REUFSM
REVISTA DE ENFERMAGEM DA UFSM

Rev. Enferm. UFSM - REUFSM
Santa Maria, RS, v. 10, e51, p. 1-17, 2020
DOI: 10.5902/2179769234841
ISSN 2179-7692

Original Article Submission: 20/09/2018 Acceptance: 03/02/2020 Publication: 03/07/2020

Women's experiences with home birth: retrieval through history

Vivências de mulheres com o parto domiciliar: resgate por meio da história oral

Las experiencias de las mujeres con la casa del nacimiento: rescate por medio de la historia

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Abstract: Objective: to retrieve the experiences of a group of women regarding home birth. **Method:** qualitative, exploratory and descriptive study, performed in the household of 11 women who had had their deliveries in the home environment and whose acquisition occurred from the snowball sampling technique. The data collection occurred from August to October 2017, through Thematic Oral History interview. The data were submitted to thematic content analysis. **Results:** The parturition in the household was involved by representativeness, family care, rituals and popular beliefs, allied to the midwife's representative work. **Final thoughts:** it is necessary to reflect the concerns of the models of obstetric care, constructed over the years, characterized by the gradual loss of the lead role and autonomy of women and their families, as well as encourage new possibilities to childbirth care, guided by the cultural, humanized, personified and integral care.
Descriptors: Women's health; Home childbirth; Nursing

Resumo: Objetivo: resgatar as vivências de um grupo de mulheres a respeito do parto domiciliar. **Método:** pesquisa qualitativa, exploratória e descritiva, realizada no domicílio de 11 mulheres que tiveram seus partos em ambiente domiciliar e que foram captadas a partir da técnica de amostragem em bola de neve. A coleta de dados ocorreu nos meses de agosto a outubro de 2017, por meio de entrevista História Oral Temática. Os dados foram submetidos à análise de conteúdo temática. **Resultados:** a parturição no domicílio mostrou-se envolta de representatividades, cuidados familiares, rituais e crenças populares, aliadas à atuação representativa da parteira. **Considerações Finais:** é preciso refletir a respeito dos modelos de assistência obstétrica, construídos ao longo dos anos, caracterizados pela

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perda gradativa do protagonismo e da autonomia da mulher e de sua família, como também incitar novas possibilidades de assistência ao parto, pautadas no cuidado cultural, humanizado, personificado e integral.
Descritores: Saúde da mulher; Parto domiciliar; Enfermagem

Resumen: **Objetivo:** rescatar las experiencias de un grupo de mujeres con respecto a los partos en el domicilio. **Método:** estudio cualitativo, exploratorio y descriptivo, realizado en el hogar de 11 mujeres que habían tenido sus partos en el hogar y que fueron captadas en la técnica de muestreo en bola de nieve. La recogida de datos se produjo durante los meses de agosto a octubre de 2017, por medio de entrevista de Historia Oral Temática. Los datos fueron sometidos a análisis de contenido temático. **Resultados:** el parto en el hogar estaba cubierto de representatividades, el cuidado de la familia, rituales y creencias populares, aliado a la actuación representativa de la comadrona. **Consideraciones finales:** es necesario reflejar las preocupaciones de los modelos de atención obstétrica, construidos a lo largo de los años, caracterizados por la pérdida gradual de activismo y la autonomía de las mujeres y sus familias, así como alentar nuevas posibilidades de la atención del parto, guiadas por el cuidado cultural, humanizado, personificado e integral.
Descriptores: Salud de la mujer; Parto domiciliario; Enfermería

Introduction

Childbirth can be represented as a natural, physiological, female and singular event, which, in the past, occurred at home, with the presence of midwives and sustained by the family context. Gradually, it was transferred to the hospital environment and began to be marked by the development of routines and standards, which do not always appreciate women's lead role and autonomy.[1]

With the advancement of scientific evidence, the assistance to delivery and childbirth ceased to be restricted only to the hospital scenario, covering other spaces, such as the household and the Normal Delivery Centers or Houses.[2]

However, despite the increment and recognition of these other sites and governmental actions in favor of humanization and adoption of good practices in Brazil, in 2017, there were approximately 2,878,089 million births in the hospital environment. Of these, 1,619,781 were cesarean sections and 1,256,489, vaginal births.[3] In the same year, in Rio Grande do Sul, the numbers were similar, of 141,005 births, 88,951 were cesarean sections, and 52,021, vaginal births.[4]

Under this perspective, the cesarean sections, under real indication, indeed contribute to saving lives, but, without indication, can result in risks and increased rates of maternal and neonatal mortality.[1] Therefore, the use of interventional obstetric practices and abuse in cesarean sections are evidenced, which are in serious violation of women's rights.[1] Furthermore, sometimes, the procedures are performed without the permission of the childbearing/parturient, and can configure in obstetric violence.[1]

With this, changes have been proposed, in the environments where births occur, with the intention of making them more welcoming.[2,5] At the same time, there is the importance of retrieving the childbirth as a physiological, less interventionist and medicalized event.

Given the above, the retrieval of women's perspectives in relation to the experiences of their home births emerges as an opportunity to raise awareness among health professionals and the society in general with respect to other models of delivery and childbirth. Therefore, the following research question guided this study: what are the experiences of women living in the countryside of Rio Grande do Sul, Brazil, in relation to home birth? The study aims to retrieve the experiences of a group of women regarding home birth.

Method

A qualitative, exploratory and descriptive study carried out with 11 women whose deliveries occurred at home and who lived in the countryside of Rio Grande do Sul, Brazil. The municipality of residence of participants has 11 Family Health Strategy (FHS) and, for the development of the study, there was a draw of a FHS for acquisition of participants. When accessing the drawn service and clarifying health professionals about the research objectives, the Community Health Agents (CHA) indicated the first participant. This, in turn, indicated the second participant and, thus, successively, according to the snowball sampling technique.[6]

The inclusion criteria were women who had experienced home birth, without age limit nor temporal clipping regarding the occurrence of this experience. There were no exclusion criteria for participants. The number of interviews was not predetermined and, to interrupt data collection, the criterion of data saturation was adopted[7]. Once the reading and interpretation of the discourses proved sufficient for achieving the research objective.

The women indicated were personally contacted or through phone calls, aiming to invite them to participate in the study. All the women accessed and invited accepted to participate in the research. Upon the acceptance, the data collection date was scheduled through the technique of Thematic Oral History.[8]

The data collection occurred between the months of August and October 2017, at the participants' home, and the interviews were audio-recorded and lasted 13 through 49 minutes. Previously, an instrument to characterize the participants was used and, as a result, the interview was conducted from the question: “How was it since the discovery of pregnancy until the moment of delivery and postpartum?”. After the interview, the data were transcribed and a new meeting was scheduled with each participant for data validation, through the reading of the transcriptions and text of their stories.[8]

The data were submitted to thematic content analysis.[9] In the first step, called pre-analysis, the interviews were transcribed in Word format and, after, printed for the floating reading and identification of the meaning units. Then, we carried out the exploration of the material through the thematic categorization. At this stage, the speeches were highlighted with different colors. Finally, the results obtained were treated and interpreted, emerging three themes that will be discussed in the results.

The participants were identified by the letter “W”, the first letter of the word woman' and the order number of the interview, in order to preserve their identities. Women who agreed to participate in the study received the Informed Consent Form, which was read and signed before

starting the interview, also being offered a letter of Free Assignment of Rights of Oral Testimony and Ethical Commitment of Non-Identification of the Deponent, both signed by the participants and researchers.

Since this research involved human beings, the project followed the standards of resolutions 466/2012 and 510/2016 of the National Health Council. The Research Ethics Committee approved the study on 02 August 2017, under CAAE: 71334817.3.0000.5353.

Results and discussion

The participants' age ranged between 64 and 87 years. In relation to schooling, ten of the eleven participants had incomplete elementary education and one of them was not literate. Regarding marital status, seven were widows, three married and one divorced. Concerning income, four were retired, four pensioners (receiving one minimum wage), two retired and pensioners (receiving two minimum wages) and one worked and had an income of one minimum wage.

In terms of religion, five were Catholic and six, evangelical. The number of pregnancies ranged between six and sixteen, and the number of pregnancies does not coincide with the number of home births, because some of the participants had hospital births or abortions, as observed in Table 1.

Table 1- Characterization of participants regarding age, total number of pregnancies and home births. Santiago, Rio Grande do Sul, Brazil, 2017.

Woman's identification	Age	Total n. of pregnancies	Total n. of home births
W1	78 years	7	5
W2	87 years	13	9
W3	64 years	7	3
W4	76 years	16	14
W5	76 years	8	3
W6	76 years	9	9
W7	80 years	7	4

W8	74 years	7	4
W9	75 years	6	2
W10	77 years	11	7
W11	83 years	15	15

After data analysis[9], three themes emerged: "At home, I felt safe and feared nothing": the representativeness of home birth; "I think I wouldn't have given birth without her": the role of midwives in the parturition process and "They kept waiting, in any case, they were there": the family participation in childbirth and puerperium.

"**At home, I felt safe and fear feared nothing": the representativeness of home birth**

The childbirth represents a rite of passage,[10] which may be experienced by the woman and her family. Regardless of the route, modality or place of birth, it represents a biological event, imbued with social, emotional, subjective, spiritual and cultural aspects. When it occurs in the household, it has specific representativeness, assigned by each woman.

> *At home, I felt safe, I feared nothing.* (W4)
> *I was forty-one when I had* [daughter's name] [...] *normal delivery at home, only with God's providence, nothing else.* (W6)
> *To see how it is, God helps, because, without God, how would we go through it? And if a hemorrhage occurred? What if there was a problem in the birth? What would happen with us? We didn't think about that.* (W8)
> *They are all raised* [children]*, thanks God, they're all healthy, they were all born at home*. (W11)

Women expressed satisfaction in giving birth at home and attributed the aid of God as a relevant aspect in this process. Under the cultural and symbolic perspective,[11] the faith or spirituality represent elements capable of providing protection and safety. Therefore, regarding the experience of the unknown or unexpected in the parturition process, the belief in God assumed the representation that could support them and help them achieve a positive outcome.

Moreover, the experience of home birth was represented by labor signs. These were symbolized by the pain of contractions and expressed as a form of illness.

> *I felt so bad, so sick, and I had to give birth.* (W1)
> *I felt sick for hours, hours and hours feeling pain and couldn't stand on feet.* (W3)
>
> *I felt sick in the afternoon. It seemed I was going to give birth.* (W8)
>
> *When I felt sick, I was going to give birth.* (W11)

The representation of the birth as a process of illness reveals the cultural contextualization of this event.[12] Therefore, it reflects the cultural values of every woman from the allocation of senses and meanings to physical and emotional manifestations presented during labor and delivery.

Studies[12-13] highlight that, for certain groups, childbirth represents a dramatic event, marked by pain and physical suffering. Authors emphasize that these representations comprise a cultural vision, which is widespread among women, in society and in the media.[13] For the study participants, this process has a pathological perspective, which can be "controlled" and/or "treated" with the birth of the baby.

Thus, when referring to the pain of contractions, they ascribe as something bearable and even necessary. Therefore, although recognized as an event marked by fatigue, pain and physical suffering, they attach positive representations in relation to the experience, because it results in the birth of the baby.

> *When a woman is getting ready to give birth, the more pain, the better.* (W2)
>
> *The pain is horrible, there is nothing to do and gets stronger, and when it's time, there comes the strongest pain, the one the body opens for the baby's birth, then you scream and, when you realize, you see your baby in your arms.* (W6)
>
> *Not so much pain, some complain of it, but it wasn't so much, I've never had.* (W10)

> *The pain is like cramps, you know?* [...] *a strong "little pain" indeed and increasingly stronger, until that pain comes for the baby's birth.* (W11)

The reports show that the pain in labor and childbirth can manifest in different ways, being influenced by the cultural context in which values, beliefs, traditions and perceptions were created and transmitted.[11] However, in the biomedical and technocratic model, introduced in contemporaneity, the pain started to be rejected[14], which lead to an increasingly high number of cesarean sections in an attempt to eliminate any painful process.[1]

Despite this, women in the present study continued to experience labor and childbirth at home, in some cases, using the relief through non-pharmacological measures. These involved oil massages performed by midwives, pelvic movements, which they termed "swing-pad", the offer of teas and ambulation.

> *She* [midwife] *got here and started getting things ready for me to give birth, my first one was with her, she kept swinging us to push to give birth and, when I was about to give birth, she kept saying the child would be born real soon* (W1)

> *She* [midwife] *heated that oil and passed it on the belly, the help she gave me, and the chicken broth at home, they fattened that chicken, prepared and brought me in a glass for me to drink, I drank while in labor.* (W5)

> *I kept walking, walking, sometimes it hurt, and I grabbed a chair, the bed, stayed there, and the pain got better, and then came another.* (W6)

> *They* [midwives] *told me to "swing" and they swung. I don't know, may they knew the easiest way for getting the baby out.* (W9)

These midwives had rituals[10] of care specific for the assistance to childbirth. These rituals rooted into popular and traditional knowledge propagated between generations of midwives, but mainly from their practices in the monitoring of the labor and delivery of other women.[15]

In addition, there is the possibility of the midwife to offer, in the household, a more individualized and personalized care to women,[16] using their own family resources, such as teas. With this, there is the role exercised by the midwife during this period, helping, caring and

accompanying women, children and families in the process of labor and birth. Therefore, the role played by the midwives contributes to the singular care with women during labor, delivery and postpartum, through popular care modes.

"I think I wouldn't have given birth without her": the role of midwives in the parturition process

The midwife emerged in the interviews as a figure crucial to the positive experience of childbirth. Some of them considered themselves unable to give birth without her presence.

> *I was lucky I've never got hurt, the midwife was great, I got better fast, I think, without her, I would've never given birth because, when the other midwife came, I found it strange, she conducted the birth, left and returned on the next three days, to see how I was e bathed the child because that was the deal.* (W1)
>
> *She came* [midwife] *and conducted the birth.* (W5)
>
> *We got there before the pain got stronger, they ran to pick up the midwife, so that I could have the midwife with me while giving birth.* (W8)

The midwife was mentioned as essential for the good evolution and recovery of childbirth, with whom a strong bond was established. In this direction, a study highlights the important and representative activity of traditional midwives in the parturition scenario, especially in the past, in which her work was appreciated and respected.[17]

In this sense, one refers to the current scenario of obstetric care, which, in some countries, such as Ireland, has maternities exclusively led by midwives.[18] These act on assistance to low-risk women, offering safe care, through strict criteria for transferring the parturient when necessary.[18] Such actions result in low rates of obstetric complications and interventions without scientific backing.[18]

Nevertheless, one could also observe the influence of midwives in childbirth process. They directed the experience of parturition of these women from the movements, breathing and position to be adopted during labor and delivery.

> *She* [midwife] *placed us on a wooden box, only with our coccyx on it, and we got wide open, and she kept helping, pulling, righting.* (W6)
>
> *She* [midwife] *has to lead us, and the breathing, we cannot inspire, only expire, because, when we inspire, he* [baby] *ascends, and they squeeze here* [epigastric region]*, for the child to go down, and take care of it down there* [vagina] *if the child is in the right position to be born.* (W7)
>
> *I gave birth in the bed, because she said that, when the pain ceased, the woman could rest.* (W8)
>
> *She* [midwife] *told us not to open our mouth, we had to take it with our mouth shut, we couldn't because if we inspired, every inspiration, pulled him* [baby] *more and more.* (W8)

The reports show that the decision power was mostly of the midwife and the woman followed her orders, since they trusted their practice and knowledge; although studies underline home birth as a process covered by women's autonomy and lead role.[15,19] In addition, although not recognized as harmful due to the few known and existing scientific evidence at that time, some of the approaches adopted by the midwives who attended their labors were clearly harmful or ineffective practices, with current recommended elimination,[20] such as the effort of long and directed pull and the routine use of supine position during labor. Other practices, such as the uterine pressure during labor and the maneuvers for the management of the cephalic pole and active manipulation of the fetus at the time of delivery, currently have no sufficient evidence supporting their recommendation.[20]

In the same direction, there were practices currently recognized as beneficial and recommended during labor, such as early contact between mother and child and breastfeeding

in the first hour after birth.[20] In the reports, the participants emphasized that, after the birth, the priority was to bathe and dress the newborn.

> *After the birth, she* [midwife] *gave the first bath and dressed the child, then she put the child to nurse, but, at that time, the children nursed little, because it took three days for the milk to do down and they gave us tea, it takes a time for the breastmilk to exit.* (W1)
>
> *After the birth, she bathed, changed and nursed, all of them on the breast.* (W3)
>
> *She* [midwife] *bathed, dressed, swathed the baby, and put him in the bed.* (W4)
>
> *They took the baby, but the clothes on, put him with me, and he stayed in my arms, a few hours later, he was already nursing.* (W5)
>
> *She* [midwife] *cut the baby's navel, bathed him and gave him.* (W10)

The immediate interaction between mother and child and the breastfeeding itself were not urgent for midwives. All other care and steps preceded the early contact between the dyad, possibly because, in this period, the benefits of these practices were not known. In this context, there stands out the stimulation to lactation even in the immediate postpartum, due to skin-to-skin contact between mother and child.[21] This period is ideal to start and ensure the effectiveness of breastfeeding, besides reducing the rates of hospital admissions during the first days of life.[21] Nonetheless, even with known benefits for mother and baby, this practice is not performed universally. [22]

This study found that the participants expressed the role of midwives positively, similar to other studies.[15,23] This perception may result from the differentiated service provided by midwives,[15] but also because, at the time, they were known and indicated by relatives and friends, lived near and charged an affordable price for delivery assistance.[23]

"They kept waiting, in any case, they were there": the family participation in childbirth and puerperium

The family participation was highlighted as an important aspect in the women's experience, especially in the postpartum period. The presence and participation of mothers, sisters, mothers-in-law and the partner reinforces the idea that close people chosen by the parturient are capable of providing safety and confidence.

> *My husband was there, stayed with me, also did my mother, she was there and they kept waiting, they were there in case I needed.* (W2)
>
> *My mother, her mother and the mother-in-law, my mother-in-law wished me the best, so did my father-in-law.* (W7)
>
> *He* [husband] *kept caressing my head, calming me down, because he saw I was suffering.* (W8)

Although the family had not specific actions during the parturition process, their presence was necessary for this experience. The authors of a study on planned home birth reinforce that family participation in labor contributes to retrieving the birth humanization, implying greater safety, tranquility and affection for the woman.[24] Thus, it confirms the importance of the family participation in the entire child birth process, once the institutionalization of childbirth led to the gradual family separation, contributing to the birth artificiality and dehumanization.[24]

In relation to the postpartum recovery, the participants describe care, beliefs, habits and customs, guided by midwives and the family. Among these, they highlight the food that should be ingested and the care during this period.

> *We couldn't wash the head before the fortieth day, even if it was too dirty, it was too dangerous give a "suspension" in the head, as the elderly and my mother used to say, dirt is no murder* [laughter] *and we had to take it, and I took care of myself, I was so afraid, because so many things can happen.* (W1)
>
> *I gave birth to my first child with my mother-in-law, who was Italian, and the Italian women had the so-called quarantine, I had to take care of myself within the forty days, I couldn't even wash my head, nor take a shower, just clean myself.* (W6)

> *During the forty days, I ate only broths, a chicken soup, just chicken.* (W7)
>
> *They* [children] *nursed during a little more than one year, I didn't have too much milk because I got bad in almost all their births. This I show it works: the milk decreases, because we got up working, doing the house chores, because no one else would, doing the laundry, pulling well water, because we had no piped water, so to wash their clothes, I had to pull the well water.* (W9)

The popular or family knowledge were disseminated and appreciated among women, who believed that non-compliance with the guidelines could result in some undesired outcome. Even currently, many traditions and popular beliefs are perpetuated, despite the knowledge and dissemination of scientific evidence.

The labor and birth represent events imbued with different meanings, viewed in different ways in each group and/or society, according to the sociocultural and family context of every woman. Therefore, beliefs, guidelines and restrictions cited by the participants have cultural value for them and their families.

Final considerations

The event of childbirth in the home environment was involved by multiple representations, encompassing from the beginning of labor, that is, as a process of illness, until the pain experienced and relieved by these women and their midwives. The woman not always acted as a protagonist or central figure of this process, being the midwife appreciated and regarded as the center of care due their baggage of knowledge and practice, although the participants have not expressed this perception.

The family was close and attentive to the needs of the parturient and their presence gave safety and tranquility to the woman. Furthermore, they were also responsible for disseminating beliefs, knowledge and traditions, especially in relation to care during the puerperal period.

As limitations found in the study, there were the participants' difficulties to recall the experiences due to advanced age, although the reports of family members and other individuals from family and cultural context of women have not been privileged. This fact shows the need for new researches involving the family network that experienced, along with the woman, the home birth, as well as the health professionals and the midwives that attended it.

Among the implications of this study, there is the possibility of retrieving the experiences of a group of women on home birth, care model that, currently, is at the margin of the conventional health system, but, which, in the past, represented the first, if not the only, birth option. With these findings, one expects to provide reflections on the obstetric care models built along the years, characterized by the gradual loss of lead role and autonomy of women and their families, as well as encourage the importance of (re)thinking new possibilities of childbirth care, guided by the cultural, humanized, personified and integral care.

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How to cite this article

Serres WP, Pieszak GM, Gomes, GC, Prates, LA, Rodrigues, AP. Women's experiences with home birth: recovering through history. Rev. Enferm. UFSM. 2020 [Cited: Year Month Day]; vol.10 e51: 1-17. DOI: https://doi.org/10.5902/217976923484