



MOTIVATION OF MIDWIVES FOR HOUSEHOLD CHILDBIRTH PLANS
MOTIVAÇÃO DE ENFERMEIROS OBSTETRAS PARA O PARTO DOMICILIAR PLANEJADO
MOTIVACIÓN DE LAS ENFERMERAS PARTERAS PARA EL PARTO EN CASA PLANEADO

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ABSTRACT

Objective: analyzing the motivations of the obstetric nurse for the practice of planned homebirth. **Method:** an exploratory and interpretative study of qualitative approach, with 22 midwives nurses. The data production was by semi-structured interviews and the speeches were analyzed by thematic categories. The research project was approved by the Research Ethics Committee, CAAE 0137.0.168.000-11. Results: the motivation to serve on planned home childbirth surpasses the professional choice. The art of midwifery is perceived as a mission, a vocation that many professionals already possessed before their academic training. **Conclusion:** The study revealed that family tradition, mission, vocation, and quality of care are important factors in motivation; midwives in their work encounter obstacles and challenges of social and political nature, but create new coping mechanisms and remain working tirelessly. **Descriptors:** Household Childbirth; Humanized Birth; Obstetrical Nursing.

RESUMO

Objetivo: analisar as motivações do enfermeiro obstetra para a prática do parto domiciliar planejado. **Método:** estudo exploratório e interpretativo de abordagem qualitativa, com 22 enfermeiros obstetras. A produção de dados se deu por entrevistas semiestruturada e os discursos foram analisados em categorias temáticas. O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa, CAAE 0137.0.168.000-11. **Resultados:** a motivação para atuar no parto domiciliar planejado ultrapassa a escolha profissional. A arte de partejar é percebida como missão, vocação que muitas profissionais já possuíam antes de sua formação acadêmica. **Conclusão:** o estudo revelou que tradição familiar, missão, vocação, e a qualidade do atendimento são fatores relevantes na motivação; enfermeiros obstetras em sua atuação se deparam com obstáculos e desafios de natureza social e política, mas criam novos mecanismos de superação e permanecem atuando incansavelmente. **Descritores:** Parto Domiciliar; Parto Humanizado; Enfermagem Obstétrica.

RESUMEN

Objetivo: analizar las motivaciones de la enfermera obstétrica para practicar el parto planeado en casa. **Método:** un estudio exploratorio e interpretativo con enfoque cualitativo, realizado con 22 parteras. Los datos de producción se dieron a través de entrevistas semi-estructuradas y se analizaron los discursos en categorías temáticas. El proyecto de investigación fue aprobado por el Comité de Ética de Investigación, CAAE 0137.0.168.000-11. **Resultados:** la motivación para actuar en el parto planeado en casa excede la elección profesional. El arte de la partería se percibe como misión, la vocación que muchos profesionales ya poseían antes de su formación académica. **Conclusión:** el estudio reveló que la tradición de la familia, la misión, la vocación y la calidad de la atención son factores importantes en la motivación; parteras en su actuación se deparan con obstáculos y desafíos de carácter social y político, pero crean nuevos mecanismos de superación y se mantienen trabajando sin descanso. **Descriptor:** Parto Domiciliario; Parto Humanizado; Enfermería Obstétrica.

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INTRODUCTION

Childbirth is a natural process. Pregnancy and childbirth are among the most significant and impactful experiences to the women's life that can bring positive or negative results, influencing in future pregnancies and births.¹⁻³

During the course of life, the woman undergoes many processes favoring changes in their behavior, and, accordingly, childbirth is an event of major changes to the mother. However, the autonomy and their decision about their body should prevail in moment of giving birth.⁴

The events involving the process of labor and birth in the hospital setting mark a hazardous atmosphere, suffering, frustration of expectations, physical or symbolic violence and becoming painful and exhausting for the woman and her family, difficult to turn this experience into something positive, rewarding and healthy.⁵

During the decades 60-90, in the labor and birth process prevailed the technocratic model bringing the institutionalization of labor, misuse of invasive technologies, incorporating a large number of interventions, often unnecessary, and as a consequence, high rates of cesarean sections, fetal monitoring, episiotomies, induction with oxytocin, among other behaviors.

The humanistic model emphasizes the welfare of the parturient and her baby, trying to be the least invasive as possible. It uses technology appropriately, and the assistance is characterized by continuous monitoring of the birth process.⁶

The act of humanizing health care for women in labor process directs attention turned to the wife and family in their uniqueness, with specific needs that go beyond biological questions and include the social, ethical, educational and psychological conditions present in human relationships.⁷

Humanization and quality in birth care are essential conditions for health actions will result in the resolution of identified problems, satisfaction of users, strengthening the capacity of women to identify forward their demands, recognition and claim their rights and promoting self-care in order to improve the quality of life of the mother and newborn.⁸

According to standards established by the Ministry of Health, it ensures to the parturient the right of a companion during the labor, choose the position to give birth, have measures of pain control during expulsion,

breastfeeding in the birth room, what contributes to uterine emptying and mother-child interaction.⁹

In 1996, the World Health Organization (WHO) published the Practical Guide to Care in Normal Birth which was translated into Portuguese and distributed by the Ministry of Health to health facilities and professionals for obstetric care in 2000. This document classifies obstetric care in four categories: a) clearly useful practices that should be encouraged and b) clearly harmful or ineffective practices that should be eliminated c) practices without sufficient evidence to support a recommendation and it should be used with caution, as additional research demonstrating the issue and, d) practices often used in an inappropriate way, causing more harm than benefit.

The midwifery practices when deploying services in health, in search of humanization recommended by the World Health Organization puts at the disposal of pregnant women, specific and qualified professional attention, because it is essentially relational and derived from a structured knowledge in nursing service. This knowledge is applied transversely, integrating popular and diverse disciplines in the construction of care knowledge. Why have the basic tools bodies, provides comfort and autonomy to encourage women to recognize and develop their own skills. With support and based on scientific evidence, midwives began to use techniques that consider favorable to the physiological evolution of labor and non-pharmacological practices for pain relief.¹⁰

The Report of the National Demographic and Health of Children and Women reports that 44% of births in the country are cesareans, and 97,07% of the physiological births are performed in hospitals. In the State of Goiás, 99,65% receive birth care institutionally.¹¹⁻²

The parturition assistance by the professional Nurse in Brazil totalizes 8,3% of the procedures performed on the national territory. In the Midwest region of Brazil, only 3,3% of births are performed by the professional nurse.¹² Between the years 2001 to 2007, traditional midwives were responsible for the birth of 206.918 million children in Brazil, 81% of births in the region northeast.¹³

In the 60s, in Brazil, the institutionalization of childbirth parturition showed considerable change in this scenario, promoting quality of care at birth with the introduction of multidisciplinary team care practices in childbirth, brought with it a range of

technological advances that now contribute to the reduction of maternal and neonatal mortality. However, this change in the environment has also brought considerable increase in the number of interventions in birth, as the cesarean parturition. This type of labor began to be treated electively hindering the process of humanization of birth.^{8,14}

The noninvasive nature of the midwifery care technologies lies in believing that when the subject establishes a bond of trust with the professional; both share decisions in planning their care.¹⁵

The nurse is a professional licensed, of a technical form, enabled for assisting parturition. Since 1998, the Ministry of Health and its Secretaries initiated strategies, establishing policies with a focus on professional qualification of Nursing and Midwifery to work in assisted vaginal birth. Financing of the Specialization in Obstetrics and ordinances for the inclusion of labor performed by the Nurse in the payable of the Unified Health System (SUS); some measures were developed by the Ministry of Health.¹⁶

In recent years we have experienced major changes in the setting of obstetric care, in which values that go beyond the scientific and technological aspects, pointing to the rescue of the historical model of the birth, again bringing home environment as conducive to the birth site is restored. In this context, midwives emerge on the rise for planned homebirth, aiming at recovering the quality of midwifery care for the mother and newborn.¹⁷

The birth assistance shows the movement of change for the least interventionist cultural practices observed by the pursuit of pregnant women by home birth, ie, known for planned home birth, in great capitals of Brazil. The residence presents itself for these mothers, as a safe and viable environment for giving birth.¹⁸

In this understanding, this paper aims to:

- Analyzing the motivations of the obstetric nurse to practice planned homebirth.

METHODOLOGY

This is an exploratory and interpretative study of a qualitative approach, based on Grounded Theory. The study subjects were 22 midwives working in the birth of low-risk, at home, in the States of Santa Catarina, Minas Gerais, Rio de Janeiro, Sao Paulo, Federal District, Bahia, Ceará and Pará. The respondents were in their majority female, with only one male.

There were included in the research, nurses who carry the title of specialist in obstetric nursing; who acted in planned home birth from the year 1986, after the implementation of the Professional Practice and agreed to participate in the research by signing the Informed Consent (WIC). There were excluded from the study traditional midwives, without higher training in midwifery.

The production and analysis occurred simultaneously, following the steps proposed by PDT: open, axial and selective coding. The interviews were produced in the period from January to July 2012, through virtual scenario (internet) Skype or Messenger in voice chat mode. The respondents of this study operate in the delivery of low-risk, at home, most are female, only one male. In the text that follows, participants were identified by letters in alphabetical sequence.

In the PDT model is constructed from continuous comparison between the codes, including codes and data, thus identifying the similarities and differences that allow categories gradually emerge and are related to each other.

This project was approved by the Ethics Research Committee of the Pontifical Catholic University of Goiás, registration 1887, and dated 10/28/2011 under the CAAE 0137.0.168.000-11.

RESULTS

The role of the nurse midwife at domiciliary planned birth is permeated by different motivations and values that have been built over the years, and promote the quality of birth care. The motivations, often perceived as a vocation, or even experienced, emphasize attention in the hospital birth experiences were building a conception of humanized birth and awakening an interest in this action times. Some women felt adept even after the experience of having their own home birth.

From our interviews about the motivation of the obstetric nurse to act in homebirth, 2 themes emerged, namely: Family history, mission and vocation; the quality of care as motivation.

♦ The family history, mission and vocation.

The motivations often been perceived as a vocation, or even dissatisfaction experiences in attention to hospital birth. Respondents reported that they were building a conception of humanized birth and awakening interest in this type of activity.

Some nurses felt even geared for family history of maternal births and birth in your own home:

[...] I truly believe I was born midwife; I have this vocation long before you think about doing a degree, since I was a girl calling to midwifery (B).

[...] Since before I graduated in Nursing, I wanted to be a midwife, but in Brazil at that time had no course for midwives, as a child, I always had an interest; it seems that was really my calling (J).

The motivation to work in the planned home birth goes beyond a career choice. The art of midwifery is seen as a mission, a vocation that many professionals have had even before an academic background:

I think each of us has a mission in this world and I think my biggest mission was to come with the home birth (A).

The process of interpersonal relationship among professionals is also a motivator for this practice. For example, contact with other nurses who have worked in homebirth and friends who had the same line of affinity in childbirth and humanized birth, sparked an interest in several professional for this type of activity:

Contact with other women who attended parturitions, traditional midwives, midwives, professional and know the reality of families who had been through the experience, were motivating for me to take over as sole activity after my retirement (F).

[...] Talking to a friend, we saw that we had pretty much the same ideas, then from there we plan on building a business and offer regular home birth for women who wanted to have a child at home (S).

The personal experience of home birth aroused interest in several professionals to act in homebirth. The sure wanted to act in the planned home birth came after their experience of their own birth. This experience culminated motivation:

[...] I even got my kids at home. My obstetric practice opened my mind a lot, but specifically for the home birth was my own experience (D).

My daughter was born in homebirth and from there I was sure that I wanted to act in homebirth; Until then I had never attended one labor at home, but when I had my daughter at home, I decided I also wanted to work at home (J).

The vocation cited by interviewees resembles the work of midwives. Based on the question of vocation, many professionals give up even their compensation to meet the home births.

♦ The quality of care as motivation

The inquiries into the work of professionals in-hospital birth is related to the motivation of nurses to work in planned home birth. Some interviewees reflected on the high number of interventions and procedures, often unnecessary. These behaviors aroused concerns about the quality of care provided to the mother during institutional normal parturition.

[...] I started working in a public hospital and the women were met during labor, birth and immediate postpartum by midwives. But the hospital has generated some concerns me the high number of interventions, the posture that the woman had to stay at this period, the performance of routine episiotomy, the indiscriminate use of oxytocin. During this period I had an experience, the patient admitted in low-risk pregnancy, as was routine obstetric nurses monitor. The laboring woman was hospitalized and I host, when I saw her, she had a normal parturition without serum, then I started to think our women have a condition of gaining their child without serum (E).

[...] I was already involved with the humanized birth, I've defended the flag, but home birth for me was a very distant thing, far short of my practice and I did not see myself in homebirth... My practice was only hospital, and I always asked myself and did not agree with the practice that was employed in the hospital (A).

The respondents said that the recovery of the area is an important aspect in building the quality of care. The professional growth was highlighted as a condition of quality in birth care at home. The undergraduate and graduate students do not bring itself a luggage enabling direct action to homebirth. The attention to the intra-hospital birth makes the practice and experience in obstetric emergencies and adverse situations of births as identifying dystocia - difficulties identified during the course of a labor and other complications.

Several interviewees said that there is no need for specific experience in home birth but the hospital birth:

If I were newly formed today, I would join today at no homebirth. I need hospital practice, field evaluation of dilatation of the cervix and even practicing in urgency to feel prepared to work in home birth because the homebirth. It's you and yourself, you must have experience and be prepared. It is the responsibility you take two lives. This experience us not leave college with her, it just our practice will give (A).

You must have experience in the parturition in identifying dystocia (C).

[...] It is very important to have an experience with childbirth care. Professional experience brought me to safety I follow homebirth (K).

I think the important thing to have super experience. And I think the experience is not experience in home birth. The person does not have to watch a lot of home birth; she goes home and home she will learn [...] It does not need to know why it is not working. She just needs to know what is not working and have this woman to the hospital (Q).

The update was pointed out by professionals like quality condition on acting. In this context, the respondents showed the importance of participation in courses, reading scientific papers and general updates, national and international level, but also know wisdom of midwives:

[...] Other requirement I think is update, take courses to upgrade you. I try to be making progress all the time, mainly geared for training within the home so I can do a job as best as possible (A) delivery.

[...] Every time we update on the most [...] is a continuous recycling, and seek not only the Brazilian scientific work that has very little really, but study off (B).

We look for updates about humanizing birth at national and international level; we have contact with midwives from another country, to know how things work. So, we always sought to partner with other traditional midwives, who already have a long history of childbirth, to absorb the experience for us (S).

Professional training should always be associated with sensitivity to quality service delivery in the home environment. The ability to be wise in the conduct of labor is a key to the physiology of the natural process of giving birth, always respecting the woman's actions, partner and family member:

The sensitivity is critical, because it is amazing, but I know many professionals who had the same training as me and are not sensitized to serve a homebirth as I (I).

It is also important to homebirth a person has sensitivity to respect the process (J).

[...] Sensitivity to the woman, to know're dealing with that patient at that time (S).

The sensitivity of the woman is very, very important to give the opportunity to be full, to really experience, family experience that moment. It is a family that is born (B).

You can see that the performance of midwives goes beyond the professional aspect. The acting is experienced intensely, as an art of midwifery or mission. These professionals believe that quality for performance at home, the nurse should have experience in conducting hospital deliveries, scientific

knowledge to identify possible events or complications during childbirth. Also, consider upgrading as a continuous process, combining a keen sensitivity to the needs of women in different aspects of labor. This association is a differential for professional competency, which allows nurses to detect the risks and be sensitive to act at the right time, without invading the natural process of women.

DISCUSSION

In this study, the motivation of nurses is related to family history, mission and vocation to care and birth is an art of midwifery goes beyond a work activity. The interviewees believe that acting in homebirth is not just related to career choice, but has a vocation related to the significance that the midwives had before having academic education in Nursing.

With regard to the priesthood or vocation, it is a mission last family from mother to daughter as part of tradition of midwifery, this data is strongly present in the discourses and corroborates the recent past in the practice of assisting childbirth before seen solely as a vocation but that nurses start to perceive and act in a professional manner, requiring a combination of scientific knowledge and vocation.^{19,20}

The quality of care as motivation highlights two distinct points, is actually a dissatisfaction with the approach of institutional delivery focused interventionist practices, women as passive agent of the birth process and decisions of the professionals in choosing the type of parturition, too, was evident in the speech of some nurses by emphasizing the importance of scientific and technological advances in obstetrics, however, the way you use technology caused a gap in the natural model woman giving birth to her son.

These data corroborate other studies that claim, the insertion of childbirth in the hospital setting favored the increase in the number of interventions in an attempt to facilitate the birth process, a range of devices and drugs entered the scene of childbirth transforming birth care.²⁰⁻²

Some concerns observed regarding adopted in hospital labor birth conduits aroused in nurses interest in investing in the rescue planned home birth as humanized childbirth and neonatal care model.

Realizing a significant number of unnecessary interventions, the respondents stated that the noninvasive nature of the midwifery care technologies lies in believing

that when the subject establishes a bond of trust with the professional; both share decisions in planning their care.¹⁵

The current model of childbirth care has undergone major changes, in which values that go beyond the scientific and technological aspects, pointing to the rescue of the historical model of the birth, again bringing home environment as conducive spot for birth are taken.¹⁷ In this context, midwives emerge on the rise for planned home birth in order to resume the quality of midwifery care for the mother and the newborn.^{14,20}

Regarding the quality of humanized childbirth care, it means putting women in the center and in control of her actions as a subject, giving her a sense of security during parturition and care of newborns. The mother is given the autonomy to actively decide their own labor. The professional team acts as a facilitator of a natural process, in which the woman is prepared during the pre-natal care for self.²²

To act in the homebirth many nurses surveyed believe that it is necessary to have previous experience of dealing with childbirth. According to the interviewees' discourse, this would not necessarily experience in home birth, but a practice in hospital parturition that enables the professional to act in cases of dystocia. According to the resolution of the Federal Council of Nursing (223/1999) is for the nurse midwife obstetric identification of dystocia and taking all necessary steps until the arrival of the physician must act in accordance with its technical-scientific training, adopting essential to understand the procedures to ensure the safety of mother and child.²³

The World Health Organization - WHO - technical document related to obstetric nurse or midwife as the provider best suited for the role primary health care. And, recommends greater involvement of professional care to pregnant women in low-risk and normal delivery without dystocia.

CONCLUSION

By analyzing the motivations of the obstetric nurse for normal home planned birth of low risk was found that the humanized care can also be performed by obstetric nurse, midwife, obstetrician, family doctor and midwives. However, for home care is necessary that the professionals being trained to identify and emergency obstetric and neonatal emergencies, as well as obstetric dystocia, if necessary, refer to the reference service.

The study revealed that the family tradition of parturition vocation or mission were relevant factors in the motivation of midwives to engage in approach to planned home birth. Although there are many challenges and obstacles which these professionals remain active, creating new mechanisms to overcome every situation experienced hindrance.

Some nurses reported that they sometimes attend home births planned even without pay, for believing that such assistance includes values that go beyond the scientific and technological aspects, concerning the physiology of labor and birth and when the mother establishes a bond of trust with both share the professional decisions in the planning of their care, and contemplate the option of choice of pregnant women giving birth.

In the study it was clear that nurses have expanded operations in the setting of planned home births in the country. Previously, this model of childbirth care was more focused on the cultural practices of communities isolated by traditional midwives in some poor regions of the country or rural areas. In contrast, the current model is territory the large urban centers, dominated the insertion of midwives. It should be emphasized that in recent years the quantitative growth of professionals which has directed attention to homebirth, and you can find this type of care across the country, with more significant presence in capital cities and occurs in metropolitan areas.

The midwives who attend home births seek to rescue home birth performed by traditional midwives, however, during the service launch hand knowledge based on scientific evidence associated with cultural practices, techniques used by midwives and also aids the birth assistances.

The midwives considered the household as conducive to normal birth care for low-risk site. Continuous monitoring of labor offers security bond of trust covering the parturient with professional and family participation is essential as a therapeutic element and facilitator of a physiological process contributing to low rates of intervention, thus, the nature of women to act by itself, and childbirth happen naturally, preserving maternal and newborn health.

The experience of nurses in the care planned homebirth provides increased credibility of society that will respect the work of this person and seeking the quality of practice nurses always seeking to broaden their knowledge through the exchange of experiences between colleagues, with other

teams, participation in scientific events, courses, production and publication of knowledge related to their practice.

In Brazil, the Ministry of Health, through its ordinances, has adopted a policy of valuing the nursing professional who aims to encourage vaginal parturition by obstetric nurse with the inclusion of this procedure in the payable of SUS, and regulation of new report to be issued by a physician or nurse midwife, among other actions. However, the table regulates the payment of fees births SUS performed by Nurse Midwife specifically planned vaginal birth at home the public health system, health plans and private health plans still show incipient as the inclusion policy, effectively missing resolutions allowing professionals to acquire materials and medicines for obstetric use in the home.

Although the challenges and obstacles still persist, the midwives move towards what they consider ideal and ratify the WHO recommendations - the best environment for childbirth is one in which the woman feels secure, among others, the residence is a safe environment for the birth, provided that the wife and family decision. Therefore, the insertion of planned home births attended by midwives, demonstrated that motivation is a factor in the qualitative difference in overcoming institutional break paradigms consolidated for several decades with inappropriately interventionist obstetric practices that certainly pose risks to maternal and perinatal health and above all for rescuing labor and birth as existential and socio-cultural event as well as meet the needs of women during pregnancy and postpartum period. However, it is noteworthy that it is the of the pregnant woman the option to choose for the type of birth, the female population as a right guaranteed in the constitutional precepts.

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