning, while others were interested in performing specific rituals.

The key informant shows the cardboard she bought to do the “placenta print.” According to her, the print works as a “rubber stamp.” To do the print, she explains that, after the

placenta expulsion, you should dunk it in the own blood or in ink, and then displace the umbilical cord and the placenta on the cardboard. She states she will frame this print, and then she intends to plant the placenta in a vase, which she has already purchased. In this vase, she will plant the placenta and, above it, a fruit tree seedling. (Field journal)

Key informant 1 reveals she intends to freeze the placenta in the fridge so they can plant it in the roots of a tree in the backyard of her parents-in-law's house. (Field journal)

“There is always positive thinking”: care rituals when preparing pregnant women to home birth

In addition to all the preparations of the home and the family, women and their partners also developed care rituals when preparing for home birth. These rituals involved the pregnant women and, in some moments, the couple.

Key informant 3 states that she started walking because she believes that this practice assists in the cervical dilation. Her partner walks with her. (Field journal)

From the 34th week, I started using EPI-NO [device used in the preparation of the vaginal and perineal muscles for childbirth and postpartum], but I think it's more effective to massage the perineum. At the beginning it's a little uncomfortable, it's weird, but the massage itself is good. My partner does it. (K11)

The pregnant woman [K11] have been taking clove and cinnamon tea to stimulate contractions. (Field journal)

I want to get out, to walk. [...] I know that it will help the labor process. I'm eating foods that help to stimulate contractions. There's no proof, but I'm eating pineapple, cinnamon, spicy things. (K12)

The preparation of pregnant women to home birth involved the preparation of the body, by walking, the use of devices to assist in the preparation of vaginal and perineal muscles, and the ingestion of food or teas to stimulate uterine contractions. We perceive, in these rituals, the idea that women need to prepare their bodies for home birth. At the same time, care rituals for the mind also emerged, from positive thoughts, dreams, and predictions about the birth.

The plan is to give birth at home, but if I have to be transferred, I'm ok with that. [...] But the thought is always positive. (K11)

I dream about her [the baby] almost every night [...] she has already been born or [the labor] is happening. [...] Grandma told me that the Moon when I got pregnant was the Moon of birth. [...] I checked the date of my last period, it was in New Moon, and there will be the same Moon on the 10th, and the baby will be born in this Moon. [...] I thought this last week: “does it have to do with childbirth? Could it be the nerves?” [...] I realized my immunity decreased, because I've got oral herpes, I've got a cold, and it had never happened during pregnancy. I was hung up about it. (K12)

DISCUSSION

The knowledge acquisition of the families was established, in our study, as a tool to support decision-making, since this strategy is the most appropriate way for claiming and achieving a safer and more respectful delivery method within the Brazilian reality^(7,12). Other factors, such as education, socioeconomic conditions, life story, childbirth reports shared between generations (or childbirths experienced with family and friends), knowledge and stories about the conditions of childbirth assistance and access to information⁽¹³⁾, in addition to previous experiences, medical power and that of the own family's, lack of dialogue in prenatal care, interest, curiosity, and the cultural basis influence the choice of vaginal birth⁽¹⁴⁾.

Regarding education, we emphasize that pregnant women, key informants of the study, held a college degree, and two of them were also doulas; as for the partners, two held a college degree, and one held a high school degree; the three families have expressed a desire for home birth planned and assisted by nurse-midwives. These data corroborate the findings of Feyer, Monticelli and Knobel⁽¹⁵⁾, according to which most of the couples who opted for home birth held a college degree, and, as it was also verified in our study, had complementary health insurance plans, carrying out prenatal care with physicians from such plans.

In this perspective, the authors highlight that having complementary health insurance plans and still opting for home birth assisted by nurse-midwives reveals the real desire for this care model⁽¹⁵⁾. Although with conditions of performing labor in private institutions, if they wanted only the experience of childbirth itself, couples still have opted for home as the place for giving birth.

Thus, the option for assisted home birth is not due to lack of information, rebellion, or a passing fad, but because these families know, analyze, and question the Brazilian obstetric care model in all aspects, procedures, and routines. Therefore, when faced with obstacles and setbacks involved in childbirth assistance in institutionalized contexts, they state with consistency, clarity, and knowledge the choice for home birth^(7,12).

When preparing for this moment, the families seek health professionals and services that can ensure this experience, while respecting and valuing their expectations and desires. When having this information, women reveal the need to be assisted by health professionals who believe in their ability to give birth naturally⁽⁷⁾, seeking for spaces to socialize their experiences and, at the same time, to identify skilled professionals willing to stimulate and promote their autonomy during the labor process.

The desire for a less interventionist care, lack of autonomy, and the fear of not being in control during the labor experience provoke in women and their partners the need to find strategies to change this reality and experience this moment in a more humanized way, thus seeking health professionals who effectively believe in their potential to give birth and who allow them to make their choice in a shared way⁽⁷⁾.

We also observed the dissatisfaction with the assistance provided in health institutions, in which women did not agree with the hospital delivery model, questioning the institutional

procedures and routines, not identifying with the care logistics and associating the hospital with diseases⁽⁷⁾.

Regarding the hospital environment, in another study⁽⁷⁾, informants mentioned the impossibility of other family members to experience the childbirth, lack of intimacy and hospitality, coldness and impersonality of relationships, lack of familiarity with the environment, external interferences with the labor process, separation between mother and baby at birth, performance of procedures not recommended during when welcoming the newborn, in addition to the excessive and inconsistent bureaucracy with the labor.

The choice of home birth is made considering the differentiated information concerning the safety of this procedure for the mother and the baby, and also aiming the demedicalization of such experience⁽¹²⁾, in a set of ideas that are opposed to the current hegemonic model, which is centered on the figure of the doctor and/or unnecessary practices and interventions of a scope able to depersonalize individuals. Hence, home is seen as an environment that provides seclusion and introspection for the woman and the family in the labor experience⁽¹⁰⁾.

This option reveals itself as a rite of separation, because it resembles the ceremonies of seclusion of the pregnant woman, which often take place in shacks or in peculiar places of the house⁽¹⁾, in order to promote privacy for her and the family to experience the birth in an intimate and locally significant way. Home also represents rebirth and revitalization of this process as an essentially familiar event⁽¹⁰⁾ in addition to, according to one of the informants and supported by another study⁽¹⁵⁾, be interpreted as a safe place for the labor experience. Evidence shows that the assistance provided by nurse-midwives to the usually risky home birth has lower rates of intervention, greater satisfaction of women, and is considered as safe as the hospital birth^(5,7).

The informants understand that home birth provides the resumption of their protagonism; therefore, women claim for themselves their own childbirth and control over their body by the opportunity to safely make their choices⁽⁸⁾, in addition to being a way to restore the intimacy and privacy of the birth process in the family context⁽¹⁵⁾, also configuring a welcoming environment related to the lifestyle of the family^(8,10,16).

Thus, the partner's support was reinforced as a fundamental aspect to the decision and idealization of the home birth. More than partners, they can play an active role⁽¹⁰⁾, experiencing childbirth as a rite of passage in which they "are born" as fathers⁽¹⁾ and reaffirm their equal partnership with their female partners⁽¹⁰⁾.

Moreover, labor represents a rite of passage⁽¹⁾ for the entire family, and thus the woman needs a support network that encourages her in this process. Hence, we understand the informants' need to report the family about the choice of home birth, to provide confidence, tranquility, and affection, and encourage a positive outcome⁽⁸⁾.

In addition to the support, we also verified some confrontations on the part of the family. When facing these negative perceptions, the mothers have developed rites of separation⁽¹⁾, breaking, even if temporarily, the bonds established with some individuals of their social network, and thus breaking a social structure and/or a set of cultural conditions. Authors explain

that this rupture reaffirms the idea that decisions regarding the labor and the birth processes concern only the family intimacy, not requiring external interference⁽¹⁰⁾.

In the current context, in which the care model is predominantly technocratic and based on explanations and procedures of biomedical rationality, families who opt for home birth face conflicts with friends, family, health professionals, and society as a whole to reassure their decision⁽¹⁶⁾. At the same time, the education of obstetricians is usually directed to complications and high-risk pregnancies, which hinders their acceptance regarding home birth even in pregnancies with the expected risk. Therefore, normally, doctors turn to technology and interventions such as in the case of the caesarean section⁽¹⁴⁾.

We highlight the importance of the family's support to the experience of this rite of passage at home, since their participation in childbirth is one of the prerogatives to recover birth humanization⁽⁸⁾. Accordingly, one of the informants used the documentary *O renascimento do parto* ['The Birth Reborn'] to demonstrate to her father, her stepmother, and her best friend scientific evidence on the safety of home birth.

This strategy was identified in a study in which women used the documentary aiming to deconstruct the family's perceptions about the planned home birth and to raise reflections on the current model of the predominantly interventionist obstetric assistance⁽³⁾, demonstrating that they analyze all the possibilities and share them with whom they keep affective bonds and trust^(10,16).

Rituals for preparing the eldest child to the experience of home birth also reassure the belief that such should be seen as an event in the life cycle, highlighting the importance of the involvement of older children in the labor process⁽¹⁰⁾. Their presence can be symbolically perceived as a care ritual of the parents and as a rite of passage of this individual, who adds a new status to the family⁽¹⁾, considering the profound changes caused in the family structure by the birth of a new member.

We also point out that home birth presents a different logic from that identified in the hospital environment: the family does not go to the hospital to greet the new member; the home is organized to welcome the newborn⁽¹⁰⁾. Through the preparation of materials required to assist in the labor process, such event is helped by protecting the mother-baby-family triad. Such preparation reinforces the importance of childbirth in family life cycle as a rite of passage that integrates the intimacy of the group⁽¹⁰⁾.

Aromatherapy through the lavender oil, another care ritual we observed, can be justified by its soothing and calming action; music therapy is able to intervene in the cycle of fear and tension, providing relaxation and minimizing the pain⁽⁶⁾; on the other hand, high intensity electric lamps are associated with reduced levels of melatonin, the hormone that generates stress and increases the pain, justifying the importance of low light at childbirth⁽¹⁷⁾.

We verified concern about the food ingested in this event: the provision and free access to food enables women to have better physical condition, especially in the expulsion period⁽¹⁸⁾. Furthermore, being able to previously choose and prepare foods they consider to be necessary allows putting into practice habits that make the home suited for their beliefs⁽¹⁶⁾. Hence, the family can experience the labor process according to their own ethos⁽¹⁹⁾.

We also observed that the birth plan directs the health care provided, facilitating communication between woman, family, and the childbirth assistance team, assisting its preparation and increasing the decision-making control of women⁽²⁾. In the plan, the informants have free choice to decide who will participate in the home birth⁽¹⁶⁾, inviting significant individuals of their social network who respect and share similar perceptions. Thus, this event represents a rite of separation⁽¹⁾ that allows recovering its intimate and familiar quality.

Concerning rituals involving the placenta, we observed that its printing in a cardboard represents a way to record the gestation and the labor processes, which will be recovered in the future, with the child; on the other hand, planting is related to the renewal of life, since by planting the placenta near trees, it will continue feeding other life forms the same way the mother did to the baby during pregnancy⁽⁹⁾.

Another ritual valued by women was the preparation of the body to experience childbirth⁽¹⁰⁾. The women of our study regarded walking and healthy nutrition practices essential for the fetus' well-being as well as for preparing their body to give birth. The desire for vaginal birth can encourage the proactive attitude of behavioral change characterized by body care rituals. Similarly, women's feelings can provide vitality to the fetus⁽¹⁰⁾.

Thoughts, dreams, and expectations can catalyze positive forces, projecting attitudes and postures to be adopted on the delivery day. When preparing the mind with ideas and perspectives, women introject demands for themselves about the attitudes and conducts they should adopt to satisfy their wishes at the time of delivery⁽⁹⁾. On the other hand, predictions regarding the day of the birth involve the family's expectations and planning for the arrival of the baby and, in some cases, the cycles of nature⁽¹⁰⁾. Under this perspective, individuals understand that the rites of passage are related to cosmic passages such as lunar phases⁽¹⁾. In different cultures and mythologies, the Moon is related to fertility, pregnancy, and childbirth, and although this belief is often referenced in popular culture, there are still consistent scientific evidence demonstrating the influence of the lunar cycle in the labor process⁽²⁰⁾.

Study limitations

The narratives of the general informants were not privileged, since they were observed, but not interviewed during data production, which we can consider as a study limitation.

Contributions to the fields of nursing and public policies

We intend to provide other perspectives concerning home birth, a practice still not very recognized by the conventional health care system, but which can promote the capacity of free choice and the condition of women's citizenship. With these findings we aim to provide health professionals with the opportunity to know and reflect on care rituals, not always accessed or valued, because this lack of knowledge generates difficulties in promoting a culturally congruent care. In addition, we seek to provide bases for new health actions that ensure women and their families more access to information about their rights in relation to labor and birth, as well as professional assistance, regardless of the labor process taking place in home or in the hospital, whether naturally or by cesarean section.

FINAL CONSIDERATIONS

The care rituals developed by families when preparing for childbirth involved the understanding of home as a safe environment, in which the pregnant woman and the family can put into practice their wishes and habits. Opting for the home featured a rite of separation due to the possibility of seclusion and introspection of the family unit to experience the labor process.

Families who had already experienced childbirth in the hospital environment reinforced the wish and the idealization of an intimate, particular, and significant experience to the mother-baby-family triad, understanding childbirth as a family's rite of passage, and not of health professionals'.

From the choice of the home, families and, in some moments, especially women, embraced preparation rituals of the family, the eldest child for experiencing the childbirth, the home itself, the body and mind of the woman, and also some rituals related to the destination of the placenta after its expulsion from the organism.

When preparing home, specific organizations are considered, such as changes in luminosity and use of music therapy and aromatherapy, in order to provide a peaceful environment for the woman in labor; it also comprises the use of certain teas and/or foods and the preparation of individuals that are part of the woman's social and family network. These care rituals are related to information obtained over the course of the gestation, in addition to the beliefs, values, traditions, lifestyles, and world views.

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