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DIFFICULTIES IN HOME BIRTH CARE FROM THE PERSPECTIVE OF OBSTETRIC NURSES

DIFICULDADES DA ASSISTÊNCIA AO PARTO DOMICILIAR NA ÓTICA DE ENFERMEIRAS OBSTETRAS

DIFICULTADES EN LA ATENCIÓN DOMICILIARIA DESDE LA PERSPECTIVA DE LAS ENFERMERAS OBSTETRAS

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Objective: to investigate the difficulties encountered by obstetric nurses who are working in home birth care. Method: descriptive study, with qualitative approach. Data collection was performed through a semi-structured interview with nine obstetric nurses who had been attending home births for more than one year. The data were analyzed according to Content Analysis. Results: the statements gave rise to three categories that revealed difficulties related to: scarcity of information about home birth; transfer from home to hospital; and gaps in the work process. Conclusion: obstetric nurses faced social and practical difficulties that weakened and hindered home birth care. These difficulties seem to be related to the lack of regulation of this model of delivery care in the country's public health policies.

Descriptors: Obstetric Nursing. Nurse Midwives. Humanizing Delivery. Home Childbirth. Women's Health.

Objetivo: investigar as dificuldades encontradas pelas enfermeiras obstetras que estão atuando na assistência ao parto domiciliar. Método: estudo descritivo e de abordagem qualitativa. A coleta de dados foi realizada por meio de uma entrevista semiestruturada com nove enfermeiras obstetras que atendiam partos domiciliares há mais de um ano. Os dados foram analisados segundo a Análise de Conteúdo. Resultados: os depoimentos deram origem a três categorias que revelaram dificuldades relacionadas à: escassez de informações sobre o parto domiciliar; transferência do domicílio para o hospital e lacunas do processo de trabalho. Conclusão: as enfermeiras obstetras enfrentavam dificuldades de ordem social e prática que fragilizavam e dificultavam a assistência ao parto domiciliar. Estas dificuldades parecem estar relacionadas à falta de regulamentação desse modelo de atenção ao parto nas políticas públicas de saúde do país.

Descritores: Enfermagem Obstétrica. Enfermeiras Obstétricas. Parto Humanizado. Parto Domiciliar. Saúde da Mulher.

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Objetivo: investigar las dificultades encontradas por las enfermeras obstétricas que trabajan en la asistencia al parto domiciliario. Método: estudio descriptivo y de enfoque cualitativo. La recolección de datos se realizó a través de una entrevista semiestructurada con nueve enfermeras obstétricas que realizaban partos domiciliarios durante más de un año. Los datos se analizaron de acuerdo con el Análisis de Contenido. Resultados: de las declaraciones, surgieron tres categorías que revelaron dificultades relacionadas con: escasez de información sobre el parto domiciliario; transferencia de casa al hospital y lagunas en el proceso de trabajo. Conclusión: las enfermeras obstétricas encontraron dificultades sociales y prácticas que debilitaron y obstaculizaron la atención al parto domiciliario. Estas dificultades parecen estar relacionadas con la falta de regulación de este modelo de atención de la prestación en las políticas de salud pública del país.

Descriptores: Enfermería Obstétrica. Enfermeras Obstétricas. Parto Humanizado. Parto Domiciliario. Salud de la Mujer.

Introduction

According to the National Guidelines for Normal Delivery Care of the Ministry of Health (MH), health professionals should not discourage the home as a place of choice for childbirth[1], since home birth is an option recognized by the World Health Organization (WHO) for several decades, provided that care is performed by a qualified professional and with a transfer plan established for the indicated cases[2].

In Brazil, there is no law prohibiting home birth. Currently, this type of care, performed by the midwife or obstetric nurse and supported by the Federal Nursing Council, is understood as a guarantee of women's reproductive rights[3]. In addition, the WHO, the MH and the last review on the Cochrane library theme recommend the normal-risk birth care by obstetric nurses, since these professionals are widely recognized for practicing care aligned with scientific evidence, which is based on the rational and judicious use of interventions. The care provided by obstetric nurses values the physiology of the parturition process, reduces unnecessary procedures and increases the rates of normal delivery and maternal satisfaction[1-2,4].

On the theme of home birth, the current literature presents well-designed studies that point to satisfactory maternal and fetal outcomes. A recent systematic review with meta-analysis, for example, demonstrated a higher rate of spontaneous deliveries, lower chances of interventions and cesarean surgery, lower risk of fetal dystocia and postpartum hemorrhage, and similar rates for neonatal morbidity and mortality when comparing the hospital and home environments[5].

From women's perspective, the literature points to dissatisfaction with the current hospital obstetric model as one of the main reasons for choosing planned home birth. In-hospital care is seen as a depersonalized care, based on inflexible norms and routines, which appropriates the moment of maternal vulnerability to impose behaviors and procedures arbitrarily, without considering dialogue and maternal decisions, besides understanding childbirth as a pathological process[6-7].

Given this scenario, statistics show a trend of growth in home birth rates at national and global level. In the United States, for example, the planned home birth rate increased by 77.0% from 2004 to 2017[8]. In Brazil, the same phenomenon is observed in the most urbanized regions (South, Southeast and Midwest) in the period from 2010 to 2017, with the category of obstetric nursing most adhering to this care model[9].

Although the international literature on the subject is broad, a recent literature review on home birth shows that the national production on this theme is still scarce, and mainly portrays the maternal and neonatal outcomes of this type of care[6], in addition to motivations that justify the choice to give birth at home[6-7].

In view of this conjuncture, and for being a field of action of obstetric nursing in the country and in order to raise reflections that can

contribute to the refinement and qualification of this type of work, this research aimed to investigate the difficulties found by obstetric nurses who are working in home birth care.

Method

This is an exploratory, descriptive and qualitative research. The target audience of this study were obstetric nurses who worked in home birth care. The following inclusion criteria were defined: nurses specialized in obstetrics; minimum time of one year of home birth care and professionals working in the city of Campinas (SP) and surroundings. Obstetric nurses working outside the delimited region with less than one year of experience in the care of planned home birth were excluded from the participation.

The number of participants in this study was defined using the concept of "saturation point", widely used in qualitative investigations. The saturation point is reached when the new participants start to repeat information that has already been mentioned in previous interviews and the addition of new contents is no longer necessary, since it does not alter the understanding of the phenomenon studied[10].

Data were collected through an online questionnaire constructed by the authors, based on a free Internet application (Google Forms), composed of two parts: sociodemographic profile of the participants; and semi-structured interview, containing an open triggering question: "Have/Do you experienced/experience challenges in home birth care? If so, tell us a little bit about them."

The participants were recruited by the Snowball Sampling technique performed from August to October 2019. In this technique, the first interviewees indicate the next ones, who, in turn, will indicate others and so on[11], until the moment when the new information is repeated (saturation point)[10]. In this course, 14 obstetric nurses were indicated, but only nine agreed to participate in the research. When one refused to participate, the last interviewee was asked for a new indication. Upon reaching the saturation point, the data collection process was terminated.

The answers were inserted into excel spreadsheets. The data were analyzed according to the Content Analysis proposed by Bardin, which comprises a technique of data processing that aims to obtain, through systematic procedures, indicators that allow the inference of knowledge related to messages and the unveiling of the relationships that are established beyond the statements themselves[12].

Content Analysis predicts three fundamental phases that were followed in the treatment of the interviews: pre-analysis, exploration of the material and treatment of the results (inference and interpretation)[12].

Aiming at the methodological rigor of the study, the Consolidated Criteria for Reporting Qualitative Studies (COREQ) checklist was used during the data production process.

To ensure anonymity, the interviewees were identified by the letter "N" followed by a random number. The research followed the norms of Resolution n. 466/2012 and Resolution n. 510/2016 of the National Health Council, being conducted according to the ethical standards required for researches involving human beings.

The study was approved by the Research Ethics Committee, protocol n. 3.437.075/2019. The consent and agreement with the Informed Consent Form were a prerequisite for the release of the electronic questionnaire.

Results

The participants were nine female urban midwives aged between 27 and 50 years, with mean age of 36 years. All of them self-reported as white, three (33.3%) were married, seven (77.8%) had children, five (55.6%) graduated from public educational institutions, five (55.6%) had been working in home care for more than five years and three (33.3%) had another employment relationship concomitant with home birth care.

Among the participants, eight (88.9%) stated that, before starting home care, they already worked in the area of obstetrics and all (100%) stated that they intended to remain in home birth care for the next five years.

The statements revealed the difficulties experienced by these professionals in home birth, which were grouped and gave rise to three thematic categories: Scarcity of information about home birth; Transfer from home to hospital and Gaps in the work process.

Scarcity of information about home birth

The reports of this category showed that obstetric nurses faced prejudice by various social strata in relation to the home birth care, due to the lack of information about this care model:

> *First of all: the lack of information by health professionals themselves on the subject; the non-acceptance* [of home birth] *by most health professionals who, due to lack of information, trivializes or ridicules this care model and, the worst thing is that they describe it as irresponsible or unsafe, despite being a safe care model, when offered by trained professionals*. (N2).

> *The biggest challenge is the prejudice, of both the society and the family of the couple who chooses to do so, as well as of health institutions and professionals* [...] *the stereotypes are numerous. And so it is seen: normal birth is controversial; home birth is almost insanity*. (N1).

> *The prejudice and erroneous concepts established in our country's culture about the place of delivery*. (N3).

> *This [home birth] is not part of Brazilian culture. People believe that we midwives aim to "cause" harm to the mother and baby. While what we want to bring is safety and comfort to women who are eligible for home birth*. (N6).

> [...] *cultural prejudice, it is a distorted and misguided view about home birth*. (N7).

> *They blame us for any negative outcome. If the woman had hemorrhage, it is the home birth's fault; if the baby developed an early neonatal sepsis, the same as before*. (N4).

Transfer from home to hospital

The discourses that compose this category portray the situation of transfer to the hospital as a major obstacle experienced by obstetric nurses within the work process of home birth care:

> *The possibility of transferring to a hospital is a stress for everyone. The family will be judged, the team will be judged and often threatened. There is no support for situations like these* [hospital transfer]. *We are at the mercy of chance and luck, or lack thereof, about which professional will receive us in the hospital and how his performance and behavior will be. In other countries, where home birth is already part of the culture, it is possible to warn the nearest hospital that a delivery is happening nearby and, in case of transference, everything happens harmoniously*. (N2).

> *The big challenge is when we have transfers. The professionals judge us as if we were doing something illegal, slaughter women and blame us for any negative outcome*. (N4).

> [...] *if, for some reason, we need a hospital transfer, we have a resistance and we suffer a terrible violence that marks our lives as professionals... so does the family's life*. (N6).

> *The pressure that the patient suffers in the hospital environment, in cases of transference, is very intense*. (N1).

> *Difficulties in transfers, because professionals receive us pretty bad and mistreat pregnant/postpartum women*. (N5).

> *Every time we transfer a patient, it is a delicate situation, especially when the hospital staff knows that the woman comes from a home birth attempt*. (N9).

Gaps in the work process

The work structure in home birth care presents gaps that were mentioned as important difficulties for obstetric nurses' performance in this context. These gaps refer to the absence of: service that performs laboratory tests requested by obstetric nurses during prenatal or postpartum follow-up; a place that allows purchasing basic supplies (medications) for use in the home environment by the obstetric nurse; and guidelines/protocols that address the performance of obstetric nurses in a homogeneous manner. The following statements are illustrative:

> *The health insurances do not accept examinations requested by an obstetric nurse*. (N4).

> *We have little infrastructure to carry out the assistance. We rely on doctors to, for example, buy medications that we need to use at home*. (N7).

> *We do not have a unified protocol guiding our behaviors during home care. So each team act in their own way...* (N8).

Discussion

The results of this research showed that obstetric nurses faced a prejudice from various social strata, including other health professionals, when providing home birth care, which seems to be the result of the lack of consistent information about how delivery is performed in the home environment.

This prejudice can be explained by a historical contextualization, since civil society and health professionals have built, over the last decades, a paradigm regarding childbirth

care that understands advanced technology as a synonym of quality and safety[13]. Thus, the conflict generated before the changed care model is understood, which starts from a technical and interventionist assistance, to a practice that rescues natural childbirth with little or no use of technological devices, as is the case of home care. Regarding this aspect, a single study available in the literature was found, which was in accordance with the finding of this study, showing that, socially, planned home birth is perceived as a setback, because it denies women the advantages of the progress of modern medicine[13].

The results of this research show that a portion of society recognizes planned home birth as an act of irresponsibility and risk for the binomial, since the participants report being victims of stereotypes and blaming before any situation involving home birth. Nevertheless, this interpretation differs from the recent evidence available in the literature, which demonstrates good maternal and neonatal outcomes, higher maternal satisfaction rates, lower intervention rates and similar neonatal mortality rates when comparing home births to those that occurred in the hospital environment[6,14-20].

Thus, it seems that the assistance of planned home birth represents a current counterculture movement that suffers all the stigmas and pre-concepts of a profession that, thus far, is not recognized by society. However, this can be explained because, according to current statistics, more than 98.0% of deliveries in Brazil occur in health institutions[9], making the hospital environment a socially recognized place of excellence for birth[13]. This scenario reinforces the hospital culture of delivery and overestimates the safety it provides[13].

Prejudice and lack of information about home birth hinder the work of obstetric nurses, making them the target of constant social judgment. In this sense, a suggested coping strategy is the design of measures to expand scientific knowledge on the theme of home birth to common sense, especially the lay population, which would broaden the understanding of this care modality and could help deconstruct prejudices about the care offered by obstetric nurses. Furthermore, the knowledge base about planned home birth should be increased among all maternity providers. The main themes that should be addressed include criteria for selecting the place of birth, the management of obstetric emergencies in planned home births, the critical evaluation of the literature on the safety of home birth and interprofessional communication/ collaboration when women are transferred from home to the hospital[21].

In this sense, publications should also be disseminated in scientific journals, as well as interviews in newspapers and reports on the internet and social networks of women who experienced positive experiences of home birth, as strategies to popularize knowledge on the subject[14].

The results also showed that some families, for fear of judgment, prefer not to socialize the decision about home birth. This finding corroborates the current literature, which shows the choice of many couples not to expose to their family and/or society the decision regarding where the delivery will be, especially when family members show prejudice or resistance to this choice[14].

This research showed that, thus far, obstetric nurses occupy a disadvantaged position in the context of home birth care in Brazil, since they have not yet conquered a socially accepted and legitimized space to act, although studies show a substantial quantitative growth of nursing professionals who have entered this care modality, especially in large capitals and metropolitan regions[6,14].

On the other hand, the international scenario is more favorable to the performance of obstetric nurses in home birth, especially in countries where this care modality is integrated to the local health system, as is the case of Canada[21], United States[22] and the Netherlands[23].

The other difficulty that emerged in this study concerns the need to transfer from the home to hospital environment. Regarding this aspect, the available literature is vast, demonstrating

rates of transfers in home births ranging from 7 to 24.0%[15-19]. However, there was a scarcity of studies addressing the context and quality of care in the presence of a transfer from the home to the hospital environment, as revealed in this research.

The participants' reports brought important contributions on this aspect and unveiled the violence experienced by women and home care teams in the hospital environment in the event of a transfer. This situation was identified in another study that, in view of this vulnerability, pointed out the omission of some families regarding the information of the home birth attempt when they arrived at the hospital, in order to avoid judgment and retaliation[14].

The statements of this research showed behaviors and attitudes of threats, retaliation, blaming and hostile treatment by health professionals, which are characterized by the literature as obstetric violence[24]. This phenomenon may result from an association of several factors, such as: absence of ethical and respectful behavior on the part of hospital teams; lack of information about the work process of obstetric nurses at home; invisibility, on the part of the country's health policies, of this work model; and lack of communication between care teams and health services.

The literature shows that several countries recognize home birth care, integrating them into the health system. In Canada, for example, home birth is also assisted by midwives and this articulation with the health system facilitates access to emergency transportation and the transfer of obstetric or neonatal care when they are requested[16,21]. Furthermore, the WHO suggests that midwives trained, regulated, licensed and fully integrated into the health system are able to reduce maternal and neonatal deaths by 80%[2], which justifies the need for this articulation.

However, the lack of communication between the reference service and the work of obstetric nurses makes the occurrence of a home birth invisible. The invisibility of this work process represents a serious threat to the parturients' health and to the maintenance of this type of care, besides attributing to home care impressions that refer to irresponsibility and/or hiding. Thus, a study points out two factors that weaken home birth care, which were also perceived in the statements of this research: lack of recognition of this service by health policies and maintenance of a referral and counter-referral that does not work[14].

In this context, it is considered important, within the scope of public health policies, the determination of a flow of communication between those involved (health institution and home birth team on call), to ensure the possibility and legitimacy of hospital transfer. The accomplishment of this transfer, according to the WHO and the MH, is one of the prerequisites for safe home obstetric care[1-3,5].

Therefore, it is important to ensure timely transfer linked to hospital reception free of judgments and ill-treatment, in order to avoid a conflicting and violent embracement of the parturient in the hospital environment[14]. As shown in the discourses of this study, the literature also points out that, when receiving the woman from a home birth attempt, some health professionals stigmatize her for having adhered to a practice that is technically not contemplated by the public health system[13] and is not accepted by the professional's personal opinion. This occurrence, however, shows a serious lack of ethical character, besides characterizing violation of human rights.

In view of the findings of this research, it is considered important to include planned home birth in the country's public health policies, so that legal protection is guaranteed, not only for women who make this choice, but also for obstetric nurses who are involved in this care.

The last category of this study was less representative, but no less important. It brought to light the practical difficulties experienced in the work process of obstetric nurses, such as the impossibility of acquiring basic supplies for care, requesting laboratory and imaging tests, one of the essential practices for determining gestational risk and consequent evaluation of eligibility for home birth, in addition to the absence of

a care protocol that can guide and support the behaviors practiced in the home environment.

According to the literature, the use of protocols that standardize the procedures favors the decision-making of nurses, allows correcting non-conformities, allows all workers to provide standardized care, according to technical-scientific principles, besides providing greater satisfaction and safety for the nursing team and for the patient[25]. Thus, the need to develop protocols and/or guidelines that can guide and support the care practices of home birth care by the country's health regulatory agencies is justified.

Regarding the difficulty of purchasing supplies and requesting tests by obstetric nurses who are part of home birth, there was no literature to support such findings, allowing the interpretation that these results are unprecedented.

Therefore, the exposed working condition limits the care offered, decreases the degree of autonomy of obstetric nurses in home care and hinders the achievement of the best results. Thus, this research showed that the weaknesses of the work process found represent important gaps that need to be solved, as they are indispensable to the safe performance of obstetric nurses in home birth care.

Moreover, it is considered a mistake that the MH recognizes the women's right to choose the place of delivery[1], the regulatory agencies authorize the performance of obstetric nurses at home, including the federal council of the category[3] and, nevertheless, there is no work structure designed by health policies that makes feasible the home birth care by obstetric nurses.

Thus, the invisibility of this care modality in the country's health policies is a factor that hinders the debate about the work process that has been practiced by obstetric nurses and the possibilities of qualifying it.

It is understood that the results of this research have limitations related to the regionalization of the sample, which does not allow generalizations. Thus, future researches should be developed, expanding the sample to other regions of the country in order to unveil (or reaffirm) the difficulties found by obstetric nurses in home birth. Furthermore, the scarcity of studies addressing the difficulties experienced in this modality of delivery was a limitation for the discussion of the results of this study.

Conclusion

The results of the study indicate that obstetric nurses face important difficulties in the trajectory of care for planned home birth, which include social prejudice with the care performed, generated by the lack of information on the subject; stigma and obstetric violence in the event of a transfer to the hospital; difficulties in the acquisition of inputs and services necessary for safe and quality home practice; and absence of protocols that direct the performance in the home environment.

The difficulties are related to the invisibility of home birth in the country's health policies. In this sense, obstetric nurses face social and practical difficulties that weaken and hinder home birth care. These difficulties seem to be related to the lack of regulation of this model of delivery care in the country's public health policies.

The recognition of the difficulties faced by obstetric nurses in home delivery care contributes to give visibility to the work developed by this category, allowing reflection on coping strategies that can improve and legitimize this care model that is currently in full expansion in Brazil.

Collaborations:

1 – conception, design, analysis and interpretation of data: Gabriela dos Santos Pascoto, Antonieta Keiko Kakuda Shimo and Clara Fróes de Oliveira Sanfelice;

2 – writing of the article and relevant critical review of the intellectual content: Gabriela dos Santos Pascoto, Erika Zambrano Tanaka, Luciane Cristina Rodrigues Fernandes and Clara Fróes de Oliveira Sanfelice;

3 – final approval of the version to be published: Gabriela dos Santos Pascoto,

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