Cogitare Enfermagem

ORIGINAL ARTICLE

Meanings attributed to planned home birth by obstetric nurses working in a hospital setting

HIGHLIGHTS

1. How are the meanings of nurses in home birth defined?
2. What are the inequalities in access to home birth?
3. What gaps are there in home birth care?

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ABSTRACT

Objective: to understand how obstetric nurses working in a hospital environment perceive planned home births. **Method:** qualitative, descriptive, exploratory study. Semi-structured interviews were conducted with 15 obstetric nurses working at the Regional Reference Hospital in the state of Pará, Brazil, between January and May 2024, using the Snowball Sampling recruitment technique. The data were analyzed using Content Analysis, with the support of ATLAS.ti 22.7 software. **Results:** the perceptions of obstetric nurses showed prejudice, judgment, value judgments, inequality in access, maintenance of the biometric and hospital-centered obstetric model, and the absence of a national policy to encourage home birth. **Conclusion:** there is a need to reform the current obstetric model and ensure access to home birth for all Brazilian women, thereby contributing to the strengthening of practices and autonomy among obstetric nurses, the primary professionals involved in home birth care.

DESCRIPTORS: Home Childbirth; Obstetric Nursing; Nurse Midwives; Attitude of Health Personnel; Home Care Services.

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INTRODUCTION

In recent decades, the medicalization of childbirth has been an ongoing trend in the context of childbirth and birth care in Western societies. In addition, since the mid-1960s, there has been a shift from routine births at home to hospital births, despite the lack of high-quality evidence to justify such a change[1]. Thus, with the development of the biomedical model, obstetric care, and the widespread use of cesarean sections, there has been an increase in interventions in women without due concern for the iatrogenic effects of a procedure for which there was no clinical indication[2].

Given this scenario, the World Health Organization (WHO) has expressed concern about the significant increase, especially in the last two decades, in interventionist practices that aim to initiate, accelerate, terminate, regulate, or monitor the physiological process of labor. It also pointed out that this medicalization of childbirth tends to interfere with women's own ability to give birth and negatively impacts their childbirth experience. Thus, Planned Home Birth (PHB) emerged as a new proposal to reduce obstetric interventions, respect women and the physiology of childbirth, and thus break with the hegemonic birth model [1-5].

The American College of Obstetricians and Gynecologists (ACOG) in its Obstetrics Practice Committee opinion stated that planned home births, when compared to hospital births, are associated with fewer maternal interventions, including labor induction, continuous fetal monitoring, instrumental vaginal delivery, episiotomy, and cesarean section. It also pointed out that planned home births are associated with fewer vaginal and perineal lacerations of the third or fourth degree and lower maternal infectious morbidity, thus reflecting lower obstetric risk factors[6].

The National Institute for Health and Care Excellence (NICE) recently published guidelines recommending that low-risk women receive support regarding their choice of birth location, regardless of the environment chosen. They also recommend that homes and birth centers are particularly suitable birth locations for low-risk multiparous women, because the rate of interventions is lower and the perinatal outcome is not significantly different compared to an obstetric hospital unit[7].

In Brazil, the Ministry of Health (MS), through Technical Note No. 2/2021 of the Department of Strategic Programmatic Actions of the Department of Primary Health Care,8 advises against PHB based on the principle of safety in maternal and child care and promotes the need for pregnant women to receive guidance on the risks related to home birth. However, countless obstetric nursing professionals have been ensuring this access, with qualified and safe care, in accordance with their professional nursing practice.

The Federal Nursing Council (COFEN) recognizes PHB as an alternative for maternal care. In this sense, it instituted Resolution No. 737, dated February 2, 2024, which regulates the performance of obstetric nurses and midwives in assisting women, newborns, and families in PHB[9].

The rate of home births in Brazil is less than 2.4%, with births predominantly occurring in hospital units, such as maternity wards and birth centers. The country has only one public home birth service, through an initiative of the Sofia Feldman Hospital (in the state of Minas Gerais), which is a benchmark for humanization in Brazil[5].

The main point of disagreement at the heart of this issue concerns childbirth safety, promoting healthcare institutions as places with lower obstetric and perinatal risk, contradicting international regulatory bodies and the latest scientific evidence[10]. Studies[11-13]

have pointed to the safety of home births, demonstrating that there are no differences in perinatal/neonatal mortality compared to hospital births.

The northern region of Brazil, including the state of Pará, needs investment in the field of health, and historically, home births have been the norm, especially in traditional communities with traditional midwives. Currently, there is a demand for qualified teams to ensure women a safe and respectful PHB.

Therefore, understanding the practice of obstetric nurses working in a hospital environment will promote understanding of the subject, and dialogue will enable the construction of knowledge, fostering debate within society. In this sense, this study's guiding question is: How do obstetric nurses working in hospitals see the PHB? The study aims to understand how obstetric nurses working in hospitals perceive the PHB.

METHOD

This is a qualitative, descriptive, exploratory study. The Consolidated Criteria for Reporting Qualitative Research (COREQ)[14] instrument was used to help researchers clearly and accurately describe the findings of qualitative research.

Fifteen obstetric nurses working at a regional hospital located in the metropolitan region of the state of Pará participated in the study, using the Snowball Sampling technique, also known as "snowball," to recruit participants[15]. No participants refused to participate in the study.

The hospital was chosen because it is a reference in the metropolitan region of Pará for normal risk deliveries. This unit cares for women who have had complications in the PHB and is a reference for existing teams in the region, but without an agreement to support home births. In addition to this unit, the region has a hospital complex for high-risk deliveries. The aforementioned health facility is linked to the state government and provides care under the Unified Health System (UHS).

Home births in the region are performed by a single team of obstetric nurses who have no ties to hospital facilities. Hospital births are predominant in the region. Hospital care for childbirth follows the humanized model recommended by the Ministry of Health, with the participation of obstetric nurses in the units.

Initial contact with the hospital unit coordination was made to enable free access to information from nurses, observing the following eligibility criteria: being an obstetric nurse who had graduated at least one year ago and had been working in the obstetric center for at least one year. Exclusion criteria included obstetric nurses on vacation or any type of leave, whether for illness or study. The points inherent to the research, such as the objectives, risks, benefits, and data collection strategies, were clarified.

After this process, data collection was scheduled in person, with individual semi-structured interviews conducted during January and May 2024 in a reserved room at the health unit during the participants' working hours. The average duration of the interview was 50 minutes, containing closed questions regarding the profile: gender, age, ethnicity/race, marital status, undergraduate education, year of graduation, *lato sensu* and/or *stricto sensu* specialization, and length of service in the field of Obstetrics, in addition to guiding questions, namely: What is your perception of the PHB? How do you see access to the PHB in the country? What are the main obstacles to access and assistance to the PHB?

After each interview, the participant indicated three more possible interviewees, continuing the recruitment process using the snowball sampling technique. Theoretical saturation was applied to define the number of participants; the process occurs not when no new meaning is obtained, but when there is a similarity of meanings in each interview conducted, resulting in 15 obstetric nurses as participants in this study.

The data were collected using recordings, with the prior authorization of the participants. The interviews were conducted in a single session between the researcher and the interviewee, enabling the investigation of the participants' perceptions of the PHB. The speeches were transcribed in full and sent the following day to the interviewees via the WhatsApp® application for validation of the responses given, following the COREQ guidelines[14].

It should be noted that data collection was conducted by a single researcher with a doctoral degree and mastery of the technique employed to avoid bias in the interviews. The research team was responsible for data processing and analysis.

Data processing was conducted based on Content Analysis[17], with the support of ATLAS.ti 22.7 software. During the 15 interviews with obstetric nurses, the first stage was carried out—pre-analysis, with a cursory reading of each transcript and the selection of relevant and representative elements. The second stage consisted of exploring the material, involving coding interventions and relating the nurses' discourses, with a view to categorization[17]. In this stage, inductive analysis was used in the ATLAS.ti 22.7 software, with the coding of excerpts from the speeches, the identification of codes, and the creation of themes, namely: prejudice, judgment, value judgments, childbirth risk, childbirth obstacles, purchasing power, knowledge, obstetric model, cesarean section, and public policies[17].

Thus, a thematic unit was developed: The context of home birth in Brazil, which gave rise to the following categories: Prejudice of health professionals in referral hospitals regarding PHB; Economic inequalities and limitations in access to PHB; Knowledge gap about PHB; Public policies that encourage PHB. The discussion will be based on public policies in the field of childbirth and birth, as well as on scientific literature on PHB.

The study was approved according to protocol No. 4.463.291/2020 by the Research Ethics Committee of the Institute of Health Sciences of the Universidade Federal do Pará (CEP-ICS/UFPA), under the terms of Resolution No. 466/2012 of the National Health Council (NHC). To preserve confidentiality, anonymity, and reliability, the interviewees were identified by the letter (N) for Nursing, followed by a numerical digit corresponding to the sequence of the interviews (N1, N2, N3, ..., N15), with voluntary participation guaranteed by the participant's signature on the Free and Informed Consent Term (FICT).

RESULTS

Fifteen female nurses participated in the study, none of whom had experience with home births.

In terms of age, four were between 26 and 30 years old, four were between 31 and 35 years old, three were between 20 and 25 years old, three were over 40 years old, and one was between 36 and 40 years old.

In terms of race/ethnicity, 10 self-identified as brown, four as white, and one as black. In terms of religion, nine identified as Catholic, four as Evangelical, one as Spiritist, and one as having no religion. In terms of marital status, nine were single, three were married, two were in stable relationships, and one was divorced.

Regarding the professionals' level of education, nine graduated from public institutions and six from private institutions. According to the length of their education, nine professionals completed their studies in 1 < 5 years, five in 5 < 10 years, and one in >10 years. All had a *lato sensu* specialization. Regarding *stricto sensu* degrees (Master's), nine had a Master's degree in Public Health. Regarding the time length working/experience in the field of obstetrics, 13 professionals had worked between one and five years, one between six and 10 years, and one for >10 years.

Discrimination among healthcare professionals in referral hospitals regarding PHB

Midwives mention that, due to the choices they make, women may suffer discrimination when being treated by other health professionals. They face judgment from these health professionals, as evidenced by the following reports:

[...] there is still a lot of preconception. I believe that there is potential for progress in this area if it is discussed more, but I still feel that the entire team, especially the hospital staff, is very reluctant to be more open to planned home births. (N2)

[...] so, if a woman has complications during a planned home birth, she arrives at the hospital and will be judged by the professionals for having had a planned home birth. (N4)

The PHB is an alternative that aims to ensure the best perinatal care, with a specialized team offering all the necessary support. Even so, many professionals make judgments and value judgments about the team and the woman's choice of PHB:

[...] these teams face discrimination; they are not valued or respected. (N1)

[...] I need to have a hospital where the reception team does not judge, because this happens a lot: judgmental comments, such as, "Oh, but she wanted to give birth at home and now it went wrong." "Oh, but who told her to give birth at home?" "She didn't want to come to the hospital." "The hospital is where you must give birth to your baby." So, we also need a change in the mindset of professionals. (N10)

The obstetric nurses' reports are strongly related to preconceptions based on value judgments about PHB. However, it is crucial that the professionals' concerns about PHB are not based on value judgments, but rather on scientific evidence.

Economic inequalities and limitations in access to PHB

According to the study participants, the PHB covers a privileged segment of women—those with higher purchasing power. Economic inequality is an obstacle to choosing this type of delivery, since there are still no strategies for accessing the PHB within the UHS:

[...] women don't have the means. The vast majority of women who have planned home births are wealthy. (N3)

[...] because, currently, only those who have home births—we're talking about planned ones—planned ones are only for those who have sufficient purchasing power, because home births are not cheap, in terms of care, in terms of materials. And, since they don't

have access to the public health system, they can only do it privately, with a team. So, it's not cheap to have access to it. It's very difficult. (N4)

For obstetric nurses, many women expressed a desire to perform PHB, but the lack of financial resources to hire qualified staff is a major obstacle:

[...] I've met people who think it's wonderful, who have studied, because we always encourage women to study, and they studied and saw that there are women who have their babies at home, especially in Europe and North America, and we see that and say: "So, do you want to?", " I want to, but it would never be possible." Why would it never be possible? Because it's only for those who can afford private care. (N5)

Thus, higher purchasing power is an important factor for women's access to PHB, since many Brazilian women still do not have this accessibility due to a lack of resources and the absence of this modality within the UHS.

The PHB knowledge gap

The PHB is not widely publicized in Brazil, which has contributed to the maintenance of the biomedical model, marked by hospitalization and intervention on women's bodies, according to the testimonies:

[...] it is not widely known or talked about; few people have access to it, and few people talk about it. (N7)

[...] it is still little known, and many women are unaware that this form of planned home birth exists and can be done. (N12)

Other reports from obstetric nurses highlighted the lack of knowledge among women, who, due to the scarcity of information and the culture of cesarean sections in the country, i.e., many women prefer cesarean sections, influenced by the obstetric model.

[...] patients who come here (to the hospital) often request cesarean sections; they don't even know what normal childbirth is, or the benefits and harms of a cesarean section. So, for them, there is no discussion of what a planned home birth is, and sometimes home births happen: they go into labor at home and end up giving birth there, but not because they planned it, but because they didn't have time to get to a maternity ward. (N6)

[...] we also see that the patients themselves have no idea how much better it would be for them to give birth at home. They want to come to the hospital at 2 cm, 3 cm. Giving birth at home, then, is something out of this world for them. (N11)

Public policies that encourage PHB

The participants emphasized the importance of having an organization directly focused on the PHB in national policy.:

[...] a national policy focused on planned home births, distinct from the general national policy. But there needs to be a policy focused solely on planned home births. (N2)

[...] one of the initiatives would be a policy focused on planned home births. (N4)

[...] policies that can encourage women. Because many women do not have access to, nor are they familiar with, planned home births, as they are only accustomed to hospital births, right? And the incentive would be very good for reducing both maternal and

fetal mortality, and this would contribute to a decrease in unnecessary interventions. The issue of dehospitalization would also be greatly reduced, but for that, we need an incentive from the government. (N9)

The reports from obstetric nurses highlighted the importance of the UHS in offering this type of birth method, as many women wish to opt for this form of delivery. However, as this option is not offered in public institutions, many women do not have the financial means to do so. The PHB, when offered by the UHS, would promote equity in access to this method throughout Brazil.

[...] for women who want to have their babies at home, they could literally have this care covered by the UHS, through public health policies. (N7)

[...] a patient who cannot afford to pay. She wants a planned home birth. It would be a matter of investment by the government. (N14)

DISCUSSION

Although the WHO recognizes PHB as a safe and humanized form of childbirth[18], there is concern about this choice among nursing professionals. Many health professionals, especially doctors, are opposed to PHB, opposing women's desire to choose this form of home care[5].

Women should be provided with unbiased information explaining the risks and benefits of each form of birth, based on scientific evidence. The literature shows that when a woman who has opted for PHB is received, she is stigmatized by some health professionals who, because they disagree with this type of delivery, assume the position of gatekeepers of birth method, curtailing and removing the woman's power of choice and decision[5].

In addition, healthcare professionals who provide this type of delivery face judgment when they need to refer these women to backup hospitals, suffering retaliation in some cases[20]. With the emergence of maternity wards, the delivery process became hospital-centric, with these women's individuality increasingly being overlooked. With this whole process of institutionalization, some procedures such as episiotomy, Kristeller maneuver, trichotomy, and medicalization have become routine, even without scientific evidence to prove the need for their use in all women[5].

A study conducted with women in Ireland showed that the desire for home birth is established in the relationship between the professional and the woman, with a relationship of trust allowing for the establishment of consent and shared autonomy for home birth[21] - a fact that contributes considerably to the reduction of unnecessary interventions.

The training of obstetric nurses, at the lato sensu specialization level, is still largely based on the institutionalized model, with a focus on humanization, but with the development of their skills and abilities centered on hospital childbirth, in accordance with the International Confederation of Midwives (ICM). There is only one initiative at Sofia Feldman Hospital, in the state of Minas Gerais, in the field of home birth, through the Obstetric Nursing residency, which also covers this area of practice. However, in most specializations or residencies in Obstetric Nursing, there is no room for this professional experience during training.

Obstetric nursing training, in general, in nursing courses in Brazil, does not include home birth care, as it focuses on training for work in the UHS. This situation allows for the existence of private courses with this training proposal and/or discussions at scientific events.

Thus, the trajectory of obstetric nurses working in the PHB is built on their particular professional experiences. These are consolidated in their praxis, reaffirming their competencies and skills, as well as in the promotion of precursor training courses for home birth care[22,23]. These nurses' practice in the PHB contributes to the expansion of a new professional field and to new entries into the labor market. However, it should be noted that training in nursing courses could ensure greater safety and capacity for the performance of obstetric care, offering a safe alternative for home births.

Home birth is not yet a practice based on equity, as guaranteed by the UHS, but rather a service acquired through purchasing power. In Brazil, PHB is not yet part of the experience of many women; only a small group has satisfactory socioeconomic conditions to invest in their form of birth, which constitutes a major obstacle to accessibility, especially given the lack of incentives from government organizations and the Brazilian government[5,20].

A study of women who had home births in the United States showed that many invested around USD 4,650.00,[24] demonstrating the investment required to guarantee PHB among American women. There is a global women's movement for universal health care and equity[5,7,18].

From a biomedical and hospital-centric perspective, PHB is represented as a risky event for mother and child in relation to hospital delivery, contributing to the maintenance of the hospital-centered obstetric model.

Thus, a qualitative study with women and their partners in the Balearic Islands, Spain, showed that home birth is perceived as outside the norm and standard of birth, which breaks with the obstetric model. This condition highlights the need to disseminate information about PHB to promote a change in the birth model, giving women the choice to decide where to give birth.

In Brazil, public options for childbirth care are limited to hospitals. Only in some regions of the country are there Normal Birth Centers, but hospital births predominate, accounting for 98.36% of births. In addition, some women dissatisfied with the hospital care model have opted for PDP[26]. Births performed in a hospital setting are considered "ideal" in Brazilian biomedical culture. In this sense, women who wish to give birth elsewhere end up having less access to quality information, especially during prenatal consultations—a situation that violates the principle of woman-centered care[5,19-20,26].

In Brazil, the UHS and health insurance plans do not cover PHB. Furthermore, the absence of public policies on the subject contributes to the lack of guidelines for health professionals, especially obstetric nurses who provide this type of care. However, in 2024, Resolution No. 737, dated February 2, was published by the Federal Nursing Council (COFEN), regulating the practice of Obstetric Nursing in PDP[9].

With this regulation, COFEN establishes in the normative field the guarantee of the performance of professionals specializing in Obstetric Nursing in home births. Added to this is the creation of the Alyne Pimentel Network, established by Ordinance No. 5,340, of September 5, 2024, to reorganize the network and actions in favor of reducing maternal mortality. As this political advance consolidates, it becomes necessary to implement the PHB within the scope of the UHS.

Therefore, this whole issue reflects the lack of information about the possibilities of home birth in Brazilian society. The Ministry of Health is not a network that supports the real needs of women during pregnancy and childbirth[5]. This body must promote discussions about this type of care, guaranteeing the right to choose the place of birth as an integral part of women's sexual and reproductive rights in the Brazilian context[26].

The study was limited by the small number of nurses at the hospital, which made it difficult to expand the sample and the scope of the discussion about the study.

FINAL CONSIDERATIONS

The study sought to understand the meanings attributed by hospital obstetric nurses to PHB, highlighting the need to overcome the current obstetric model in Brazil through changes in attitudes and meanings by health professionals toward this type of delivery.

In their interpretations, obstetric nurses reveal the prejudice and marginalization faced by women who choose home birth, many of whom are judged by health professionals based on value judgments. These facts stem from the biomedical model established in obstetric care, in which the hospital environment is considered a safe place for birth, while home birth is seen as unnecessary, creating insecurity for the woman and her child.

Other meanings attributed show economic limitations as barriers to women's access to home birth. This obstacle currently prevents most Brazilian women from hiring a specialized team, highlighting economic inequality in access to this birth option.

Thus, obstetric nurses reaffirm, in their discourses, the need for public policies at the national level as a pillar for encouraging home birth, with the PHB for all Brazilian women, regardless of race, education, or socioeconomic status.

The UHS should recognize PHB as a safe form of home birth care, making it an integral part of obstetric care through public policies that support and guarantee this type of delivery in the country. This inclusion contributes to the appreciation of home birth from a global perspective, with its provision in health systems, valuing the guarantee of women's rights regarding how they wish to give birth and bring their children into the world.

Thus, it is essential to promote studies that support initiatives aimed at overcoming the current obstetric model, guaranteeing access to PHB for Brazilian women and implementing public policies that guarantee the right to choose the form of birth.

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Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - **Cavalcante JS, Rodrigues DP.** Drafting the work or revising it critically for important intellectual content - **Cavalcante JS, Rodrigues DP, Alves VH, Vieira BDG, Calandrini TSS, Marchiori GRS, dos Santos MV.** Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - **Cavalcante JS, Rodrigues DP, Alves VH, Vieira BDG, Calandrini TSS, Marchiori GRS, dos Santos MV.** All authors approved the final version of the text.

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