

Social representations of health professionals in the hospital area about planned home birth

Representações sociais de profissionais de saúde da área hospitalar sobre o parto domiciliar planejado

Representaciones sociales de los profesionales de la salud en el área hospitalaria acerca del parto planificado en el hogar

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Abstract: Objective: apprehending the social representations of health professionals in the hospital area about the planned home birth. **Method:** a qualitative study based on the Theory of Social Representations and conducted with 15 health professionals of a teaching hospital. Data were collected in the second half of 2019 through semi-structured interviews. Thematic Content Analysis. **Results:** the reports originated two themes: 1) Home birth: one possibility, with eligibility criteria and 2) Home birth: a miscellany of concepts, opinions and interpretations. The social group investigated understands planned home birth as an option of care, with eligibility criteria. However, a association of this mode of birth with urgent/emergency situations prevails in the collective sense, with potential risk for women and newborns. **Conclusion:** the shared representations reveal the generalization of information without scientific support about planned home birth.

Descriptors: Women's Health; Obstetrics; Home Childbirth; Obstetric Nursing; Health Personnel

Resumo: Objetivo: apreender as representações sociais de profissionais de saúde da área hospitalar sobre o parto domiciliar planejado. **Método:** estudo qualitativo, fundamentado na Teoria das Representações Sociais e realizado com 15 profissionais de saúde de um hospital de ensino. Os dados foram coletados no segundo semestre de 2019, por meio de entrevista semiestruturada. Utilizou-se a Análise Temática de Conteúdo. **Resultados:** os relatos originaram dois temas: 1) Parto domiciliar: uma possibilidade, com critérios de elegibilidade e 2) Parto domiciliar: uma miscelânea de conceitos, opiniões e interpretações. O grupo social investigado entende o parto domiciliar planejado como uma opção de

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assistência, com critérios de elegibilidade. No entanto, prevalece no senso coletivo uma associação desta modalidade de parto com situações de urgência/emergência, com potencial risco para mulheres e recém-nascidos. **Conclusão:** as representações compartilhadas revelam a generalização de informações sem respaldo científico sobre o parto domiciliar planejado.

Descritores: Saúde da mulher; Obstetrícia; Parto domiciliar; Enfermagem obstétrica; Pessoal de Saúde

Resumen: Objetivo: aprehender las representaciones sociales de los profesionales de la salud en el área hospitalaria acerca del parto planificado. **Método:** un estudio cualitativo basado en la Teoría de las Representaciones Sociales y realizado con 15 profesionales de la salud de un hospital escuela. Los datos fueron recolectados en el segundo semestre de 2019 a través de entrevistas semiestructuradas. Se utilizó el análisis de contenido temático. **Resultados:** los informes originaron dos temas: 1) Nacimiento en el hogar: una posibilidad, con criterios de elegibilidad y 2) Nacimiento en el hogar: una miscelánea de conceptos, opiniones e interpretaciones. El grupo social investigado entiende el parto planificado en el hogar como una opción de atención, con criterios de elegibilidad. Sin embargo, una asociación de este modo de parto con situaciones de urgencia/emergencia prevalece en el sentido colectivo, con riesgo potencial para las mujeres y los recién nacidos. **Conclusión:** las representaciones compartidas revelan la generalización de la información sin apoyo científico sobre el parto planificado en el hogar.

Descriptorios: Salud de la Mujer; Obstetricia; Parto Domiciliario; Enfermería Obstétrica; Personal de Salud

Introduction

Planned home birth is an option recognized by the World Health Organization (WHO), provided that care is performed by a qualified health professional (obstetrician/obstetric nurses) and qualified.¹ In Brazil, the Ministry of Health (MoH) declares that, although this modality of childbirth care is not part of current health policies in the country, planned home birth should not be discouraged from the multiparous habitual risk, for which access to a maternity hospital should be ensured in a timely manner, if there is a need for transfer.² According to the current literature, home birth is related to satisfactory maternal and fetal outcomes. Among them, we highlight the higher rate of spontaneous births and maternal satisfaction, lower chances of intervention and cesarean section surgery, lower risk of fetal dystocia and postpartum hemorrhage, in addition to similar percentages for neonatal morbidity and mortality, when compared to the hospital and home environments.³⁻⁶

From the perspective of women, dissatisfaction with the current hospital obstetric model is one of the main reasons that justifies the choice of planned home birth. In the hospital model,

service users perceive that childbirth is seen as a pathological process, being treated in a depersonalized and imposing manner, about institutional routines. Therefore, in this scenario of great maternal vulnerability, conducts can sometimes be taken arbitrarily, without considering dialogue and maternal decisions.⁴⁻⁷

In this context, the statistics show a trend of growth in the search for the option of planned home birth, which can be observed when analyzing rates at national and international level. In the United States, for example, the planned home birth rate increased 77% from 2004 to 2017⁸, and in Brazil, the same phenomenon is observed in the most urbanized regions of the country (South, Southeast and Midwest) from 2010 to 2017.⁹

It is important to highlight that, in Brazil, the category of obstetric nursing is the profession that fully adests to this model of care.¹⁰ Thus, all information related to planned home birth directly affects the work of nurses, which justifies the deepening of the investigation on the subject and its interfaces. Although there is a vast international production on the subject, a recent review of the literature on planned home birth showed that the national production on this theme still has gaps, as it portrays, mainly, the maternal and neonatal outcomes of this type of care/service.⁴

In this sense, it is considered that there is a need to deepen the understanding of planned home birth beyond technical issues, allowing the understanding of the phenomenon from the perspective of other social actors, for example, health professionals who do not work in home birth care. For this, this study was based on the Theory of Social Representations (TSR), proposed by the French social psychologist Serge Moscovici, in the years 1960.¹¹

TSR can be understood as a form of socially elaborated and shared knowledge, with a practical objective, and that contributes to the construction of a reality common to the social set.¹¹ This movement allows the formation of groups that share the same conceptions on the subject and, therefore, adopt similar behaviors and practices.¹²

The articulation of the concepts of TSR with the field of obstetrics shows that the idea of

predominant birth and birth, which corresponds to the consensual universe, is that of institutionalized birth, attended by the physician and with massive use of intervention and technology throughout the process. That is, the shared thought in common sense is that childbirth and birth should occur in the hospital, preferably with minimal "pain and suffering" for the woman. The option for planned home birth can be understood as an unfamiliar fact of the consensual universe (common sense), generating tension and discomfort.⁷

In view of the above, the study aims to answer the following research question: What are the social representations of health professionals in the hospital area about planned home birth? It is believed that this investigation has the potential to expand knowledge about the object of study and promote the capillarization of discussions about planned home birth among different health professionals, as well as to add to the knowledge of obstetric nursing. In this sense, the aim of this study was to apprehend the social representations of health professionals in the hospital area about the planned home birth.

Methods

TSR was used for the theoretical basis of this study. It has been widely used in the nursing area, due to the possibility of the researcher capturing the interpretation of the participants themselves from the reality that is intended to research, allowing the understanding of the attitudes and behaviors that a given social group has in the face of a psychosocial object.¹²

When social representations are focused as a product, as in the case of this study, the research aims to decant the constitutive elements of the representations (information, images, opinions and beliefs), always having as reference the social conditions of its production. On the other hand, when it is concentrated as a process, the research focuses on the understanding of the elaboration and transformation of representations under the force of social determinations.¹²

This is a qualitative, exploratory and descriptive research. The target audience included health

professionals working in a public university hospital, located in the interior of the State of São Paulo. This hospital serves an average of 230 births/month and is a reference for pregnant women at habitual risk and high risk in six municipalities in the region. The following selection criteria were defined: professionals graduated in medicine or nursing, with specialization in obstetrics or neonatology; located in one of the three units (Obstetric Center, Joint Accommodation and/or Neonatal Intensive Care Unit) of the institution scenario of the study.

The number of participants was defined using the concept of "saturation point", which is widely used in qualitative investigations. It is considered that 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 content is no longer necessary, since it does not alter the understanding of the phenomenon studied.¹³

The group to be studied was defined by convenience, being the first interviewee indicated by the coordination of the units, and the other participants were recruited from the snowball sampling technique. In it, the first interviewees indicate the next ones, which, in turn, will indicate others and so on,¹⁴ until the moment when the new information is repeated (saturation point).¹³

During the collection, there was no refusal to participate. Data were collected in the second half of 2019, through a semi-structured script, composed of two parts: 1- Sociodemographic profile; and 2- Semi-structured interview, containing three open-key trigger questions: a) What is your opinion on planned home birth?; b) In your opinion, can every woman give birth at home?; c) Do you think that this type of birth can bring benefits and/or harm to the mother and the baby? To validate the instrument used, a pilot test was performed with four health professionals from another institution, and the semantic adjustment of only one question was necessary.

Participants were invited to participate in the research within the hospital facilities, on the days when they were on duty. Initially, the objectives of the study were presented and then, the invitation was made. The interviews were conducted in a reserved environment of the institution, at

the time when the professional thought it was the most pertinent so that there was no compromise of the work routine.

The interviews lasted, on average, 10 minutes, were audiorecorded with digital recorder and, immediately after collection, transcribed by the main researcher. The transcriptions were presented to the participants, in the week following the survey, for validation and/or corrections.

The data were analyzed according to thematic content analysis, which comprises a data processing technique that aims to obtain, through systematic procedures, indicators that allow the inference of knowledge related to messages and the unsealing of relationships that are established beyond the speeches themselves.¹⁵

This methodological framework provides for three fundamental phases, which were carefully followed: 1) pre-analysis; 2) exploitation of the material; and 3) treatment of results, inference and interpretation.¹⁵ In the pre-analysis stage, the material was organized to become operational. This process was performed four phases: floating reading; choice of documents; elaboration of hypotheses/objectives; and, finally, referencing the indexes and elaboration of indicators. Then, the material was exploited, and the codification, classification and categorization by themes were carried out. Finally, condensation and the prominence of information for analysis, culminating in inferential interpretations, inherent to the treatment phase of results, inference and interpretation.¹⁵

Aiming at the methodological rigor of the research and the credibility of the research, the checklist Consolidated Criteria for Reporting Qualitative Studies (CCRQS) was used during the production process of the research. To ensure anonymity, the interviewees were identified by the letter "E" followed by a random number. The study followed the guidelines and was conducted according to the ethical standards required for research involving human beings arranged in Resolutions 466/2012 and 510/2016 of the National Health Council, obtaining approval, on April 30, 2019, by the Research Ethics Committee, under protocol nº 3,294,813. All participants signed the Free and Informed Consent Form (TCLE).

Results

The study was attended by 15 health professionals, including physicians and nurses with different specializations, as shown in the table below:

Table 1- Profession and specialization of research participants. Campinas/SP, 2019

Profession	Specialty	N	%
Doctor	Obstetrics	5	33.4
	Neonatology	2	13.3
Nurse	Obstetrics	6	40.0
	Neonatology	2	13.3
Total		15	100

Among the participants, 13 (86.6%) were female and two (13.4%) were male, the average age was 35 years, ranging from 25 to 58 years old; the average working time in the institution was nine years and all had complete higher education. Regarding color, 13 (86.6%) declare themselves white and two (13.4%), brown.

None of the interviewees had experience/experience with planned home birth care, but some participants cited situations in which women arrived transferred from home to the hospital, including planned situations and those not planned, experiences that probably interfered in the construction of the opinions expressed.

Data analysis allowed the construction of two themes that were named as: a) Home birth: a possibility, with eligibility criteria; and b) Home birth: a miscellany of concepts, opinions and interpretations. The following statements will be presented, which constitute the above-mentioned themes.

Home birth: a possibility, with eligibility criteria

A portion of the participants demonstrated to understand that home birth is a viable option

for women, provided that some eligibility criteria are adopted. Among those mentioned, the stratification of gestational risk appeared as the most relevant.

I think there's a criterion! [...] depends on pregnancy, prenatal care, maternal status, it is multifactorial! I don't think all[women] can't! (E4)

If she has all the favorable conditions, that she has no comorbidity and that everything is fine with her prenatal care. (E12)

If it is a low-risk prenatal care, with no change during pregnancy. High risk doesn't have the possibility to take that risk. (E2)

It can't be a bad prenatal care, or you haven't had any evaluations of the mother and the baby, and just think that you're going to be born at home that's going to be all right. You're in danger of going wrong. (E14)

I don't think every woman could give birth at home. I think you have bias, prenatal risk, risk of being a risky baby. No, not every [woman] doesn't. Low-risk mothers. High-risk ones need to be adequately monitored in an appropriate service. (E3)

The statements show that the professionals recognized the existence of pre-established criteria for women who intend to experience planned home birth. Other variables related to eligibility criteria have been unveiled.

[...] if it is to have a home birth, if it has a support team, if it has a rearguard. (E11)

This type of birth needs preparation [...]. A structure, a prepared team, that knows how to conduct this birth, that knows how to act if something does not go as planned. A guideline for this pregnant woman, so that she also knows everything that can happen, to be prepared for these situations. And support! The family, the professionals who are serving this woman, the partner. I think the most important thing is this structure. (E8)

I think criteria are needed. Explain to this right woman why she can't give birth at home. And if so, there is a need for professional preparation, to understand that something wrong can happen and be prepared to act. Assess the route to the hospital if it's a viable thing. Everything has to be well structured, and the team prepared. (E8)

Everything needs to be talked about and it is necessary that there be a joint decision between the couple and the team, which must be prepared and structured to meet this pregnant woman. (E3)

Through the interviews, it is identified that the participants view criteria related to logistics issues, such as structure for the care and training of the professionals involved, and emotional, such as women's preparation and family support. These were understood as important factors to be considered in the choice of planned home birth.

Home birth: a miscellany of concepts, opinions and interpretations

Except for the theme on eligibility criteria, which was practically unanimous among the participants, the rest of the statements demonstrated a miscellany between concepts, personal opinions and questionable interpretations about planned home birth.

Regarding the risks and the performance of the team at home, several situations were mentioned.

It's not what I think, I'm sure [home birth] carries risks for the pregnant woman and the baby. Risk of bleeding, risk of longer care for the newborn in case of need for resuscitation. (E6)

I think at home, if you have any intercourse with both the baby and the mother, you don't have time to act. So, you end up putting both the mother and the baby at risk. (E8)

So, there are some particular cases that I think, if the woman takes birth at home, this time of commuting to the hospital could jeopardize the child's future. (E3)

I think a risk of anoxia if you don't have a pediatrician to see the baby. A mother who may have a seizure, a hypovolemic shock, take time to be treated and eventually go to death. (E13)

The pregnant woman has a risk of developing hypotonia or uterine atony, will greatly increase her bleeding, and if it could not be reversed with massage? She would need to quickly have caught venous access, blood transfusion and maybe even a hysterectomy. (E2)

And if the baby needs PPV [positive pressure ventilation], it needs any care, [...] of some oxygen. You won't harvest the blood gas [blood gas] quickly to see if it anoxic or not. Loses so much parameter to know if he's okay if he's going to be okay or not. So, you kind of miss the chance to reverse that. (E2)

I am opposed to the planned home birth because I believe that, in a hospital environment, the patient has greater security. Both mother and baby. Because, as much as childbirth is a physiological situation that in a situation of low risk the tendency is to occur all well, but there are always risks involved, so in my opinion the birth must always be hospital. (E6)

A dystocia, the baby comes down and you listen to a bradycardia, and we know that this time of bradycardia already shows that it is an acidosis for children. This bradycardia generates acidosis and, if you are not in the hospital environment, this acidosis compromises this child's nervous system. If you don't make a quick intervention. Be a forceps, be a c-section. (E3)

What we are concerned about in home birth is whether we will have adequate care, just as it is in the hospital. (E5)

If planned, with a doctor, with resources for the baby and the mother and if there is an ICU ambulance [Intensive Care Unit] at the door. (E13)

No. In my opinion, every woman should give birth in the hospital. (E6)

These statements show that for health professionals the planned home birth is as an event of eminent risk to the mother and fetus, with predominance of urgent/emergency situations, which

end up basing the arguments against this modality of childbirth care. Questions about the conduct and performance of the team during the care performed in the planned home birth also appear.

Discussion

The statements showed that some health professionals understood planned home birth as a viable option if eligibility criteria for its occurrence are considered. This demonstrates that the participants recognized one of the main pillars that support this modality of childbirth care, because, according to the literature, habitual risk pregnancy is described as an essential prerequisite for the safety of planned home birth.^{2,10,16-18}

The eligibility criteria are important and must be strictly followed, since the existence of any health condition that increases maternal or fetal risk makes the option of home birth dangerous for both.¹⁸ Another aspect revealed in the interviews is related to the concern of the studied group with the competence and technical preparation of professionals who attend planned home birth, so that their adequate performance in the face of possible maternal and neonatal complications is guaranteed.

Considering this aspect, the literature shows that, for the care of a home birth, it is necessary that the professional be trained to act in obstetric and neonatal emergencies and to be able to identify possible obstetric complications that require referral to a referral service.¹⁸⁻¹⁹ The previous technical experience of the professionals involved in this modality of birth and birth care and the training to work in urgent/emergency situations are fundamental, as well as the constant theoretical-practical update. It is understood that these requirements are promoters of safe and qualified care.

In relation to the professionals qualified in the care of planned home birth, the obstetrician nurse stands out. Since this modality of care has been growing in Brazil and the number of obstetric nurses who dedicate themselves to this care has increased significantly,¹⁰ it is important to

emphasize that these professionals have legal support and are qualified to practice prenatal care and birth care at usual risk in the home environment.^{10,20-21}

At home, these specialists should have specific skills to perform a continuous evaluation of the parturition process, such as knowing how to identify early signs of risk, offer basic life support and stabilize women and neonates, until hospital transfer, in cases of complications.^{2,5} These skills are crucial in ensuring the safety of maternal-fetal health care and, therefore, may be questioned by women/families who plan home birth.

Although the statements show concern with professional qualification for care, there was no mention of which health professional can work in this scenario. In this respect, it is important to highlight that the Federal Council of Medicine, since 2012, recommends that birth occur, preferably, in a hospital environment.²²

This is an aspect that should be problematized and discussed among professional councils, since care practice should always be guided by the most recent scientific recommendations. Thus, the construction and dissemination of myths and positions misaligned to science could be avoided and that affect the freedom of choice of women/families over the place of birth of their children.

Among the unveiled representations, concern was identified on the part of health professionals with the shared decision between the care team and the woman/family or the couple. This is an important aspect in understanding planned home birth, since the choice of the place of birth should be understood as a basic reproductive right, which respects autonomy and maternal protagonism.^{10,17-18,23}

Therefore, it is necessary that women receive accurate and prejudice-free information, which addresses the risks and benefits of each type of birth, the probability of being transferred to a maternity ward, the reasons that would justify this measure and the time necessary to do so, so that they can make their choices in a conscious and informed way.^{2,17-18,21} It is also important that women understand and recognize the limits of home birth care, which is characterized as a strategy to

increase safety in this scenario.¹⁸

The decision for planned home birth must be formalized by means of a document, which can be a contract drawn up in common agreement between the parties, including the science and signature of the interested parties. This contract, called the TCLE, seeks to ensure the recording of the information discussed between the team and the woman/family or the couple, which conducts to be taken in the case of obstetric and/or neonatal complications/complications, including actions that will be performed in an elective or emergency transfer to a reference health service.²⁰⁻²¹

The statements revealed that the planned home birth is represented as a potentially risky event for the woman and her baby, with the eminence of urgent or emergency situations. Thus, the participants showed concern about the route to the hospital and the need for rear guard during home care. On this question, both the Ministry of Health and the international guidelines of countries that maintain home birth integrated with the health system endorse that women who choose to give birth at home should have ensured timely and timely access to a maternity ward.^{2,17-19} This is an important measure to be considered at the time of choosing the planned home birth, since, in the face of urgent and/or emergency situations, the time spent on the journey between the house and the hospital can be a factor of worsening and negative outcome.

According to the international scientific literature, some components guarantee better results in planned home births, i.e.: a) optimal integration of health care professionals; b) effective communication between the hospital and the care teams; (c) specific signs for emergency transport; and d) a pre-established plan for referral to a hospital in case of complications.¹⁷⁻¹⁸ Effective and anticipated communication between care teams and health services is justified for several reasons. Initially, because transfer management can be greatly favored if the hospital already has prior information about the woman to be treated (or the baby, in case of neonatal transfer).

Informing the hospital about a clinical emergency allows the service to anticipate its arrival and organize care for already hospitalized parturients is not negatively impacted¹⁸ and the care of

the woman and/or baby transferred from home birth is more effective. Considering that planned home birth is not part of Brazil's health policies, unlike countries such as the United Kingdom, the United States, Canada and Denmark,²⁴ for example, it is assumed that the necessary communication between the home care team and the health institution integrated into the health care network presents weaknesses in the country context.

It is important to note that some obstetric nurses usually work in partnership with a medical obstetrician in the rear, which is called backup. This multiprofessional teamwork is not intended to "supervise" the activities of obstetric nurses, but rather to ensure safety if the binomial requires intervention, drug and/or invasive care at the hospital level, which can receive the woman and/or the baby and continue care.¹⁰

In addition to the disarticulation between teams and health institutions, professionals who attend planned home birth in the country face several other challenges, such as prejudices related to lack of information, retaliation in situations of hospital transfers and difficulties in acquiring documents (Declaration of Live Births) and job donations.²³ Such challenges may occur because this modality of childbirth care remains outside the Brazilian health system, without a specific regulation.^{10,20}

The social group investigated believes that there are eligibility criteria for planned home birth, as well as factors that need to be considered. This view of planned home birth is satisfactory, considering that these professionals were inserted in a health service that can receive women from this mode of birth and, therefore, could provide a bias-free care in the face of the choice of the woman/family or the couple.

On the other hand, planned home birth remains represented by participants as an event that involves more risks than hospital birth. In this respect, studies indicate that, in the home scenario, women are exposed to fewer risks because they are less likely to receive drug interventions, such as induction of birth and pharmacological analgesia,^{3,6,25} undergoing episiotomy²⁵ and third- or fourth-

degree perineal lacerations.²⁵ In addition, in planned home birth, complications of labor are less likely,^{3,25} postpartum infection,²⁵ fetal complication³ and neonatal resuscitation.⁶

The practice of a minimally interventional intrapartum care model is one of the aspects responsible for the good results in planned home birth care, especially when associated with careful sorting of women and the proper integration of this model with the local health system.²⁶ Due to these findings, it is inferable that the social representations about the planned home birth of the professionals studied are at odds with what the current scientific productions on the subject demonstrate.

In this sense, it is understood that there is a fragility in understanding the causality of most complications of the parturition process. Even if fatalities may occur during care, it is suggested that the interventional care model, much practiced in the hospital environment, is a crucial factor in the genesis of complications and in the consequent need for advanced care, which does not apply to the home environment. In the context of the care model practiced in planned home birth, hospital birth makes little use of technologies that favor the physiological progression of labor and uses, excessively and often unnecessarily, interventions that generate pain and suffering.²⁵ These interventions, when routinely applied or without scientific support, are associated with unfavorable maternal and personal outcomes.²⁷

The scientific literature reinforces that intrapartum care with minimal intervention represents one of the pillars for a positive birth experience,²⁶ which can contribute to the high rate of maternal satisfaction with the experience of planned home birth. Thus, there is an emerging need to understand the possible cause-effect phenomenon that involves the abusive use of interventions and the consequent complications in childbirth care.

Understanding this problem can contribute to deconstructing the conception, predominant in common sense, that women who choose to give birth at home are putting themselves at eminent risk. This is because planned home birth is a less interventionist care model that, consequently,

makes parturients and their fetuses less subject to complications.

It was possible to verify that there is a common belief among health professionals that urgent and emergency situations cannot be managed in the home environment (lack of time to act, more time-consuming care, absence of basic supplies, loss of time during transfers, etc.). It is worth noting that no scientific studies were found that investigate the management of urgent and emergency situations during the care of a planned home birth, which could be used to affirm or refute such data collected in the interviews, which makes this subject cloudy and favors the construction of several scenarios in the common imaginary.

To date, only one national publication has been identified that presents and describes the organization of the planned home birth service.²⁰ Thus, the need for delineation and dissemination of specific guidelines and/or protocols on this type of care is emerging, to thoroughly clarify the work process developed. In these guidelines (or in protocols) aspects such as: instruments and work materials used could be included; service flow; measures to be taken in urgent/emergency situations; profile and prerequisites of the professionals who provide this care, among other details that may favor the understanding and operationalization of home birth.

On the issue of time spent in hospital transfer situations, a single study conducted in England aimed to estimate the duration of transfers in planned home births and their effects on neonatal outcomes.²⁸ The researchers found that the average transfer time, which includes the period between decision-making and first care in the health service, was 49 minutes. In situations prior to birth, considered as potentially urgent, this time decreased by about 8-10 minutes, with a median of 42 minutes. Most transfers were not urgent in nature and emergencies and adverse outcomes were uncommon. Regarding the neonatal outcome, adverse results were found in 1-2% of the women who gave birth within 60 minutes of transfer.²⁸

The findings of the literature show that transfer to the hospital is not a frequent condition in planned home births, which is the opposite of that represented by the health professionals

participating in this study.

In Brazil, a national systematic review on home birth showed a maternal transfer rate ranging from 7.4 to 20%,⁴ falling below or around what is presented in an international study (54% for primiparous women and 14% for multiparous women).²⁹ Regarding the transfer of newborns, this review detected rates between 0.7 and 1%,⁴ and no transfer occurred due to the care provided at birth or the parturition process itself, and no NB was admitted to the neonatal Intensive Care Unit (ICU). The reasons for the transfers were cardiac arrhythmia and epidermolysis bullosa not diagnosed prior to birth.⁴

Another national study, conducted in the Federal District, presented similar rates, 21.1% of which were maternal transference and 1.2% that of newborns, and none of the cases presented a negative outcome after transfer.⁵ This information deconstructs the belief that planned home birth has frequent neonatal complications. It is, in fact, without scientific basis and needs to be problematized in discussions on the subject.

It is understood that the results of this research have limitations related to the regionalization of the sample, which generalizes difficult. Therefore, it is advocated the need to conduct future investigations that include teaching hospitals (or not) located in different regions of Brazil.

Moreover, the approach of only two categories of health professionals was also configured as a restriction of this work. However, the initial step was taken by a path that can be followed with new investigations that expand samples and scenarios, focusing on the object of study treated.

Conclusion

For the social group investigated in this research, health professionals of a teaching hospital, planned home birth is a possibility of assistance to the parturient, provided that some eligibility criteria are met. However, a strong belief prevails that this event is potentially more dangerous for women and their newborns compared to hospital care, with the binomial being subject to eminent

emergency situations.

The opinions shared in the group show lack of clarity about various aspects of the work process in home birth care, such as training and qualification of the professionals involved, maternal and fetal risks in care, work logistics and clinical management in urgent and emergency situations. Moreover, it was noticed that many opinions revealed do not find support in the scientific literature available today, which negatively impacts the work performed by obstetric nurses and their care teams.

The limited national production and dissemination of scientific evidence on planned home birth may justify the lack of clarity on the subject for study participants. This reinforces the need for further research on this theme, with the objective of breaking with certain beliefs and myths and increasing the visibility of this modality of health care.

Finally, it is considered that this study adds knowledge to the field of nursing by elucidating social representations of two professional categories involved in obstetric care and that can influence the context of planned home birth care, since transfers are planned and may occur in the care of this type of birth. In addition, the unveiled representations can broaden reflections and discussions in the field of teaching, in the scientific and professional practice, paving the way for the understanding of the challenges faced by the nurses who provide this service, as well as for the construction of strategies to handle them.

References

1. World Health Organization (WHO). Strengthening quality midwifery education for Universal Health Coverage 2030: working together to ensure quality care for all mothers and newborns [Internet]. Geneva: World Health Organization; 2019 [cited 2019 Oct 29]. Available from: https://www.who.int/maternal_child_adolescent/topics/quality-of-care/midwifery/strengthening-midwifery-education/en/
2. Ministério da Saúde (BR), Secretaria de Ciência, Tecnologia e Insumos Estratégicos, Departamento de Gestão e Incorporação de Tecnologias em Saúde. Diretrizes nacionais de assistência ao parto normal: versão resumida [Internet]. Brasília (DF): Ministério da Saúde; 2017 [acesso em 2019 out 29]. Disponível em:

https://bvsmms.saude.gov.br/bvs/publicacoes/diretrizes_nacionais_assistencia_parto_normal.pdf

3. Rossi AC, Prefumo F. Planned home versus planned hospital births in women at low-risk pregnancy: a systematic review with meta-analysis. *Eur J Obstet Gynecol Reprod Biol.* 2018; 222:102-8. doi: 10.1016/j.ejogrb.2018.01.016
4. Cursino TP, Benincasa M. Parto domiciliar planejado no Brasil: uma revisão sistemática nacional. *Ciênc Saúde Colet.* 2020;25(4):1433-44. doi: 10.1590/1413-81232020254.13582018
5. Santos SS, Boeckmann LMM, Baraldi ACP, Melo MC. Resultados de partos domiciliares planejados assistidos por enfermeiras obstétricas. *Rev Enferm UFSM.* 2018;8(1):129-43. doi:10.5902/2179769228345
6. Doherty D, Nathan L, Hutchinson M, Somerville S, Hauck Y, Hornbuckle J. Planned home and hospital births in western Australia: 2002–2013. *J Paediatr Child Health.* 2017;53(Suppl 2):3–17. doi: 10.1111/jpc.13494_72
7. Sanfelice CFO, Shimo AKK. Social representations on home birth. *Esc Anna Nery.* 2015; 19(4):606-13 doi: 10.5935/1414-8145.20150081
8. MacDorman MF, Declercq E. Trends and state variations in out-of-hospital births in the United States, 2004–2017. *Birth.* 2019;46(2):279-88. doi: 10.1111/birt.12411
9. Ministério da Saúde (BR). Rede Interagencial de Informações para a Saúde. DATASUS. Nascimento por residência mãe por ano do nascimento segundo região/domicílio (2010-2017) [Internet]. 2017 [acesso em 2019 out 29]. Disponível em: <http://tabnet.datasus.gov.br/cgi/tabcgi.exe?sinasc/cnv/nvuf.def>
10. Conselho Federal de Enfermagem (COFEN). Parecer Técnico CN SM/COFEN N°003/2019 dispõe sobre a Regulação e Prática da Enfermagem Obstétrica no espaço do parto domiciliar planejado [Internet]. Brasília (DF): COFEN; 2019 [acesso em 2019 out 29]. Disponível em: http://www.cofen.gov.br/parecer-tecnico-cnsm-cofen-no-003-2019_74671.html
11. Moscovici S. Representações sociais: investigações em psicologia social. Petrópolis: Vozes; 2003.
12. Silva SED, Santos AL, Costa JL, Cunha NMF, Araújo JS, Moura AAA, et al. A teoria das representações sociais sob a ótica das pesquisas de enfermagem no Brasil. *J Health Biol Sci.* 2017;5(3):272-6 doi: 10.12662/2317-3076jhbs.v5i3.1319.p272-276.2017
13. Nascimento LCN, Souza TV, Oliveira ICS, Moraes JRMM, Aguiar RCB, Silva LF. Theoretical saturation in qualitative research: an experience report in interview with schoolchildren. *Rev Bras Enferm.* 2018;71(1):228-33. doi: 10.1590/0034-7167-2016-0616
14. Naderifar M, Goli H, Ghaljaie F. Snowball Sampling: a purposeful method of sampling in qualitative research. *Strides Dev Med Educ.* 2017;14(3):e67670. doi: 10.5812/sdme.67670
15. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2011.
16. Ministério da Saúde (BR), Secretaria de Ciência, Tecnologia e Insumos Estratégicos, Departamento de Gestão e Incorporação de Tecnologias em Saúde. Diretrizes nacionais de assistência ao parto normal: versão resumida. Brasília (DF): Ministério da Saúde; 2017.

17. Campbell K, Carson G, Azzam H, Hutton E. Statement of planned homebirth. *J Obstet Gynaecol Can.* 2019;41(2):223-7. doi: 10.1016/j.jogc.2018.08.008
18. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). Home Births [Internet]. Melbourne: RANZCOG; 2017 [cited 2020 Oct 15]. Available from: [https://ranzcof.org.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Home-Births-\(C-Obst-2\)-Review-July-17.pdf?ext=.pdf](https://ranzcof.org.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Home-Births-(C-Obst-2)-Review-July-17.pdf?ext=.pdf)
19. Santos EVM, Lima CB. Parto domiciliar assistido: abordando a atuação do enfermeiro obstetra. *Temas Saúde* [Internet]. 2018 [acesso em 2020 out 15];18(1):192-203. Disponível em: <https://temasensaude.com/wp-content/uploads/2018/04/18110.pdf>
20. Mata JALM. Enfermagem obstétrica no parto domiciliar planejado: responsabilidade legal e organização do serviço. In: Associação Brasileira de Enfermagem (ABEn), Associação Brasileira de Obstetras e Enfermeiros. *Obstetras (Abenfo). PROENF: Programa de atualização em enfermagem: saúde materna e neonatal: ciclo 8.* Porto Alegre: Artmed Panamericana; 2017. p. 75-125.
21. Conselho Regional de Enfermagem de Santa Catarina (COREN/SC). Parecer técnico COREN/SC nº 023/CT/2016. Assunto: Parto Domiciliar Planejado. Florianópolis: COREN/SC; 2017 [acesso em 2020 out 15]. Disponível em: <http://www.corensc.gov.br/wp-content/uploads/2017/01/PT-023-2016-Parto-Domiciliar-Planejado.pdf>
22. Conselho Federal de Medicina (CFM). Recomendação 1/2012. Recomenda que a realização do parto ocorra em ambiente hospitalar de forma preferencial por ser mais segura. Brasília (DF): CFM; 2012. Disponível em: https://portal.cfm.org.br/images/Recomendacoes/1_2012.pdf
23. Pascoto GS, Tanaka EZ, Fernandes LCR, Shimo AKK, Sanfelice CFO. Dificuldades da assistência ao parto domiciliar na ótica de enfermeiras obstetras. *Rev Baiana Enferm.* 2020; 34:e36633 doi: 10.18471/rbe.v34.36633
24. Nygaard SS, Kesmodel US. Home births: here are we heading? *Acta Obstet Gynecol Scand.* 2018;97:1155-6 doi: <https://doi.org/10.1111/aogs.13441>
25. Reitsma A, Simioni J, Brunton G, Kaufman K, Hutton EK. Maternal outcomes and birth interventions among women who begin labour intending to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: a systematic review and meta-analyses. *EClinicalMedicine.* 2020;21:100319. doi: 10.1016/j.eclinm.2020.100319
26. Taheri M, Takian A, Taghizadeh Z, Jafari N, Sarafranz N. Creating a positive perception of childbirth experience: systematic review and meta-analysis of prenatal and intrapartum interventions *Reprod Health.* 2018;15:73. doi: 10.1186/s12978-018-0511-x
27. Leal MC, Bittencourt SA, Esteves-Pereira AP, Ayres BVS, Silva LBRAA, Thomaz EBAF, et al. Avanços na assistência ao parto no Brasil: resultados preliminares de dois estudos avaliativos. *Cad Saúde Pública.* 2019;35(7):e00223018. doi: 10.1590/0102-311x00223018
28. Rowe RE, Townend J, Brocklehurst P, Knight M, Macfarlane A, McCourt C, et al. Duration and urgency of transfer in births planned at home and in freestanding midwifery units in England: secondary analysis of

the Birthplace national prospective cohort study. *BMC Pregnancy Childbirth*. 2013;13:224. doi: 10.1186/1471-2393-13-224

29. Cross-Sudworth F, Hindley J, Cheatham C, Clarke P, McAgree T. Creating a dedicated homebirth service: results of a 3-year pilot. *Br J Midwifery*. 2018;26:3. doi: 10.12968/bjom.2018.26.3.164

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