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Mothers' birth care experiences in a Brazilian birth centre

Milena T. Jamas (Nurse Midwife, Masters in Nursing Student)[a], Luiza A.K. Hoga, PhD (Nurse Midwife, Associate Professor)[a,*], Ana C.A. Tanaka, PhD (Midwife, Professor)[b]

[a] *School of Nursing, University of São Paulo, São Paulo, SP, Brazil*
[b] *Faculty of Public Health, University of São Paulo, São Paulo, SP, Brazil*

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ABSTRACT

Objective: to explore the reasons why women with previous hospital experience seek care at a birth centre, and their perceptions related to the care received in both settings.
Design, setting and participants: in-depth interviews focusing on the care experiences of 18 women who received birth care in a birth centre of the Brazilian public health system.
Findings: three key themes emerged from the analysis: 'Confrontation with strong problems in the hospital setting', 'Reasons to seek the birth centre' and 'Satisfaction related to birth centre care'. The main aspects that the mothers mentioned in the first and third themes were related to the institutional structure and system of care.
Key conclusions and implications for practice: mothers' narratives suggested that their previous experience of problems in the hospital setting was the main motive for seeking care at the birth centre. The most important components of birth care were attention, meeting personal care demands and establishment of an adequate interpersonal relationship. More sensitive birthing care in the hospital setting is necessary, and this can be promoted through continuing professional education.
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Introduction

Birth care principles are based on the hegemonic paradigm in most Brazilian maternity units (Nagahama and Santiago, 2008). This paradigm focuses on medical intervention and technologies, frequently used abusively and without criteria (Davis-Floyd, 2001).

A social movement led by Brazilian midwives and a non-governmental organisation has argued against this situation, particularly the hegemonic attitude adopted by professionals. Many meetings have been held and measures introduced in to academic and government policy (Carr and Riesco, 2007). The movement resulted in the inauguration of the first birth centre in the Brazilian public health system in 1998 (Hoga, 2004).

As this birth centre reported favourable obstetric and neonatal outcomes, federal health authorities elected it as a model for other birth centres (Health Ministry, Brasília, 1999a), and a law was issued authorising new birth centres (Ministério da Saúde, 1999b). In response, some birth centres were established as a new alternative for birth care.

Ethnographic research of the first public birth centre has been undertaken. Nurse midwives working in this setting were mainly concerned with ensuring that pregnant women were cared for as social beings with specific needs and as the centre of the birth care process. Compliance with personal care demands and the humanisation of the care a woman received were respected throughout the birth care process (Hoga, 2004). The birth care model used in this unit (Hoga, 2004) reflected international recommendations (Davis-Floyd, 2001).

The replacement of an interventionist medical model by a humanised birth care model is a current social demand in Brazil (Carr and Riesco, 2007). Researchers and professionals are working to achieve this ideal. However, despite these efforts, the interventionist model still predominates in many Brazilian maternity settings (Nagahama and Santiago, 2008).

Research focusing on birth centre care is rare in the Brazilian literature due to the recent introduction of these institutions in the country. In other countries, many researchers have looked into this theme. Australian researchers have described perceptions related to the care offered by a birth centre among women with previous hospital experience (Coyle et al., 2001a, b). Beliefs about pregnancy and childbirth, the nature of the relationship, interactions during care and the care structures were the four main themes of mothers' narratives. The non-interventionist attitude, the relationship of equality between professionals and women, and the preference given to clients' decisions were valued by the women (Coyle et al., 2001a). They particularly appreciated cumulative interactions, the feeling of comfort during moments of interaction, and being understood by professionals (Coyle et al., 2001b).

Other researchers have reported that having control over labour and childbirth (Gibbins and Thomson, 2001; Hildingsson,

* Corresponding author.
E-mail address: kikatuca@usp.br (L.A.K. Hoga).

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2003), the birth environment (Espósito, 1999), using non-pharmacological pain relief, knowing the professional staff, seeing birth as a physiological and social event (Hildingsson, 2003), receiving collaborative support from midwives (Espósito, 1999), being able to receive information about birth, participating in the decision-making process (Gibbins and Thomson, 2001), feeling safe during birth and being treated with dignity and respect (Espósito, 1999) are some of the main reasons why women prefer birth centres.

Reasons why women with previous birth care experience in hospitals seek care in a birth centre, and their perceptions related to birth centre care have not been explored by Brazilian or Latin American researchers. In 2008, 10 years after the inauguration of the first birth centre in São Paulo City, when the birth centre was recognised by the population as an alternative to the hospital, the women who attended this setting reported their birth care experiences. A systematised description of these issues could promote the future quality of care in birth care settings.

Objective

To explore the reasons why women with previous hospital experience seek care at a birth centre, and their perceptions related to the care received in both settings.

Methods

A narrative analysis method (Riessman, 1993) was used as this was deemed to be most appropriate for the naturalistic nature of the birth experience (Morse et al., 2001). The essence of this method consists of accessing the primary experience as represented by the person who has lived it. Researchers need to respect and describe the perspective of the person who is telling the experience as trustworthily as possible. The five steps of the method, integrally developed in this research, were attending, telling, transcribing, analysing and reading the experience (Riessman, 1993).

The first step was carried out at the moment when the research project was proposed, aiming to attend to these mothers' experiences.

The institution focused on in this study is located in São Paulo City, Brazil. It is affiliated with the Family Health Program of the Brazilian Public Health System and provides free birth care. It has the symbolic value of innovation of birth care, and the nurse midwives responsible for birth care in this institution follow the recommendations of the World Health Organization (WHO) (Hoga, 2004). Substitution of the medicalised birth care model predominant in the Brazilian context (Carr and Riesco, 2007) and the dissemination of its symbolic value (Hoga, 2004) were the main objectives when this birth centre was founded.

The second step involved reporting the experience. Prior to this stage, carried out with the completion of individualised in-depth interviews, an explanation of the research project was offered to women, including that approval to undertake the study had been granted by the institutional ethics committee authorised by the National Research Ethics Committee. The mothers signed a consent form that guaranteed the confidentiality of their personal data and authorised the use of data for scientific purposes. Personal data were obtained before the beginning of each interview.

On average, 36 women received birth care at the birth centre every month (Zerbini Foundation, 2005). The mothers' names, addresses and telephone numbers were obtained from a register. They were contacted two months after the birth. This period was considered adequate as mothers had had enough time to recover from the birth and to reduce the occurrence of the 'halo effect' (Bramadat and Driedger, 1993).

The initial contact with mothers was established by telephone. Some facts were clarified, such as the aim of the research and that the researchers involved were neither members of the birth centre nor governmental staff. Women were asked for their permission to be interviewed, and none of the women refused to collaborate. All women chose to be interviewed in their own homes.

In-depth interviews were conducted, starting with an open-ended question (Kvale, 1996): 'Tell me about your reasons to turn to the birth centre and how you experienced the care in this setting'. When appropriate, additional questions were asked for a deeper understanding of mothers' experiences. An active listening attitude was maintained according to the recommendations of Kvale (1996) in order to preserve the spontaneous nature of mothers' narratives and its sequence.

During the interviews, mothers talked about their experiences of birth care in a hospital setting and in a birth centre. Data collection was performed from February 2006 until March 2007; each interview lasted between 20 and 60 minutes. The criterion used to end the recruitment of women was theoretical saturation or continuous data repetition; this was observed after the 15th interview, but 18 women were included to guarantee one of the main criteria for rigor in the qualitative method (Morse et al., 2001).

In the third step of the method, transcription of the experience, the recorded interviews were fully transcribed by the interviewers who carried out this research. The sequence of the narratives was not changed, and the characteristics of individual expression were preserved. Grammatical mistakes were corrected. The fourth step of the research was carried out when each narrative was read attentively.

Themes describing mothers' experiences were elaborated according to the stages of data coding as described by Fereday and Muir-Cochrane (2006). A code manual was created, which included identification of the name of the code, definition of what the theme concerns, and a description of how to know when it occurs. The reliability of the codes, or the relationship between the code and the raw information, was verified. Initial themes were identified and summarised. Application of the template of codes and additional coding was performed when meaningful units of the narratives were identified.

Three themes emerged from the narratives. Their titles were meant to express, in the deepest, most comprehensive and trustworthy way possible, the mothers' previous experience of birth care in the hospital setting, reasons to turn to the birth centre and the last birth care experience in the birth centre setting, according to the mothers' narratives.

The content and meanings of the themes are illustrated by quotes, extracted from mothers' narratives. A sequential number was attributed to each mother and the numbers corresponding to the women who expressed a similar experience are displayed after each quotation in order to preserve the personal perspective, considered crucial in the use of the narrative analysis method (Riessman, 1993). The clearest example was quoted to represent all women who expressed a similar experience.

As with all studies, this study has limitations. Due to the subjective nature of this research, the interviewed mothers, mainly those who had negative experiences in the hospital setting, may have reported the negative aspects of hospital care and the positive aspects of birth centre care more strongly. The researchers, may have attributed more evidence to the positive aspects of birth care and to the negative aspects of hospital care during the data analysis process.

In order to guarantee rigor in the data analysis process, a colleague who was not involved in the research was asked to

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