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Social representations on home birth

Representações sociais sobre o parto domiciliar

Representaciones sociales del parto en domicilio

Clara Fróes de Oliveira Sanfelice[1]
Antonieta Keiko Kakuda Shimo[1]

1. Universidade Estadual de Campinas. Campinas, SP, Brazil.

Abstract

Objective: To identify the Social Representations about the home birth of women who have made this choice due to the lack of studies evaluating this phenomenon from a human, historical and social perspective. **Method:** We conducted a qualitative, exploratory and descriptive research, based on the Theory of Social Representations. Fourteen women who experienced at least one practice of home childbirth were interviewed in the city of Campinas-SP and region, from February to March of 2014. It was used the criterion of theoretical saturation to define the sample size. **Results:** The data revealed a social representation: my body, my choices, my childbirth. The participants were discordant with the actual institutionalized care model and look for home birth as a concrete alternative to contemplate their expectations, which are strongly underpinned by the principle of autonomy. **Conclusion:** The reflections presented contribute as inputs to the debate and reformulation of Brazilian obstetric health policies.

Keywords: Midwifery; Home Birth; Humanized Childbirth.

Resumo

Objetivo: Conhecer as representações sociais sobre o parto domiciliar de mulheres que fizeram esta opção diante da escassez de estudos que avaliem esse fenômeno sob uma perspectiva humana, histórica e social. **Métodos:** Pesquisa qualitativa, exploratória e descritiva, fundamentada na Teoria das Representações Sociais. Foram entrevistadas 14 mulheres que vivenciaram ao menos uma experiência de parto domiciliar, assistido e planejado, na cidade de Campinas-SP e região entre fevereiro e março de 2014. Utilizou-se o critério de saturação teórica para definição do tamanho amostral. **Resultados:** Os dados analisados revelaram uma representação social: meu corpo, minhas escolhas, meu parto. As participantes mostraram-se discordantes com o modelo de atendimento institucionalizado da atualidade e buscam o parto domiciliar como uma alternativa concreta de contemplação às suas expectativas, as quais estão fortemente alicerçadas pelo princípio da autonomia. **Conclusão:** As reflexões apresentadas servem como subsídios para o debate e reformulação das políticas de saúde obstétrica brasileira.

Palavras-chave: Tocologia; Parto domiciliar; Parto humanizado.

Resumen

Objetivo: Conocer las representaciones sociales sobre la elección del parto en domicilio frente a la escasez de estudios que evalúen este fenómeno bajo la perspectiva humana, histórica y social. **Métodos:** Investigación cualitativa, exploratoria y descriptiva, fundamentada en la Teoría de las Representaciones Sociales. Fueron entrevistadas 14 mujeres que vivenciaron al menos una experiencia de parto en domicilio, asistido y planificado, en Campinas (SP) y región, entre febrero y marzo de 2014. Se utilizó el criterio de saturación teórica para definir el tamaño de la muestra. **Resultado:** Los datos revelaron una representación social: mi cuerpo, mis decisiones, mi parto. Las participantes fueron discordantes con el modelo de atención institucionalizada actual y buscaron el parto domiciliario como una alternativa para atender a sus expectativas, respaldadas por el principio de la autonomía. **Conclusión:** Las reflexiones presentadas sirven de contribución para el debate y la reformulación de las políticas de salud obstétrica brasileña.

Palabras clave: Tocología; Parto domiciliario; Parto humanizado.

Corresponding author:
Clara Fróes de Oliveira Sanfelice.
E-mail: clara_sanfelice@yahoo.com.br

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INTRODUCTION

On the world stage, institutional care rates for labor improved in recent decades because women are increasingly being encouraged to use health institutions through actions to generate demand, community mobilization, education, financial incentives and policy measures[1].

Parallel to this scenario, a growing volume of research on the experiences of women during pregnancy and childbirth, in particular, describes a disturbing painting. Worldwide, many women experience abuse, disrespect and negligence during childbirth assistance in health institutions[1].

This is a violation of trust between women and their health care teams and can also be a powerful disincentive for women seeking the obstetric care services[2-4].

In Brazil, the current obstetric panorama has been the target of much criticism due to merger of factors that result in a cruel scenario and potentially dangerous to the health of women and newborns, characterized by a medicalized model of attention, high rates of caesarean surgery and indiscriminate use of technology and routine procedures without scientific backing[5].

According to national data, just over 98% of births occur in health care institutions[6]. The cesarean section rate approached 54% in 2011 in the public sector[7] and 80% in the supplementary health sector[8].

These values are not found in any other country in the world and culminate with maternal and perinatal outcomes worse than those observed in countries with equal or lower levels of socioeconomic development[9].

It is also an inconsistent scenario the abusive and indiscriminate use of the technology in parturition: on one hand the illness and death due to lack of appropriate technology and on the other, the illness and death by excessive inappropriate technology[10].

Allied to this situation, the recent nationwide survey conducted by Fundação Perseu Abramo found that one in four Brazilian reported to have suffered ill-treatment during labor and childbirth[11], demonstrating a weakened model of assistance that needs to be reformulated in favor of maternal and perinatal health.

Reports of disrespect and abuse during childbirth in health institutions include physical violence, humiliation and verbal abuse, coercive medical procedures or not consenting (including sterilization), lack of confidentiality, failure to obtain informed consent before performing procedures, refusal to administer analgesics, serious violations of privacy, refusal of admission in health institutions, negligent care during childbirth leading to preventable complications and life threatening situations, women's detention and their newborns in the institutions, after parturition, for inability to pay[12].

In parallel to this situation it is observed in actuality a timid but growing movement to recover the practice of giving birth at home in urban regions, even where the hospital access is possible. It is a conscious choice, planned and that seems to be related to the higher education level. The current idea in Brazilian society, shared even by health professionals, is that the home childbirth, even when planned, represents a higher risk of maternal and neonatal consequences[13].

However, this conception of risk associated with home childbirth has been diluted before the publication of various recent studies on international literature showing that obstetric and perinatal results are similar when compared to childbirth, demystifying the idea that giving birth at home gives greater risk to the health of the mother and the newborn[14-16].

The Cochrane Library, in its most recent review of the topic did not find an adequate sample of studies to establish a statistically substantiated conclusion. However, the authors concluded that there is no evidence in favor of childbirth hospital planned for low-risk pregnant women, reaching to the conclusion that there is no substantiated evidence to discourage home births for this group. The authors also highlighted that there are good results from observational studies that suggest the home planned childbirth can be as safe as hospital birth with less interventions and complications associated with[17].

The national literature on the subject, although scarce, also has good obstetrical and neonatal consequences, similar to international studies. These researches show reduced hospital transfer rate, of need for cesarean section, perineal trauma and use of drugs both in labor as postpartum home childbirth[18,19].

Although there is an extensive production on the theme of home childbirth in quantitative nature, it is noted a restriction on qualitative studies aimed at understanding the choice for the home birth not only as a physical phenomenon, but also taking into account the human, historical and social aspects involved in this event. Thus, the researches opted for the use of Social Representation[20-23] as for theoretical reference in order to understand the reasons that are leading this portion of Brazilian women for choosing childbirth at home, at the head of a movement that is against the current obstetrics model.

In this context, this research aims to know the social representations about homebirth planned to women who have chosen to live this experience, so that these representations help to enable women to express what they think, how they perceive, their opinions and experiences about this event, giving voice to socially constructed concepts and anchored in their realities.

It is considered that the information found in this study can serve as inputs to enrich the debate and support the discussions about the childbirth care model in effect today.

THEORETICAL REFERENCE

For the theoretical basis of this study it was used the Social Representation Theory (SRT), created by the French social psychologist Serge Moscovici in the 60s[20-22].

SRT can be understood as a kind of knowledge socially developed and shared with a practical purpose, and that contributes to the construction of a reality common to social set[22].

Performing the articulation of concepts of TRS to the field of obstetrics, it is clear that the predominant labor in our society, and therefore corresponds to the consensual universe, is the institutionalized childbirth, attended by the medical

professional, with massive use of intervention and technology in the physiological process of labor and birth. In other words, the shared thought on common sense is that that childbirth should occur in the hospital, preferably with a minimum of "pain and suffering" to the woman.

The option of home birth can be understood as the non-familiar fact of the consensual universe (common sense), generator of tension and discomfort. Through the construction of social representations process, women who make this option transform the unfamiliar (home birth) in familiar. This movement allows the formation of peer groups that share the same ideas on the subject and therefore adopt similar behaviors and practices.

TRS has been extensively employed in nursing because of the possibility of the researcher to capture the participants' interpretations of the reality which he aims to research, enabling understanding of attitudes and behaviors that a particular social group facing a psychosocial object[22].

The complexity of the phenomenon of social representations and the methodological and interdisciplinary possibilities it offers have led many researchers to the combination of different levels of analysis, resulting in a variety of studies. This diversity also results from the double-sided representations: as product and process[23].

When focused as a product, as in the case of this study, the research aims to infer the constituent elements of the representations (information, images, opinions, beliefs), always having as reference the social conditions of its production. But when focused as a process, the survey turns to the understanding of the development and transformation of representations under the force of social determinations[22].

METHODS

It is an exploratory, descriptive, qualitative research based on the Social Representation Theory (SRT).

The sample was composed of 14 women who have the experience of giving birth at home in a planned way and assisted by an enabled health professional (midwife, nurse midwife and/or obstetrician), during the last year (2014), in the city of Campinas (SP) and region. It was adopted as inclusion criteria the period of three to six months after postpartum, the experience of planned home childbirth and assisted by a qualified professional and be at least 18 years. The option for not interviewing the women in the first three months postpartum as it is in this period that a woman is more susceptible to develop dysphoria frames puerperal or baby-blue and psychosis[24].

Data were collected in February and March of 2014 through an instrument that contained data regarding sociodemographic and obstetrical characterizations, within a semi-structured interview consisting of 11 open questions. The interviews were recorded and immediately transcribed, it had an average duration of 25 minutes and were held at the women's home.

The participants were taken through the provision of their names given by staff working in home birth care in that region. Among all the participants invited, there was no refusal to participate in the survey.

The determination of the number of participants was through sampling by saturation, which can be understood as the suspension of inclusion of new participants when the data obtained start to present, in the evaluation of researcher, certain redundancy or repetition, and it is not considered relevant to persist in the collection. This concept has been extensively used in qualitative research in healthcare[25].

Treatment and analysis of data is given through the manual process of thematic content analysis proposed by Bardin[26], which consists of three steps as follows: 1) pre-analysis; 2) exploration of the material; and 3) treatment of results, inference and interpretation[26].

In the first step, the material was organized in order to become operational. This organization process is performed by four phases: 1) floating reading; 2) choice of documents; 3) elaboration of hypotheses and goals; and 4) referencing the contents and development of indicators. Then proceeded to the exploration of the material, performing the coding, classification and categorization by themes. In the last phase the condensation and the highlight of the information for analysis, culminating in the inferential interpretations; it is the moment of intuition, reflective and critical analysis[26].

The survey follows the guidelines and the regulatory norms for research involving human beings contained in the Resolution 196/96 (RES CNS 96/196) and 466, to 12/12/2012 of the National Council of Health. The data were collected only after approval by the Research Ethics Committee, whose approval is in the opinion of paragraph Nº 331,743 and after consent of Informed Term per participant.

In order to ensure the confidentiality of information, the participants of this study were identified by the letter E, followed by a random numbering.

RESULTS AND DISCUSSION

The results and discussion will be presented in two parts. The first contains the characterization of the subjects (Tables 1 and 2), and the second consists of exploration and foundation of shared social representation by these women.

Characterization of participants

There was an average age of 31 years, with a predominant degree of education - completed higher education (100%) -, married or in a stable union (100%), family income ≥ 10 minimum wages (50%) and health insurance (92.9%). The findings are shown in Table 1.

In relation to obstetrical data, mostly first-time mothers (57.1%) composed the sample. Among the multiparous (42.9%), it was found a prevalence of vaginal childbirth (83.3%) and hospital (83.3%) prior to the home parturition experience. These findings are presented in Table 2.

Table 1. Sociodemographic profile of women who had childbirth at home. Campinas, SP, Brazil

Interview	Age	Education	Occupation	Family Income	Marital Status	Health Insurance
1	28	Comp High School	Engineer	7	Married	Yes
2	35	Comp High School	No job	5	Stable union	Yes
3	27	Comp High School	Public Servant	8	Married	Yes
4	33	Comp High School	Nurse	12	Married	Yes
5	27	Comp High School	Psychologist	8	Married	Yes
6	27	Comp High School	Lawyer	10	Married	Yes
7	32	Comp High School	Biologist	20	Married	Yes
8	33	Comp High School	Tourism Specialist	15	Married	Yes
9	29	Comp High School	Student	10	Married	No
10	29	Comp High School	Artisan	8	Married	Yes
11	38	Comp High School	Doctor	20	Stable union	Yes
12	32	Comp High School	No job	10	Married	Yes
13	32	Comp High School	Doctor	8	Married	Yes
14	28	Comp High School	Physiotherapist	4	Married	Yes

Table 2. Obstetric profile of women who had childbirth at home. Campinas, SP, Brazil

Trevista	Parity	Obstetric history prior to PD			
		VP*	CP**	Abortion	Place/Quantity
1	First-time Mother	-	-	-	-
2	Second-time Mother	1	-	-	Domiciliary
3	First-time Mother	-	-	-	-
4	Second-time Mother	1	-	-	Hospital
5	First-time Mother	-	-	-	-
6	First-time Mother	-	-	-	-
7	Second-time Mother	-	1	-	Hospital
8	Third-time Mother	1	-	1	Hospital
9	Multiparous	2	-	1	Hospital/1 Domiciliary/1
10	First-time Mother	-	-	-	-
11	First-time Mother	-	-	-	-
12	Second-time Mother	1	-	-	Hospital
13	First-time Mother	-	-	-	-
14	First-time Mother	-	-	-	-

* VP: Vaginal Parturition; ** CP: Cesarean Parturition.

The construction of Social Representation

After exhaustive and detailed manual process of analysis of the content revealed in the interviews, all the material was divided into units of sense, followed by the grouping into subcategories so that finally were emerged three thematic categories, which were named as: 1) the power of information; 2) no agreement with the hospital obstetric care model; and 3) satisfaction with the experience without interference.

The common and shared content to these categories made emerge a single social representation showing that these women recognize the home childbirth as a consistent option to have parturition because it represents a setting appropriate to the experience of childbirth and physiological individually, which values the scientific advice available, it stimulates the rescue to female empowerment, in addition to allowing women to truly remain in control of the situation and making

decisions, participate in choices, refuse to what they should, without that representing a situation of stress/conflict. In view of these information, abstracted from the speeches analyzed, the emerging social representation was named *My body, my choices, my childbirth*.

It is noteworthy that each emerging category gave rise to texts for publication due to the wealth of information contained therein.

My body, my choices, my childbirth

The emerging social representation of this research relates to the concept of autonomy exercised by women about their bodies at the time of childbirth.

Autonomy can be understood as the expansion of capacity of making choices. The concept is related to the idea of freedom, free choice of individuals on their own actions and the ability to trace their life trajectories. Also refers to the ability of human beings to live their lives from own laws. Supposes the condition of free person to assume their choices[27,28].

The comprehension of autonomy's conception was evident on the part of those women that have as main objective the search for control of the entire process of childbirth, since they have the right to understand and insight to make their choices.

The exercise of autonomy can be understood as a feature of democratic societies marked for the right to diversity, free speech, freedom of behavior of individuals and groups, as long as respected the limits of damage to third parties[29].

What proved to be distressing to these women, however, is the impossibility of living the pregnancy and childbirth sustained by the principle of autonomy within the hegemonic obstetric care model of contemporary Brazilian society.

According to these women, childbirth view grounded on the principle of autonomy is valued within the home environment to parturition, what motivates them to this option.

> *I have always been in favor of normal childbirth, but thus we see that in the hospital nowadays, people cannot have much control over their own body, professionals do not respect you very much, do not have much respect with the patients' choices. (E13)*

Although the women wish to join their parturition and verbalize their needs, choices and preferences, women do not find favorable conditions for their care needs and the desire to participate in decisions about childbirth are made possible[30].

The consciousness that most likely the woman is unable to establish an egalitarian relationship with the health care professional when it comes to their choices and decisions taken during the assistance provided, lead to the search for alternatives capable to promote that dialogue. Women who choose home birth are looking for trust and security in a relation with the health professional, feelings built from the establishment of ties, respect to their culture, their choices and expectations[31].

Ideally, the health professional has ethical and legal obligation to provide clear and complete information about the care and give the opportunity to the customer to participate in decisions based on the information received[32].

From the perspective of these women, this most democratic dialogue does not occur when they are under professional care in a health institution, as it performs in the speeches below:

> *[...] I didn't feel well, I said "I don't want to!" Do you think in the hospital I was going to say no? (E9)*

The home enables attention focused on the woman and her family, since the one in another environment is the professional, who requires an adjustment to the site, and no longer the woman has to a fit to the routines and professionals as it is instilled in the hospital environment[33]. The excess of professional autonomy, practiced today in most health institutions decreases maternal autonomy[34].

> *[...] It doesn't make sense to us, have a childbirth where I am not myself, where is another person who will lead and not in the way that is the natural, commanded by an institution or something similar (E10)*
>
> *[...] positives points (home childbirth): [...] you have full control over your body, so you won't be forced to stay in a bed, with serum, or restricted to an environment, things that I think that happen very much at the hospital [...] some rules you have to follow, so I believe all of this bothers a lot. (E13)*

The healthcare professional should promote the empowerment of women in childbirth, beginning with the scientifically based and unbiased information, so that they can make shared and properly substantiated decisions[31] It means, the healthcare service must be available for an enlightening and dynamic dialogue, incorporating a horizontal relations environment where the construction of knowledge happens guided by evidence-based obstetrics[34].

The emphasis on autonomy when discussing the place of birth seems to be related to the need for transformation of the current scenarios of childbirth, revealing a critique of impersonality and inflexibility of hospital environments, where the hegemonic technocratic model of care prevails and requires a passive role of women[35].

Reinforcing this idea, there are scientific evidence showing that the democratization of relations between health professionals and users, in a model of co-responsibility, and the enhancement of user autonomy as regards to the choice of therapy and procedures are associated with better outcomes in health[36].

Thus, the main challenge of the professionals is the transformation of their attitudes to act ethically and in favor of

scientific caution and focused on the needs of women and their families, and not in the hospital routine or on its specific interests. The health professional must be willing to adopt new ideas and walk along with the movement of humanization of care childbirth, aware that women have their collection of knowledge and need to be heard[29].

The information process empowers women in their choices, while the absence of clarifications generates the parturient vulnerability and lack of knowledge about their condition[34].

> *It is a labor of much delivery and conscience know, delivery and responsibility because you have to take responsibility of what you are doing and I think it's different when you are in hospital you can delegate more that responsibility for the doctor [...] when you take a home birth , you have to play your responsibility, you share responsibility with the team, it is not only their responsibility. (E7)*

For the women participating in this study, the home environment and the professionals who serve it, agree, it promotes and stimulates this relationship of co-responsibility with regard to decision-making, allowing the free exercise of autonomy, giving voice and authority to these women. These aspects are present in the results found in recent studies on the subject[5,31,37].

From the perspective of active health professionals in home birth, the rescue of autonomy is a key requirement for the recovery for the humanization of childbirth[33].

At home, the woman becomes active subject of the birth, bringing to herself her own parturition and the control over her body, having the opportunity to act, to make her choices safely and without inhibiting. At home, she is free to express her feelings and be authentic in her behavior and conduct[33].

> *[...] I felt a lot this matter of them leaving the birth to be mine and my husband's, then the birth was not theirs, it was mine, ours, and then everything was done, Even when it was done, it was all touch with my consent, was not required, some suggestions I went along with it, some not, and all very quiet. (E13)*

The interviews showed that these women are not resigned to the established hospital care model. On the contrary, they recognize the contradictions and weaknesses in the system and can overcome these barriers primarily through a process of seeking information. The choice of home childbirth is related to the higher education level, which reflects the ease of access to information and biomedical knowledge, enabling critical analysis of the obstetric practices and possibility of argument and support of the decision taken[13].

Thus, these women acquire information provided by current studies and scientific evidence, take ownership of this knowledge, are able to question current practices and, from then on, they feel safe to make an informed choice, conscious and substantiated.

As well as appearing in other researches, the acquisition of information seems to be both the starting point of the whole process as the mainstay for the decision to give birth at home[5,31,37].

Since the home childbirth is directly connected to higher educational and financial level, a policy of inclusion in the Unified Health System (UHS) appears to be an alternative to offer this type of service to the underprivileged population.

In Brazil, Hospital Sofia Feldman, located in the city of Belo Horizonte (BH), recently completed 1 year of home childbirth care performed by midwives and nurses funded exclusively by UHS. It is a pioneering experience and that has given good results[38].

According to the testimonies, the hospital environment see the women and give them incompatible features with its childbirth vision, while parturient. The medicalization of the female body during labor and childbirth is one of the classic examples in actuality, convert women and healthy bodies in a patient sick, vulnerable and in need of foreign aid to win the great "obstacle" that is giving birth.

This event is understood as a reflection of social medicalization, described as a complex socio-cultural process that transforms medical needs in the experiences, sufferings and pains which were administered in the own family or community settings[38].

Thus, the medicalization of childbirth, a fact already so deeply rooted in institutionalized care of childbirth care in Brazil, projects under the mothers the vision of dependent subjects, unable to deal independently with adverse events that can and should be experienced during the labor and childbirth.

This social construction contributed to the decline of women's capacity in dealing with the phenomenon of childbirth, its unpredictability, the pain of labor, among others[39]. In this way, the vast majority of women feel unable to live the experience of childbirth, and delegates to the professional/health care institution the power and the responsibility to lead this process.

However, the women who choose home childbirth do not feel weak or scared by the event of labor and parturition. On the opposite way, and due to all the information previously absorbed, await in a natural way and celebrate with pride and great satisfaction the birth experience.

So, as opposed to excessive medical interventions in the process of pregnancy and birth, it is observed in the last decade, a significant expansion of movements of users and health professionals who are critical about this reality[39], which allows us to infer that the gradual demand for home birth option is one of the clearest pictures of dissatisfaction and frustration with the prevailing system.

FINAL CONSIDERATIONS

The results of this study allow to recognize that shared social representation by women who have the option of home childbirth is intrinsically related to the search for the labor and birth experience based on the principle of autonomy and the rescue of female empowerment.

It is observed that these women are dissatisfied with the current obstetric attention model practiced in hospitals and, therefore, seek an alternative capable of supplying and respecting their expectations and conceptions about the event of childbirth.

According to participants, the obstetric model institutionalized: 1) offers a service based on standards and inflexible routines; 2) appropriates the moment of maternal weakness to impose conduct and procedures; 3) is not conducive to dialogue between patient and health care professional; 4) does not value the maternal decisions; 5) attempts to discipline the body and its natural processes according to personal interests and/or institutional and 6) enhances the view of childbirth as a pathological process.

Thus, having childbirth at home is not an option for women less informed or following a current fad. It is a concrete option, based on extensive and comprehensive knowledge on the subject, and that in parallel demonstrates a clear dissatisfaction with the current obstetric hospital model.

It is considered that this study contributes to enrich the knowledge on this subject, especially for professionals involved in childbirth assistance, as well as collaborate with future research.

Thus, it is expected that all the thoughts raised in this study represent an important element to questioning and debating the obstetric assistance practiced today, so that this model can be rethought and reconfigured aimed at offering a safe obstetric practice, respectful and enjoyable to Brazilian women.

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