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AMAZONIAN WOMEN IN PLANNED HOME BIRTH: A QUALITATIVE STUDY

MULHERES AMAZÔNICAS EM PARTO DOMICILIAR PLANEJADO: UM ESTUDO QUALITATIVO

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RESUMO

Objetivo: explorar as experiências de mulheres amazônicas com parto domiciliar planejado. **Método:** estudo qualitativo com 20 mulheres do estado do Pará (Região Norte do Brasil), com entrevistas semiestruturadas realizadas entre agosto de 2021 e fevereiro de 2022. As entrevistas foram integralmente transcritas e analisadas por análise de conteúdo no ATLAS.ti 8.0, o que resultou em duas categorias: (1) a experiência do parto domiciliar planejado; e (2) o parto domiciliar e a ruptura com o modelo hospitalocêntrico. **Resultados:** o parto foi descrito como um ritual envolvendo o corpo e práticas de cuidado, como parto na água, relaxamento e massagem, e posições verticais de parto. O parto domiciliar planejado foi associado a menos intervenções desnecessárias e a maior autoconhecimento corporal, fortalecendo o protagonismo das mulheres no ato de parir. **Conclusão:** a experiência do parto domiciliar planejado foi caracterizada como satisfatória, marcada por autonomia e poder de decisão no cuidado, e sustentada por uma rede social escolhida pela própria mulher, com o objetivo de preservar a escolha sobre o processo de cuidado.

Descritores: Mulheres; Parto domiciliar; Política de saúde.

ABSTRACT

Objective: to explore the experiences of Amazonian women with planned home birth. **Method:** qualitative study with 20 women from the state of Pará (Northern Brazil). Semistructured interviews were conducted between August 2021 and February 2022, fully transcribed, and analyzed using content analysis in ATLAS.ti 8.0. Two categories emerged: (1) the PHB experience; and (2) home birth and the break with the hospital-centric model. **Results:** birth was described as a ritual involving the body and care practices such as water birth, relaxation and massage, and upright birthing positions. Planned home birth was associated with fewer unnecessary interventions and greater body awareness, strengthening women's agency in the act of giving birth. **Conclusion:** the planned home birth experience was characterized as satisfactory, marked by autonomy and decision-making power in care, and supported by a social network chosen by the woman to preserve control over the care process.

Descriptors: Women; Home birth; Health policy.

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What is known:

- Planned home birth shows comparable risk outcomes; choosing to give birth at home does not entail higher risk;
- Comprehensive, woman-centered care grounded in physiology and evidence supports safer obstetric care at home.

What this article adds:

- Valuing women's autonomy and agency in childbirth: shows that planned home birth enables Amazonian women to exercise greater control over their bodies, strengthening self-knowledge, freedom of choice, and decision-making power in the birthing process;
- • Break with the hospital-centric, medicalized model: indicates that planned home birth represents a form of resistance to the hegemonic obstetric model, characterized by interventionist - and often violent - practices;
- Methodological rigor and relevance to qualitative research: robustly applies the qualitative method, with thematic content analysis and the COREQ protocol, ensuring data validity and reliability.

INTRODUCTION

Planned home birth (PHB) is a childbirth option adopted in several countries — such as Canada, Australia, the Netherlands, and the United Kingdom — and is associated with greater safety and lower perinatal risk, including fewer obstetric interventions[1].

In Brazil, available data indicate a PHB rate of about 0.1%, recorded in the Southeast region, which underscores the need to broaden this option for Brazilian women[2]. In high-income countries, the prevalence of PHB attended by a qualified professional varies: 2.8% in England, 11.3% in New Zealand, and up to 62.7% in the Netherlands, where access to this modality is more established[2]. It is essential to guarantee women's right to the PHB experience as a matter of public policy in Brazil — provided the pregnancy is healthy and without apparent risk, and accompanied by comprehensive prenatal care[3].

Scientific evidence indicates that PHB is a safe way to give birth and reduces obstetric interventions — especially those not recommended as best practices, such as episiotomy, the fundal pressure, amniotomy, and elective cesarean section[4-7]. Studies show that PHB can be as safe as hospital birth.

PHB also involves a dimension of connection with the body and women's self-knowledge about the birthing process. Many choose this experience in pursuit of woman-centered care and distance from the prevailing obstetric model[4-7].

In Brazil, hospital births are characterized by the high use of interventions. A study showed that women in this setting are more likely to undergo amniotomy, episiotomy, and fundal pressure[8]. Hospitals tend to be more interventionist, which increases the risk to mothers and newborns.

The resurgence of PHB emerged as a response to excessive interventions and the medicalization of childbirth, supported by the World Health Organization (WHO) and organized sectors of civil society. These efforts culminated in public policies that favored the participation of nurse-midwives in PHB in urban centers and encouraged this alternative for birth. In Brazil, however, PHB still lacks government support: it is not recommended as a guideline by the Brazilian Ministry of Health[9].

In order to enhance the effectiveness of these initiatives, it is necessary to break with the hegemonic model of obstetric care, transform birth care, and promote PHB for women at low risk. This helps effectively secure women's right to experience their wishes, preferences, and needs[4].

This study examines the experiences of Amazonian women with PHB, discussing their rights, desires, and expectations regarding the place of birth. It seeks to provide evidence-based insights on PHB from the perspectives of these women, contributing to knowledge dissemination and strengthening this option. Notably, during the study period, the Rede Cegonha program was in effect; in 2024, it was reconfigured as Rede Alyne, with a focus on reducing racial inequities and maternal mortality. Expanding access to PHB should be part of the policy agenda to strengthen the obstetric network, make care more effective, and integrate perinatal services — particularly PHB.

In the Amazon region — particularly among traditional peoples and communities — PHB is socially constructed within a culture that recognizes childbirth as a natural phenomenon, grounded in historical knowledge and shared meanings. Nevertheless, the scientific literature on northern Brazil has gaps: there is a lack of data on the impact of PHB on maternal health, on access, and on day-to-day nurse-midwifery care in PHB. Accordingly, the guiding research question was: how is the experience of Amazonian women in PHB characterized?

The aim of this study is to understand the experience of Amazonian women in relation to PHB.

METHOD

This descriptive, exploratory qualitative study was prepared in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ), which guided reporting of the study[10].

We first surveyed health professionals on the Regional Nursing Council of Pará website and identified only one team in the state that provided care for PHB. The mapping considered only teams that attended PHB and did not include physicians or lay midwives.

We then contacted the "Naiá Parto Domiciliar" nurse-midwifery team, composed of three obstetric nurses, and requested contact information for women they had attended to enable invitations to the study. The lead researcher telephoned each potential participant to present the study — its objectives, data-collection procedures, risks, benefits, and other pertinent information — in line with COREQ recommendations[10]. This conversation preceded data collection.

Eligibility criteria were women aged ≥ 18 years who had a PHB in Belém between 2019 and 2022. Women transferred to hospital during labor or birth were excluded. No one declined or withdrew.

A total of 20 women who had a PHB in Belém, Pará, Brazil, participated. In total, 35 invitations were sent and 25 women responded. We used convenience sampling, applied the eligibility criteria, and adopted the criterion of theoretical

saturation[11], which was reached when data became repetitive and additional interviews no longer yielded new information, resulting in 20 participants.

Participants were not informed about the interviewer's personal goals or characteristics, and no researcher had personal or professional ties to the study setting, minimizing potential conflicts of interest. The study was conducted solely on the basis of the relevance of the research question.

A pilot study with three women assessed the adequacy of the interview guide to the study aims and to participants' narratives. Pilot participants were not included in the final sample.

Semistructured, individual interviews with open-ended questions were scheduled and conducted between August 2021 and February 2022, in a single session at a location chosen by each participant (home or workplace). Only the lead researcher and the participant were present. The average duration was 90 minutes. The guiding questions were (1) "Tell me about your PHB experience" and (2) "How did you feel about having a PHB, and how did you make your decision?" With consent, interviews were recorded on an MP3 device.

Interviews were transcribed verbatim and, three days after each interview, the transcript was sent to the participant via WhatsApp for reading and validation (member checking) to ensure data trustworthiness, as recommended by COREQ[10]. The material was then processed for analysis.

All interviews were conducted by the lead researcher; a female nurse and master's student trained in qualitative methods. After data collection, she received feedback from her advisor and other team members — PhD-level researchers experienced in interviewing — without any interference in the collection process. The team undertook data processing and analysis.

We performed thematic content analysis[12] in three stages: (i) pre-analysis, organizing the 20 transcripts and conducting careful, immersive reading to formulate initial hypotheses; (ii) exploration of the material; and (iii) treatment of the results. ATLAS.ti 8.0 supported the whole process.

Through coding and categorization — segmenting meaning units[12] — results emerged from recurrent patterns in the units of analysis: ritual and support network; water birth; relaxation; music therapy; upright birth; qualified team; obstetric interventions; institutional power; and knowledge and information. In the inference and interpretation stage — grounded in the constitutive elements of the meaning units[12] — we refined the significance of these findings. In the final stage, treatment of the results, inference and interpretation proved consistent and valid with the presentation of categories, constituting a controlled interpretation supported by constitutive elements (meaning and code) and by emitter/receiver positions[12]. Based on an inductive, non-a priori categorization, two categories emerged (Table 1). Findings from the analytic process were discussed under literature on PHB, public policies, and recommendations related to childbirth and birth care.

The study was approved by the Research Ethics Committee (opinion No. 4,463,291/2020; CAAE 39952720.3.0000.0018), in accordance with National Health Council Resolution No. 466 of December 12, 2012, and Resolution No. 510 of April 7, 2016. Participants were informed that confidentiality, anonymity, and privacy would be ensured. Testimonies were identified by the letter "I" (for interviewee) followed by a numeral indicating interview order (I1-I20). Participation was voluntary and formalized by signing two copies of an informed consent form — one for the principal investigator and one for the participant.

Table 1 – Categories generated in the analytic process. Belém, Brazil, 2025

Meaning unit	Thematic unit	Thematic category
Hegemonic obstetric model	Home-birth ritual	The PHB experience
	Break in the care model	PHB and the break with the hospital-centric model

PHB = planned home birth.
Source: Prepared by the authors, 2025.

RESULTS

The PHB experience

Childbirth is a singular ritual for each woman — especially at home, where the support network, particularly family, plays a concrete role in the experience, deepening self-knowledge and connection with one's body.

> *I always had a ritual of talking to my body, telling my cervix to open, for everything to flow, and that's what I kept doing in the bathroom. I was in a lot of pain. And that was it; it was very calm, very pleasant. My mom was there, someone else was helping, my doula was here, everyone, and it was very calm*. (I3)

> *I think it was the first time I really felt my body, the first time I felt inside my body, as if I owned it. Having the birth at home gave me that feeling, that passage* […] *with different meanings, but truly empowering me over my body. I said: I can do anything I want in the world!* […] *there is nothing I can't do.* (I12)

Among participants, PHB was described as a unique and demanding moment. Many reported changes in how they labored, highlighting resources such as warm showers and water birth in a birthing pool — conditions not always available in hospitals.

> *My birth was magical, in the birthing pool just as I had always dreamed and planned* […] *when I was in the water, I calmed down, I felt relaxed, and everything about home birth carried huge meaning for me.* (I6)

> *They'd ask: 'Do you want to get into the pool now?'* […] *It didn't have all those extra details that women sometimes want, and I could live that out, care that would be hard to get in the hospital. Giving birth at home made that possible.* (I15)

> *They filled the pool with warm water for me. The shower also helped; the water calmed me and helped me relax through the contractions.* (I20)

Relaxation techniques, such as massage, together with music therapy were also part of PHB, supporting woman-centered care and each woman's way of giving birth.

> *Because everything was so new, it was a very intense experience, and labor lasted quite a while, but I could eat at home, relax, lie in my own bed. I even danced with my husband to music I chose, and that care was magical, everything and more than I imagined.* (I1)

> *The massages from the team relaxed me a lot, I felt very relaxed, and then I started walking, doing a few movements, and it was wonderful; it helped me have a safe birth.* (I4)

Women took an active role in decisions about birthing position, including use of a birthing stool — contrasting with the institutional model of supine birth. Partners were commonly present and involved in care, including cutting the umbilical cord.

> *It was very intense too, after the baby was born, my husband caught the baby, placed the baby in my arms, and he cut the cord. It was an act of surrender* […] *and for me that was essential.* (I15)

> *I woke up in the pushing phase and it was super calm. I had written in my birth plan: I want to go to the pool, all of that. There wasn't time to fill the pool; there was only time to sit on the birthing stool. When crowning started, I went to the stool and it was wonderful, watching my child be born* […] *in the end, my husband cut the cord after it stopped pulsating, and it was beautiful!* (I19)

PHB and the break with the hospital-centric model

Women's experiences were marked by meanings tied to care that respects their decisions. In hospital settings, this protagonism is often constrained by interventions that, in many cases, intersect with obstetric violence.

> *If I had gone to the hospital, they would certainly have done a C-section, they would have pushed you into surgery for no reason, or they would have cut your perineum. And I had no tearing, you know? My daughter was huge, and I still didn't tear. Everyone asked: "They didn't cut you?" Cutting is obstetric violence; it shouldn't be done.* (I8)

> *Home birth is transformative. I think every woman should have access to information, because what I notice when I see pregnant women is that 90% are very afraid, not only of home birth, but of having a vaginal birth at all, because of the care they'll receive, the interventions like episiotomy or even a C-section, and the violence from some professionals. With home birth, you have love and care*. (I18)

The institutional dominance of the hospital — grounded in the authority of medical knowledge — concentrates decision-making power over obstetric care. By contrast, PHB helped disrupt this model and supported more autonomous birth experiences.

> *She said, "You need to think carefully, because there are many risks at home. If something happens, how will you get to the hospital?"* […] *I said, "Doctor, I'm sorry, but you know hospitals also have risks. I know plenty of stories of women who lost their babies, horrible stories, so I think there's risk anywhere, in hospital or at home."* (I1)

Knowledge was a key factor shaping both the choice of and the experience with PHB: it expanded body awareness and sustained women's protagonism in how they gave birth at home.

> *From the moment I knew I was pregnant, I knew I wouldn't go to the hospital under any circumstances. I already had a lot of information; I had studied a lot after my first child. I met some researchers who talked a lot about home birth, and I was sure I wouldn't go back to the hospital; I would give birth at home.* (I4)

> *We researched a lot, and I had close friends who had home births and recommended the team, the people I could talk to so I could make it happen.* (I6)

The presence of a qualified team was cited as decisive. Specialized professionals inspire trust and safety and reinforce women's protagonism in the home-birth setting.

> *If there hadn't been a qualified professional, maybe she wouldn't have known what to do, because with shoulder dystocia there's a specific maneuver. And this nurse had just taken a course on shoulder dystocia. She said a lot of professionals don't know what to do when it happens and end up breaking the baby's clavicle to get the baby out, and later the baby needs physical therapy and suffers. I thought: "My God, I was meant to have a home birth because of her." If we'd had someone who didn't know that technique, would my daughter have survived? Would she have had sequelae?* […] *She saved my daughter's life, and that's priceless.* (I10)

DISCUSSION

Women's autonomy in decision-making favors PHB[13] and underpins the embodied experiences reported at home[14-15]. In PHB, autonomy is intertwined with a support network, forming an individual and collective process. This support operates as a ritual — a bond with one's own body — that deepens self-knowledge and marks a meaningful life passage. There is a growing movement to keep women at the center of care and to ensure their decisions are heard. In this regard, the support network — especially family — plays a decisive role[16].

PHB is a significant event for women and their families[7]. When choices are informed, they safeguard autonomy and decision-making power throughout birth. Appropriate counseling of family members by health professionals strengthens this support and helps consolidate the choice[5].

Thus, women need access to trustworthy evidence to uphold their autonomy, and the State must ensure public policies that make PHB services feasible — as seen in countries

such as the United Kingdom, the Netherlands, and Sweden[17].

In Brazil, access barriers persist because PHB is not recognized by the Brazilian Ministry of Health or by medical associations[18]. Attempts to discourage PHB — viewed as a break with the prevailing obstetric model[14-15] — undermine women's autonomy and control over birth rituals. An equity gap also remains: women with better access to high-quality information and greater socioeconomic resources are more likely to exercise the right to PHB, while many remain excluded.

Among practices reported in PHB, warm showers and water birth stand out as strategies that challenge the prevailing care model, since many facilities do not provide these options. Water immersion during the first stage of labor is associated with reduced need for analgesia, fewer interventions, and a greater sense of bodily control. Upright positions, including in water birth, are not associated with adverse maternal or neonatal outcomes[2,19-20].

In PHB, women also adopt more upright positions, describing the birthing pool as the fulfillment of a desire and a confirmation of expectations[2]. Such practices contrast with hospital settings, where they are often not feasible[14-15]. Mode of birth is part of the ritual of birth itself; in this context, water birth emerges as an alternative that reshapes the relationship between care and the body, reduces interventions, and reframes the way birth unfolds.

PHB gains visibility when practiced with evidence-based care[7], respect for women's decisions, and woman-centered support that preserves autonomy. PHB teams act as facilitators, employing techniques recommended by the WHO — such as music therapy and massage during labor[20].

Aligned with international[6] and national[21] guidelines, these practices strengthen autonomy, protagonism, self-knowledge, and freedom. PHB constitutes an alternative that distances care from unnecessary interventions and breaks with the hospital-centric model[14-15]. These elements support the perception of safety in the home setting[22]. It is essential to offer concrete opportunities for women to experience innovative, evidence-aligned maternity care — encouraged by health professionals — so they feel safe, comfortable, and confident throughout the whole process.

The contribution of PHB becomes evident in the birthing process. Self-knowledge of one's body is connected to more upright positions, such as the use of a birthing stool. This freedom contrasts with hospital settings, where the lithotomy position predominates[2]. Giving birth upright reinforces women's decision-making power and forms part of the birth ritual, often shared with a partner.

PHB operates under a logic different from the hospital's: the home and family organize themselves to receive the new member. In the domestic setting, delayed cord clamping and cutting — typically between 1 and 5 minutes and often performed by the companion — are feasible, reinforcing newborn health protection, humanized care, and the intimacy between the woman and her companion[23].

Safety is also grounded in the work of experienced obstetric nurses trained to manage childbirth situations[7,24]. Their expertise inspires trust and links theory to practice to refine skills, adding a safety value to PHB care and influencing women's choices[24].

For many participants, PHB represents a departure from the prevailing obstetric model, in which hospital birth is permeated by multiple interventions[13-15,17,19,25]. Women are guided toward self-knowledge and connection with birth in dialogue with the team — especially the nurse — breaking with the interventionist paradigm and countering procedures such as episiotomy, fundal pressure, and routine use of synthetic oxytocin, among others, in favor of physiological, humanized birth[26].

Thus, breaking with the model[1] underpins the PHB experience: the pursuit of autonomy is a cornerstone of this process, oriented by women's satisfaction and preferences. The hegemonic model[26] — often associated with negative experiences and an unfamiliar, fear-inducing environment — motivates the search for PHB.

Women seek to challenge the institutionalization of birth and the hegemony of medical authority. The discourse of risk — which frames pregnancy as illness and justifies excessive procedures in the name of "good practice" and safety — contrasts with PHB as an expression of birth physiology, centered on supporting women's protagonism and bodily knowledge[7]. In this model, women's autonomy prevails, unlike the hospital arrangement, except where initiatives ensure their centrality and actions aligned with birth physiology.

Information is essential to transform the hegemonic model. It enables women to understand risks and benefits, choose PHB, and move from passive to active stances — exercising free choice according to their needs[1]. Health literacy fosters networks of knowledge and experience that expand awareness and dissemination — fundamental for understanding PHB from a social perspective[15].

Accordingly, women identify PHB as the option that best fits their needs, weighing risks and benefits. Information must be tailored to each woman's profile to support choice and encourage decision-making. Professional encouragement of PHB should reinforce decision processes and autonomy in childbirth[19].

Due to the unfeasibility of other data-collection techniques, women's accounts were the sole source of data on the PHB experience.

CONCLUSION

The findings of this study illuminate the experiences of Amazonian women with PHB, highlighting the ritual dimension of the female body and a break with the hegemonic obstetric model.

PHB emerged as a ritual of self-knowledge. Participants described practices that fostered autonomy during birth — warm showers, water birth, relaxation and massage, music therapy, and partner-performed cord cutting — made possible by the home setting. PHB functioned as a counterpoint to the hospital-centric, medicalized model, in which women's autonomy and protagonism are often constrained.

This research contributes by presenting data on PHB among Amazonian women and by offering inputs to expand public policies that guarantee this option for all women.

Further studies are needed, particularly in northern Brazil. Such investigations can inform proposals to improve the quality of woman- and family-centered maternity care.

*Article extracted from the Master's Thesis entitled "Parto domiciliar planejado no contexto amazônico: escolha e direito das mulheres," presented to the Graduate Nursing Program at the Federal University of Pará, Belém, PA, Brazil, in 2022.

CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

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All authors are responsible for drafting the manuscript, critically revising its intellectual content for the final published version, and ensuring the study's accuracy and integrity with regard to ethical, legal, and scientific aspects.