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AMAZON WOMEN'S MOTIVATIONS TO CHOOSE PLANNED HOME CHILDBIRTH

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ABSTRACT

Objective: to understand the meanings attributed by Amazon women regarding their motivation grounds to choose planned home childbirth.
Method: a research study of a qualitative nature. The study data collection tool consisted of semi-structured interviews with 20 Amazon women who underwent home childbirths between November 2021 and March 2022, through the Snowball Sampling recruitment technique. After data collection, the interviews followed the content analysis criteria.
Results: it was observed that qualified information, support networks and groups produce motivation and a feeling for home childbirth, which contribute to breaking away from the hegemonic model in Obstetrics and, thus, to refusing unnecessary interventions resulting from the established medical knowledge that oftentimes culminates in obstetric violence. Safety also emerged as a central factor to experience home childbirth, such as feelings of freedom, courage and empowerment about their choices and wishes.
Conclusion: there is convergence with the current demands on positive care regarding respect for women's choice, which, through support and information, are central aspects to ensure assistance according to Amazon women's expectations, in order to break away from the hegemonic model in obstetric care, as home childbirth effectively guarantees their will, which must be heard and respected.

DESCRIPTORS: Women. Maternal-child health. Humanized childbirth. Humanization of the assistance provided. Home childbirth.

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MOTIVAÇÕES DE MULHERES AMAZÔNIDAS PARA TOMADA DE DECISÃO DO PARTO DOMICILIAR PLANEJADO

RESUMO

Objetivo: compreender os significados das mulheres amazônidas quanto às suas bases motivadoras para tomada de decisão do parto domiciliar planejado.
Método: pesquisa de natureza qualitativa. O estudo teve como ferramenta de coleta de dados a entrevista semiestruturada, com 20 mulheres amazônidas que tiveram partos em casa, entre os meses de novembro de 2021 a março de 2022, por intermédio do recrutamento *Snowball Sampling*. Após a coleta de dados, as entrevistas seguiram os critérios de análise de conteúdo.
Resultados: observou-se que a informação qualificada, rede e grupo de apoio produzem motivação e sentimento para o parto domiciliar, que contribuem para romper com o modelo hegemônico na obstetrícia, e, assim, recusar intervenções desnecessárias, resultantes do saber médico instituído que, culmina, muitas vezes, na violência obstétrica. A segurança, também, constituiu um fator central para vivenciar o parto no domicílio, como sentimentos de liberdade, coragem e empoderamento sobre suas escolhas e vontades.
Conclusão: há convergência com as demandas atuais sobre o cuidado positivo perante o respeito da tomada de decisão feminina que, por meio do apoio e informação, constituem aspectos centrais para garantir uma assistência conforme as expectativas das mulheres amazônidas, a fim de romper com o modelo hegemônico na assistência obstétrica, visto que o parto em casa garante de forma efetiva a sua vontade, que deve ser ouvida e respeitada.

DESCRITORES: Mulheres. Saúde materno-infantil. Parto humanizado. Humanização da assistência. Parto domiciliar.

MOTIVACIONES DE MUJERES DE LA REGIÓN AMAZÓNICA PARA ELEGIR PARTO DOMICILIARIO PLANIFICADO

RESUMEN

Objetivo: comprender los significados que atribuyen las mujeres de la región amazónica a sus bases motivadoras para elegir parto domiciliario planificado.
Método: investigación de carácter cualitativo. La herramienta de recolección de datos del estudio correspondió a entrevistas semiestructurada con 20 mujeres de la región amazónica que dieron a luz en sus casas entre los meses de noviembre de 2021 y marzo de 2022, por medio de la técnica de reclutamiento *Snowball Sampling*. Después de recolectar los datos, las entrevistas siguieron los criterios del análisis de contenido.
Resultados: se observó que la información calificada y las redes y los grupos de apoyo generan motivación y cierto sentimiento favorable hacia el parto domiciliario, que contribuyen a distanciarse del modelo hegemónico en Obstetricia y, de ese modo, rechazar intervenciones innecesarias resultantes del saber médico instituido que muchas veces culmina en violencia obstétrica. La seguridad también surgió como un factor central para vivir el parto en el domicilio, como ser sentimientos de libertad, coraje y empoderamiento sobre sus elecciones y deseos.
Conclusión: se detecta convergencia con las exigencias actuales sobre la atención positiva en términos de respetar las decisiones de las mujeres, las cuales, por medio de apoyo e información, constituyen aspectos centrales para garantizar una asistencia acorde a las expectativas de las mujeres de la región amazónica, a fin de interrumpir el modelo hegemónico en la asistencia obstétrica, puesto que el parto domiciliario garantiza en forma efectiva su voluntad, que debe ser escuchada y respetada.

DESCRIPTORES: Mujeres. Salud materno-infantil. Parto humanizado. Humanización de la asistencia. Parto domiciliario.

INTRODUCTION

The Brazilian obstetric health care model is configured as an institutionalized one, with hospitals as the foundation for promoting medicalized and interventionist care, considering that 99% of the childbirths occur in this environment and with predominance of medical care[1]. It is worth noting that this birth modality has already been questioned for some years in the international scope, especially in Brazil. Thus, women seek assistance that values the field of Parturition Physiology, their protagonism and safety with inhibition of unnecessary interventions in the female body, such as episiotomy, Kristeller maneuver, synthetic oxytocin and C-section[1–3].

This search comes from a break from the obstetric care model, where women want to have a more active role in choices, becoming the protagonists. Therefore, Planned Home Childbirth (PHCB) emerges as an alternative to rescue this important role of women that was lost in delivery and in breaking away from the hegemonic model in Obstetrics.

In their guidelines, the World Health Organization (WHO) and non-governmental entities show that women should receive professional support and qualified information to ensure informed PHCB decision-making based on scientific evidence and safety of home childbirths[1,4]. In this way, these recommendations give meaning to women's rights, expectations, feelings, safety and motivations and adopt this environment as an effective expectation for their process of experiencing birth of their child.

Countries such as the United Kingdom, the Netherlands and Australia, as well as Nordic countries such as Sweden, Denmark, Finland, Iceland and Norway, ensure respect for the decision and rights of women and family members towards PHCB, which results in enhanced safety and fewer perinatal risks, such as the rate of transfers to hospitals and mortality[5].

However, in the country, there is no normative to recommend PHCB, which with publication of technical note Nº. 2/02021 of the Ministry of Health (*Ministério da Saúde*, MS), ensures that hospitals are the places that offer the highest safety levels for perinatal health. Furthermore, the Supplementary Health National Agency (*Agência Nacional de Saúde Suplementar*, ANS) does not include PHCB in the list of procedures[6]. Thus, this stance meets prohibitive measures, especially for medical performance in PHCB, with Resolutions No. 265 and Nº. 266/2012 of the Rio de Janeiro Regional Medicine Council, as it presents a higher risk for women and the concept[7].

In contrast, diverse scientific evidence shows the benefits of PHCB, where a number studies[8–11] indicate that there is no difference in perinatal and neonatal death associated with home childbirth care; therefore, there is no greater risk of this complication due to place of birth[9]; in addition to the fact that home childbirth presents lower rates of unsafe interventions, especially episiotomies[10], and lower chances of C-sections or instrumental deliveries and severe lacerations (third and fourth degree)[11].

In this study, motivation is related to the aspect reported by the women to choose PHCB. The reason supported in this paper concerns the human process of inner experience that regulates and maintains all the actions and feelings emanating from a human being for fulfilling their will and choices, which depend on specific everyday life situations[12].

In this case, feelings become one of the reasons regulated by each person's internal processes. These reasons are therefore expressed as breaking away from the hegemonic paradigm with qualified information from professionals and scientific evidence regarding childbirth safety and greater participation in decisions and their rights, which are essential factors for the effectiveness of home childbirths. It is noted that Amazon women give birth at their homes as a historical legacy because traditional peoples such as indigenous peoples, forest peoples, *quilombolas* and riverside peoples, consider family childbirth as a cultural aspect. With few research studies on the topic in the region, it becomes necessary to discuss an investigative perspective about these Amazon women on home childbirth.

Given the scenario presented, the current study had the following guiding question: which are Amazon women's motivations to choose PHCB? Consequently, the study aimed at understanding the meanings attributed by Amazon women regarding their motivation grounds to choose planned home childbirth.

METHOD

This study is characterized as descriptive, exploratory and of a qualitative nature, with the participation of 20 (twenty) Amazon women from the state of Pará, Brazil. The following eligibility criteria were defined: being aged at least eighteen years old and having undergone home childbirth from 2018 to 2022 in the metropolitan region of the state. Among the non-excluded participants, those that were transferred to maternity hospitals for any reason and had no PHCB stand out. It is noted that no participants were excluded from the study. The participants' home childbirths occurred during the last three years, when all of them mentioned a recent memory of all the situations experienced in their narratives.

The metropolitan region of the state of Pará comprises the following municipalities: Belém; Marituba; Ananindeua; Benevides; and Santa Bárbara. However, only women from Belém were included in the study by means of the process to select the participants, with six reference maternity hospitals in the region. There is a movement towards PHCB by teams and women, especially by a team of obstetric nurses in the region of Belém, who have been working since 2012 in PHCB, where they conducted the participants' deliveries. In addition, the region has only one Residency program in Obstetric Nursing run by *Universidade Federal do Pará*. There are no active physicians in the state to conduct PHCBs.

The participants were selected using the Snowball Sampling technique, in which a participant is selected and interviewed, constituting the first seed that may indicate other seeds (contacts), easing access to a group of people with common traits and possibly potential participants and, subsequently, until reaching sampling saturation[13]. Thus, there is no setting established but, rather, recruitment of possible contacts with common characteristics in relation to the study scope.

The initial seed was selected due to an indication of proximity to a study researcher, for which both the WhatsApp messaging app and telephone contact were used. When the research, its objective, risks, benefits and data collection instruments were clarified, she was invited to participate in the study. After acceptance, times and places were scheduled according to the participant's indication and availability; the interviews were conducted in-person and at the women's homes. During the interviews, it was observed that no new significant elements emerged to deepen on the subject matter: therefore, theoretical saturation was applied[14] with a total of twenty interviewees. It is stated that data collection was exclusively in charge of the lead researcher, who was previously trained for such activity.

Prior to the interview, each participant signed the Free and Informed Consent Form, ensuring confidentiality and anonymity, using the following alphanumeric code: CB (Childbirth), followed by a number according to the order in which the interviews were conducted (CB1, CB2, CB3, ..., CB20).

The semistructured interviews took place from November 2021 to March 2022 and lasted a mean of 100 minutes. They were guided by a script that contained closed questions about the characterization of the socioeconomic and obstetric profiles, as well as open questions: Tell me about your motivations to choose home childbirth. Describe your feelings about your PHCB experience. During the interviews, the researcher used the recording function in a cell phone, with each participant's prior authorization.

The data from each interview were transcribed in full to subsequently process the results by means of content analysis[15]. Coding with different colors was used, identifying each topic and, subsequently, the registration units was defined, as follows: Support group; Childbirth footage; Support

network; Childbirth in hospital; Care model; Freedom in childbirth; Institutionalized medical knowledge; Fear; Safety; Freedom; and Love. With a floating reading of the material and categorization of the central points of the results, the "Motivation for planned home childbirth" thematic unit was defined, which established the following categories: 1) Qualified information to choose home childbirth; 2) Moving away from the hospital model by rescuing home childbirth; and 3) Feelings related to planned home childbirth.

The study was approved by the collegiate Research Ethics Committee following Resolution No. 466 of December 12th, 2012, which regulates research with human beings in the country, respecting the subjects' autonomy with justice and equality.

RESULTS

Regarding characterization of the women, there was predominance of participants aged between 30 and 40 years old. The prevailing marital status was married. The most incident religion was Catholicism. The ethnicity/race with the highest representativeness was brown. Regarding schooling, there was predominance of Complete High School.

In terms of the most frequent professions/occupations, they were as follows: journalist; nurse; secretary; professor; systems analyst; and housewife. Most of the interviewees worked outside their homes. Regarding employment contracts, there was predominance of freelance/autonomous women.

Referring to family income, most of the women reported earning between four and ten minimum wages. As for participation in the family budget, there was predominance of women contributing half of the income. In terms of housing, most of them were owners.

In relation to the obstetric data, there was predominance of secundigravidae women. Most of the childbirths were to primiparous women. Referring to the miscarriage issue, the episodes were spontaneous in three participants. The majority reported that their pregnancies were planned and wanted.

Regarding the women's place of birth, it corresponded to hospital environments, most via vaginal deliveries. In relation to the participants' mothers' place of birth, the majority corresponded to home childbirth, all via normal deliveries. No participant was transferred to any hospital unit during their home childbirth as a result of any complication.

Qualified information to choose home childbirth

Qualified information was crucial as a motivating element for women to choose home childbirth as delivery method, as observed in the following excerpts: […] *then I got pregnant for the second time and I was certain that I was going to have home childbirth. And I researched, studies, saw all the risks and the benefits too, and chose home childbirth, from my second pregnancy* (CB5); […] *I tried to find out how it was here in the city, how it was here in Belém, if there were many people who were having home childbirths, I looked for the team to find out how many deliveries they had done in Belém* [...] *I looked up the incidence of taking to the Hospital unit, which was the incidence of everything being normal at home. Then I looked for information about that* (CB14).

Childbirth support groups are the foundation for women's motivations in choosing to have planned home childbirths since, due to the diverse experiences and information exchanged, PHCB is enabled as an option for many women, according to the testimonies: […] *I was pregnant, I think that about three or four months, and I was always talking to a friend, who I met I don't remember where, it's been a while, and then she pointed me to a group of women who talked about childbirth and indicated me to participate* [...] *as at this time I was looking for information, this group with the meetings was important to think about it, I started reading a lot about obstetric violence, talking to women, and that's when I decided to have a home childbirth* (CB13); […] *I followed the meetings*

and started to read about humanized delivery, about obstetric violence, all those things. And it was then that I got pregnant! I was aware of the issue of humanized delivery and obstetric violence. And then, I've always read childbirth reports, and home childbirths were those that I liked the most, but it wasn't yet final that it was what I wanted (CB15).

The *O Renascimento do Parto* (Birth Reborn) movie, widely disseminated in support networks and women's groups, was an important influencer in making the decision to have a planned home childbirth, according to the following reports: […] *the choice was through the documentary, Birth Reborn* [...] *that I watched, I made the decision that I wanted to have my childbirth more humanly, in a way that I could actively participate during delivery, he was born in a bathtub. I took my child, I put him on my lap the minute he was born. My second one, I didn't manage, I had no time to go to the bath tub, it was on the stool. Then it was my husband who took her, and placed her on my lap. Then I actually had a lot of support from my husband* (CB14).

The support and family network context was an important factor in terms of information about planned home childbirth. This information from the family allowed women to choose the way to give birth at their homes, as presented in the following excerpt: […] *I actually came to know about this option when my sister, who's also a nurse, said: "Look, they're encouraging normal delivery, sis, it's very interesting. I think that it'd be interesting for you* (CH2); […] *I had a lot of support from my husband, I didn't have much support from the family, which I think it's normal, I understand the family, but they still supported me: as it's your decision, then fine, but I think you have to go to the hospital. But, in short, he supported me a lot; it was fundamental for me, because he also accepted my decision and supported me until the end, he gave birth with me* (CB11).

Thus, it was qualified information through experiences, duly trained professionals, women's support groups, digital initiatives such as social networks, websites, movies and support in the family sphere that provided the motivations for choosing home childbirths.

Moving away from the hospital model by rescuing home childbirth

The break from the obstetric system was observed as a motivator, as an attitude not to go through countless situations that the interventionist model imposes on hospital delivery care. Thus, PHCB emerges as escaping from the hospital assistance model, as we can verify in the following phrases: […] *I talked to my sister: Look, I want a normal delivery, but I don't want to go to any hospital. And I didn't get it out of my mind* [...] *I said: I don't want to go to the hospital, I don't want to go to the hospital* [...] *I was already afraid of obstetric violence, of what happened in the hospital, the treatment* (CB10); […] *I wanted to escape from obstetric violence, which we know, especially because I'm black-skinned, we know that obstetric violence is greater among black peoples. So it was something I wanted to get away from, I was always very afraid of surgery, so I didn't want to go through a C-section at all and I was very afraid, I don't know, I'm very afraid of these things of invasion to the body, you know, so it was a choice because of that* (CB12); […] *when I decided that I wanted to get pregnant, I started to plan it almost one year in advance. And then I started researching about childbirth and discovered humanized delivery. But when I started reading about how many interventions both the woman and the baby can suffer, obstetric violence, I became much more interested in humanized delivery, until I got to home childbirth, reading research studies on that* (CB18).

Breaking away from institutionalized medical knowledge and childbirth in hospital environment has repercussions on the attempt by means of wrong information about PHCB. Many professionals portray it as a risky practice, discriminating women who choose PHCB, as can be seen below: […] *the doctor called me crazy, that I was crazy, that I had no responsibility regarding my son, that I was being influenced by others, that just because celebrities were having children at their homes, I wanted to be like them, the risk of my son dying or having complications was huge* (CB1); […] *one of*

the issues was because I had already suffered a lot with these physicians, I didn't want to see them, and I didn't want to hear nonsense anymore [...] *Jeez, people, aren't professionals tough?* (CB20).

Thus, the break from the hegemonic model that culminates in a range of obstetric interventions, disrespect and violence in the routine of maternity hospitals, was the major motivator for women not to experience these practices. PHCB is an alternative to change the logic of understanding childbirth, beyond the physiological aspect, while respecting women's convictions about their care.

Feelings related to planned home childbirth

Safety during delivery emerged as an important conditioning factor for choosing planned home childbirth. Allied to information, safety favor the necessary motivations to effectively implement PHCB, according to the testimonies below: […] *ah, the best possible* [sensation], *I had that safe sensation when I made the decision* [...] *that's what I wanted, that I was going to experience childbirth fully, not that I hadn't experienced it in the hospital, but I heard some things that weren't good, that weren't right for me, they got stuck in my head* [...] *And home childbirth promoted this safety feeling* (CB4); […] *the main motivation for me to choose my home childbirth was for safety, because from what I studied* [...] *it's as safe or even safer than in a hospital, because at home I'm free from a lot of things, considering that I am a person* (CB10); […] *yes, I was very attached to evidence-based medicine, which is now super on the agenda in recent times, but it's a thing that we've been fighting against for a long time already, mainly for Obstetrics to act in this direction, because it is very much evidence-based. Safety goes hand in hand with science and we need childbirth* (CB20).

The liberating feelings of courage and empowerment in terms of decision-making, of the power over their own body and their wishes to give birth at their homes were noticed by the women: […] *the feeling is of freedom, I had a huge feeling of freedom, of choice, I realized that there's also a little of my tradition, I'm a history teacher and this was a feeling of valuing what my mother did, she had a normal home childbirth and me too* (CB9); […] *feeling of courage, feeling of autonomy of your own body, of independence, because it was an attitude that I took, and I didn't ask anyone, I took it with my husband, he accepted it, he was wonderful, he never questioned anything*. *A feeling of full happiness, in the sense that I started taking control of my life, believing that I can be who I want to be. It was from there, it was during pregnancy and mainly in the decision to give birth. For me, home childbirth was the portal to be reborn as a woman, in the sense of who I want to become* (CB20).

Thus, the feelings of the women who underwent PHCBs are related both to safety and to happiness and, mainly, to the empowerment process, allowing a feeling of freedom, commitment and courage to make the PHCB decision.

DISCUSSION

Increasingly, women seek qualified information as a way to motivate themselves to choose home childbirth[3,16]. PHCB is recommended by many health and professional organizations[16], especially the WHO. The PHCB dissemination panorama has encouraged women to seek diverse information about this alternative.

It becomes important that women have access to all the various sources of reliable information available to decide where their childbirth will take place[3,17], ensuring an informed decision. This information should be based on an analysis of the risks and benefits of hospital and home childbirth; the rates of interventions and transfer to a maternity hospital setting; the PHCB maternal and newborn outcomes; and the complications and death, as well as regarding the health professional team and its infrastructure to ensure optimal care. All this information based on scientific evidence will support women's decision-making about the place of birth[18].

Support groups proved to be an important initiative, as an empowerment instrument with the potential to increase women's autonomy and control. These groups promote a space to generate self-confidence and co-accountability for their decision[17]. Women feel more empowered and encouraged to take ownership of their care when they participate in sharing other women's experiences. This support initiative represents a safe environment for information sharing and relationship building, fostering the establishment of an enriching support network in women's lives[16].

The exchange of experiences is a motivating factor, with qualified information provided by the mediator, and these women's experience in home childbirth ensures subsidies for their informed decision-making. This point is crucial to ensure women's safety and confidence regarding the home childbirth experience.

Decision-making goes through several information-seeking scenarios. In addition to support groups, the women reported using technological tools such as websites, movies and social media. Access to these digital tools contributes to breaking away from the hegemonic model of obstetric care and in relation to the meanings of PHCB, as the predominant conception of birth permeates the unknown and can be potentially frightening[1–2].

The movies produced that deal with home childbirth act as a sensitization tool, where, in addition to the biological dimensions, they address the biopsychosociocultural phenomenon involved in childbirth[19]. These initiatives guarantee a range of diverse information, but which needs to be qualified[18], as it provides data on the care weaknesses and draws the attention to a change in the physician-patient relationships, based on a crisis of trust in the hospital-centered environment[20].

Thus, women approach childbirth as the main figure, assisted by a duly trained health professional, and their choice about the delivery method should be respected in the face of their expectations, based on a naturalized delivery and on scientific evidence. The autonomy guarantee refers to establishing the knowledge from which women increasingly seek the digital environment to connect with other women and share their experiences with a support network, which positively influences or not the home childbirth decision. This creation of digital networks and connections allows constructing this information environment[16].

The family environment is another indicator for the motivation to choose home childbirth[19,21]. The desire for this place of birth was sometimes initiated in women themselves, followed by support from their partners and family members, acting as motivators, encouraging them to empower themselves with confidence to giving birth at their homes. Despite contrary attitudes, they receive support, in addition to their autonomy to experience home childbirth[19,22]. This intra-family support network should provide support for women to ensure their decision throughout the gestational period, through dialog, willingness and respect for the conduction of home childbirth[19].

The authors[19] state that, although disapproval attitudes are still observed, oftentimes coming from the intra-family support network that stereotypes home childbirth as inappropriate, women tend to be convinced of their decision and their ability to give birth.

In terms of the importance of qualified information for women's decision, home childbirth constitutes a break from health systems with a hospital-based care model[1,16,19,21,23]. The interventionist care model favors manipulation of the female body, oftentimes without consent and disrespecting women's autonomy through obstetric procedures.

The medical interventions performed in obstetric care, inserted in the hospital environment, refer to the following: episiotomy (26.34% of the parturients underwent this procedure and 40.59% were performed without proper consent);[24] Kristeller maneuver (performed in up to 1.9%, but being routinely used without due notification of recording the practices in the parturient's medical chart);[25] repeated and painful vaginal touches (in up to 70.9% of the situations and not consented in 58.9%);[26] and routine use of synthetic oxytocin, isolation and unnecessary C-sections. These are invisible

obstetric violence actions and procedures[27] that are oftentimes acceptable because they are part of the interventionist logic of the birth process.

Thus, in the hospital environment, procedures that overlap with the naturalization of birth are imposed and can trigger a range of unsafe interventions that alter the course of labor, oftentimes culminating in unnecessary C-sections, an eminent institutional process of hospital childbirth. This care pattern ranges from neglect to discrimination and verbal abuse, physical violence, or even sexual abuse. These situations are classified in the scientific literature as forms of violence in parturition[27]. Therefore, PHCB emerges as an element to break away from the hegemonic system, providing health workers with actions and behaviors based on humanization, beyond the biological dimension of parturition, in order to transform the obstetric care paradigms.

The naturalization and appreciation of hospital childbirth were developed together with the growing use of technologies and the increasingly frequent search for medicalization of the childbirth process, with PHCB as unsafe care that is associated with a health care deficit. The study findings are in line with the scientific evidence that classifies women as offenders or as individuals who deliberately put both their and the infant's life at risk by choosing home childbirth[28].

There is increasing opposition to PHCB by health professionals, rooted in the guidelines and norms institutionalized under the discourse of biomedical risk, propagated over these professionals' long years of academic life and clinical practice. There is a perception that women who make the home childbirth decision choose to follow a "clandestine" path and are oftentimes adjectivized as "crazy" or "irresponsible"[28]. Thus, institutionalized medical knowledge imposes rigid prescriptions, offering the false illusion of ideal and painless childbirth, taking all the responsibility and protagonism of birth upon itself.

The obstetric assistance provided at homes promotes humanized care that gives women a sense of safety and trust in the health team. One study recognized the safety of the home environment as the essence of home childbirth. The home is not merely a physical place, but also a place full of symbolism and rituals. When a woman gives birth at her home, this childbirth moment constitutes a sense of belonging[29].

Women reflect on their perception about PHCB safety, especially the contribution of the resources available for care offered at the hospital unit, while they intimately believe that PHCB also has the necessary resources to ensure higher safety levels, mentioning that birth is a natural phenomenon and that the home environment is the place where they feel safest. These facts corroborate the study data, considering that women have a feeling of confidence and safety in PHCB[30].

The ambience of their homes tends to promote a welcoming and safe atmosphere, reinforced by the attitude adopted by health professionals, who encourage maternal autonomy and protagonism. In addition to autonomy and comfort, ambience is an essential point in the feeling of safety for women, when entering this space of their preference, surrounded by people they trust, as well as for receiving assistance free from violence, more humanized and safer[2].

Childbirth can be an empowering event in a woman's life, causing important changes in her well-being and family dynamics. Intrapartum care should ensure a positive delivery experience for all women, prioritizing respect, safety, care continuity by midwives and women's overall well-being[31]. Pregnant women feel safe and in control and benefit from inner strength and contentment when they experience this care while interacting with health professionals.

Childbirth is a symbolic transition to adulthood for many women, and the hero of the moment is a person who is in control of herself during delivery, because it symbolizes reaching her full potential as a woman. The women reveal that they are satisfied with their decision, as observed in their feelings of freedom, autonomy and courage. Being able to realize these desires, face the challenges that

appeared throughout the process and overcome their fears with their own internal tools shows their strengthening ability through empowerment of their choices.

Thus, the return of home childbirth as an option for women will rescue the female roles, forgotten with the transition of childbirth to the hospital environment, in addition to providing a free, intimate and empowering environment that satisfies women and enhances their autonomy.

However, this study suggests the number of women who underwent PHCBs as a limited process, with an obstacle in achieving broadening of possible participants in the metropolitan region and contributing to a discussion on the study object.

CONCLUSION

Planning a home childbirth is still a practice on the margins of Brazilian obstetric care, and qualified information has proved to be an important facilitator of this modality, whether obtained through support groups, digital tools or even conventional media. Thus, the results showed an important strategy in contributing to the obstetric practice and providing home childbirth with support for women in decision-making.

The active search for information reveals itself as a consolidation of female decision-making and autonomy, which opposes the current obstetric model and seeks in home childbirth a safe and satisfactory alternative to giving birth. However, home childbirth is not universal or equal for many Brazilian women, as the Unified Health System still does not guarantee it effective implementation.

Institutionalized assistance imposes rigid protocols, disregarding each woman's particularities, offering mechanical and medicalized care, without respecting individuality and in a stressful environment. The data showed that there is still resistance from health professionals to change to a new obstetric care model, perpetuating misconceptions and qualifying women who choose PHCB as negligent.

In general, the women proved to be intimately inclined to believing that birth is a natural phenomenon and that their homes are the place that offers the highest safety, protagonism and autonomy levels. The feeling of freedom resulting from the experience of natural birth was evidenced, free from interventions, strengthening the family bond and the active participation of those involved. Obstetric health care proved to be woman-centered, addressing women's expectations, providing confidence and safety and ensuring positive delivery experiences.

Thus, new research studies are required to reflect on home-based obstetric care, such as support networks, feelings, decision-making, women's rights, autonomy and empowerment, such as deliveries assisted by different professionals and training of these professionals, in favor of food quality services and safety based on autonomy and professional respect.

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NOTES

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