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MATERNAL RESULTS FROM PLANNED HOME BIRTHS ASSISTED BY NURSES FROM THE *HANAMI* TEAM IN THE SOUTH OF BRAZIL, 2002-2012

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ABSTRACT

Objective: described the maternal results of the care with planned home births provided by the Hanami Team in 2002-2012.

Method: this transversal study It includes home and hospital births (212). Descriptive analysis was undertaken, with CI 95%, using the SAS/9.1.3 software.

Results: the rate of amniotomy was 9.9% (CI 95% 5.9-13.9), of episiotomy was 0.5% (CI 95% 0.5-1.5), the amniotic fluid remained clear in 95.2% (CI 95% 92.4-98), there was no change in fetal heartbeat in 94.3% (CI 95% 92-96.6). The vaginal tears perineal trauma were exclusively of first degree (64.7%; CI 95% 57.8-71.6) and second degree (7.0%; CI 95% 3.4-10.8), it being the case that almost half did not need suturing (46.8%; CI 95% 41.1-52.6). The rate of transfer to hospital was 7.4%, all these cases occurring during labor (CI 95% 3.8 – 11.0). The rate of cesareans in the sample was 9.9%.

Conclusions: the women assisted at home undergo few interventions. Rates of complications and transfers to hospital for obstetric reasons were low.

DESCRIPTORS: Home childbirth. Natural childbirth. Humanizing delivery. Term birth. Obstetric nursing.

RESULTADOS MATERNOS DOS PARTOS DOMICILIARES PLANEJADOS ASSISTIDOS POR ENFERMEIRAS DA EQUIPE HANAMI NO SUL DO BRASIL, 2002-2012

RESUMO

Objetivo: descrever os resultados maternos da assistência ao parto domiciliar planejado pela Equipe Hanami, de 2002/2012.

Método: estudo transversal. Foram incluídos os partos ocorridos no domicílio e no hospital (212), no referido período. Foi realizada análise descritiva com IC a 95%, no SAS/9.1.3.

Resultados: a taxa de amniotomia foi 9,9% (IC 95% 5,9-13,9), de episiotomia 0,5% (IC95% 0,5-1,5), o líquido amniótico permaneceu claro em 95,2% (IC95% 92,4-98), não houve alteração dos batimentos cardíacos fetais em 94,3% (IC95% 92-96,6). As lacerações vaginais foram exclusivamente de primeiro grau (64,7%; IC95% 57,8-71,6) e de segundo grau (7,0%; IC95% 3,4-10,8), sendo que praticamente a metade não necessitou de sutura (46,8%; IC95% 41,1-52,6). A taxa de transferência foi de 7,4%, sendo todas durante o trabalho de parto (IC95% 3,8-11,0). A taxa de cesárea da amostra foi 9,9%.

Conclusão: as mulheres assistidas no domicílio são submetidas a poucas intervenções. As intercorrências e transferências obstétricas são baixas.

DESCRITORES: Parto domiciliar. Parto normal. Parto humanizado. Nascimento a termo. Enfermagem obstétrica.

RESULTADOS MATERNOS DE LA ASISTENCIA AL PARTO DOMICILIÁRIO PLANEADO ATENDIDOS POR ENFERMERAS DEL EQUIPO HANAMI EN SUL DEL BRASIL, 2002-2012

RESUMEN

Objetivo: describe resultados maternos de asistencia al parto domiciliario planeado por el Equipo Hanami, 2002/2012.

Método: estudio transversal. Fueron inclusos partos en domicilio y en hospital (212). El análisis descriptivo fue realizado en SAS/9.1.3., con IC 95%.

Resultados: la tasa de amniotomía fue 9,9% (IC 95% 5,9-13,9), de episiotomía 0,5% (IC95% 0,5-1,5), el líquido amniótico permaneció claro en 95,2% (IC 95% 92,4 a 98), no hubo alteración en la frecuencia cardíaca fetal en 94,3% (IC 95% 92-96,6). Laceraciones vaginales fueron de primer grado (64,7%; IC 95%: 57,8 a 71,6) y de segundo (7,0%; IC 95% 3.4 a 10.8), y casi la mitad no necesitó sutura (46,8%; IC 95%: 41,1-52,6). La tasa de transferencia fue de 7,4% (IC 95%: 3,8 a 11,0). La tasa de cesáreas en la muestra fue de 9,9%.

Conclusión: las mujeres que reciben asistencia en el domicilio son sometidas a pocas intervenciones, complicaciones obstétricas y las transferencias son bajas.

DESCRIPTORES: Parto domiciliário. Parto normal. Parto humanizado. Nacimiento a término. Enfermería obstétrica.

INTRODUCTION

Worldwide, various studies have been published regarding maternal and neonatal results arising from assistance with home birth. Among these, one stands out – a systematic review from the Cochrane Library.[1] Practically all confirm that there is a lower rate of obstetric interventions in home births.[2-7]

The choice of this place to give birth is recommended by the World Health Organization (WHO), so long as the assistance is undertaken by a qualified professional with a transfer plan for cases in which this is indicated.[8] Physicians, nurse midwives and midwives are considered to be qualified professionals.[9]

Brazilian studies have indicated that the practice of giving birth at home, planned and assisted by a qualified professional and with a transfer plan has been the preferred choice for some Brazilian women.[10-11] Internationally, studies have demonstrated an increase in the number of women seeking to give birth at home;[12-13] a fact which may result from women's greater satisfaction with the experience of giving birth at home.[14-16]

In the Brazilian context, quantitative studies on this issue have been few in number and with small samples; they have, however, shown good maternal results. In the literature, there is a rate of maternal transfer in labor between 11.0% and 20.0%.[10-11]

There is a good scientific basis that good obstetric practices help to promote better obstetric and neonatal results, and that – on the other hand – unnecessary interventions can be harmful for the binomial's health.[17] In Brazil, the general rate of cesareans in hospital births (2011 – 2012) was of 55.4%,[18] considered one of the highest rates in the world; regarding home births, cesareans were between 5.7% and 9.0%.[10-11] Other obstetric interventions also seem to have an important reduction in care provided in the home, such as episiotomies, in which the rate was from 0.0% to 1.0% in home births.[10-11] In contrast, among women of normal obstetric risk cared for in hospital, the rate was 56.1%.[17] Home births seem to be more associated with the use of good practices, such as the presence and promotion of freedom to choose companions, positions in which to give birth, and encouragement for early skin-to-skin contact and breast-feeding.[10-11,19]

Considering that, in Brazil, this mode of care continues to be poorly accepted by health professionals, in spite of the good international indicators (low rates of transfer to hospital, of complications and of interventions), it becomes necessary to invest in the production of Brazilian data such that it may be possible to critically evaluate the results of this practice, the complications and the indications for transfer of women to a health institution during this type of attendance. As a result, this investigation aims to describe the results of care in home births planned by the Hanami Team between 2002 and 2012.

METHOD

This is a descriptive study of the attendances to planned home births, in Santa Catarina, undertaken in the period 2002 – 2012 by the Hanami Team. This team is made up of five obstetric and neonatal nurses who provide care privately during pregnancy, the prepartum period, birth and the postpartum period. The first contact of the pregnant women/couples and their family members with the team takes place in the monthly meeting termed "Getting to know the Hanami Team", which aims to present the way of working and the attendance protocol,

and to clarify doubts. In accordance with the protocol, only women who are undertaking the prenatal checkup and who have not presented comorbidities up to the point when labor begins are included.[20] In the 30th week of pregnancy, the Team makes the first contact in order to present the work contract and initiate the bonds of trust. The second meeting takes place in the 33rd week, and the weekly prepartum home care begin in the 36th week. During these consultations, the obstetric evaluation and the "sensitive prenatal check-up" are undertaken, with a view to assessing the environment/context in which the woman/family is inserted, including the socioeconomic, cultural and psychological aspects. It is at this point that the health institution and professional who will attend the pregnant woman in the event of transfer being indicated are defined, it being the case that the family will go to the previously-chosen health institution in its own car or in the car of one of the nurses when the women are in labor but without risk to their lives. In cases of emergency and/or complications, the Ambulance Service (SAMU) is actioned to carry out the transport, with the appropriate safety. It is stipulated that one of the nurses of the Team will accompany the intra-hospital attendance.[20]

The pregnant woman, upon identifying the first signs of childbirth, will make telephone contact with one of the Team's nurses, who drives to the home. In cases of labor, a further two nurses go to the locale, taking the material for attending the birth and for basic life support (oxygen, an aspirator, fluid therapy, medications, catheters, etc.) in order to deal with complications which might affect the woman and/or the newborn (NB).[20]

During the attendance to the labor and birth, besides the continuous obstetric evaluation, various nonpharmacological techniques for pain relief are also undertaken. Among those used most, one finds: taking a shower or bath, massage of the lumbosacral region, use of the birth ball and moxabustion.[21]

After the birth, the NB's skin-to-skin contact with the mother is begun and breast-feeding is encouraged. After, respecting the neonate's first hour of life, 1mg of vitamin K is administered intramuscularly, and the NB's complete physical examination, and the red reflex test are carried out. The puerpera is accompanied during the clinical periods which follow: placental expulsion and the Greenberg period. The team remains in the locale until the mother and NB are stable. The team provides assistance to the binomial until the 10th day postpartum, consultations being undertaken on the 1st, 3rd, 4th, 7th and 10th days postpartum, and on the 15th day of life, if the NB has not reached birth weight. In the first postpartum visit, (24 hours of life of the NB), the nurse undertakes the pulse oximetry screening, and the family receives guidance for undertaking the Neonatal Triage Test and that of Evoked Otoacoustic Emissions. Besides this, guidance is provided regarding exclusive breast-feeding up to the 6th month, and regarding vaccinations recommended by the Ministry of Health.[20]

This study includes all the women assisted by the Team during the period studied, that is, those who gave birth at home and those who initiated labor at home, but who were transferred to hospital. As a result, the sample includes all the vaginal births which took place at home and the hospital births, as well as the cesareans resulting from maternal transfer; there being, therefore, no exclusion criteria.

The data from the women assisted at home were collected from the respective medical records, filled out and filed by the nurses of the Team. The data of the women who were transferred were obtained from the records found in the Personal Child Health Record and from the information found in the consultations in the postpartum period.

The variables analyzed were sociodemographic and obstetric data from the pregnancy (Age: years complete on the day of birth; Educational level: junior high school incomplete/complete, senior high school incomplete/complete, higher education complete/complete, postgraduate incomplete/complete; Occupation: student, housewife or other; Medical care in the prenatal period: one, two, three, four, five, six or more than six; Nursing care in the prepartum period: One, two, three, four, five, six, or more than six; Previous births: none, one, two, three, four, five or more; Locale of the previous births: at home, at the normal birth center, hospital or other; and Need for transfer in the prenatal period: yes or no); obstetric data on the labor (fetal heart beats: normal, bradycardia and tachycardia; Rupturing of membranes: spontaneous, artificial; Color of amniotic fluid: clear or meconial; and Indication for transfer of the parturient woman: an arrest of the progression of the fetal descent, an arrest of cervical dilatation, nonreassuring fetal cardiac frequency, need for analgesia, cephalopelvic disproportion, fetus in the occipito-sacral position or other); obstetric data from the birth (childbirth position: squatting, genupectoral and semi-sitting in the water, squatting on the birthing stool; squatting, semi-sitting and

genupectoral out of the water; kneeling, standing, lying on the side (also known as the Sims position), in any position; Episiotomy: yes or no; Perineal conditions: no perineal trauma, laceration of the first, second, third, or fourth degree; and Perineoplasty: yes or no); obstetric data from the immediate postpartum period (Obstetric complications in the stage of the expulsion of the placenta: hemorrhage, expulsion of placenta delayed/prolonged or other); and of birth in the institution (Birth route: normal birth, or with forceps or ventouse, birth with analgesia, birth with analgesia and forceps or ventouse and cesarean section).

The data were collected through a standardized questionnaire and were later reviewed, codified and typed using the Epi Info program, version 2008. Descriptive analysis was undertaken (relative and descriptive frequency), with a confidence interval of 95%, using the SAS software version 9.1.3.

The research protocol was approved by the Research Ethics Committee of the Federal University of Santa Catarina on 14/12/2009, under certificate N. 552, with the expansion of the sample approved on 22/10/2012. All of the aspects which involve the study are in accordance with Resolution N. 196/96 of the Brazilian National Health Council, and Resolution N. 466 of 12th December 2012.[22]

RESULTS

During the 11 years of attendance, there was a total of 212 cases accompanied, of whom 187 gave birth at home (Figure 1). The majority of the women were aged between 24 and 28 years old, had completed higher education, and undertook paid activity (Table 1).

Table 1 - Sociodemographic and obstetric characteristics of the women assisted by the Hanami Team, Santa Catarina, 2002 – 2012. (n=212)

Variables	n	%	CI 95 %
Age (mean) (n=205)	29.2 years (SD: 4.8)		
19 – 23	21	10.2	6.1 – 14.4
24 – 28	79	38.5	31.9 – 45.2
29 – 33	71	34.6	28.1 – 41.1
34 – 34	24	11.7	7.3 – 16.1
39 – 44	10	4.9	1.9 – 7.9
Educational level (n=200)			
High school incomplete/complete	19	9.5	5.5 – 13.6
Higher education incomplete	56	28.1	21.9 – 34.2
Higher education complete	93	46.7	39.8 – 53.6
Postgraduate – incomplete/complete	26	13.1	8.4 – 17.7
Other	5	2.5	0.3 – 4.7
Data not given	1		
Occupation (n=209)			
Student	35	17.3	12.2 – 22.5
Housewife	17	8.4	4.7 – 12.2
Paid activity	150	74.3	68.3 - 80.2
Data not provided	7		
Medical care in the prenatal period (177)			
≤ 5	27	16.5	11.0 – 21.9
≥ 6	137	83.5	78.1- 89.0
Data not provided	13		
Nursing care in the prepartum period (184)			
≤ 3	97	52.7	45.5 – 59.9
≥ 4	85	46.2	39.0 – 53.4
None*	2	1.1	0.0 – 2.6

*Referred by the prenatal physician, after confirmation of normal risk pregnancy.

In the first year of attendance, 2002, only one woman was assisted at home; the highest number of home births was concentrated in 2009 – 2011 (Figure 1).

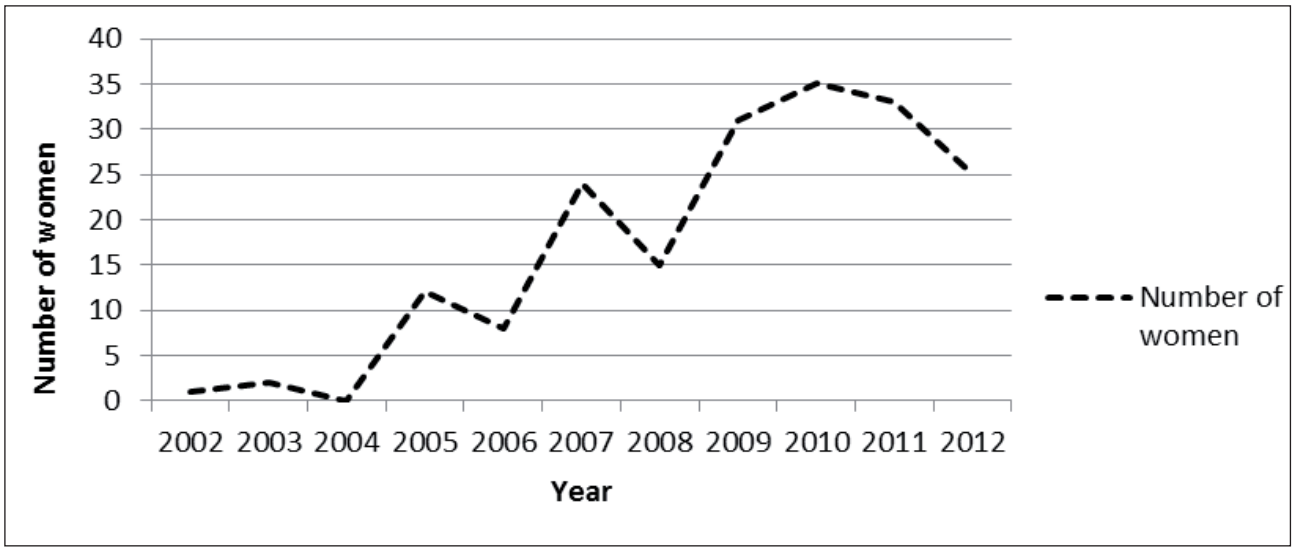

Figure 1 - Planned home births assisted by the Hanami Team. Santa Catarina, 2002 – 2012. (n=187)

The obstetric results are presented in Table 2. One can observe that the majority of those attended were primiparous, although the increase in the attendance of multiparous women is evidenced in Figure 2; likewise, the high number of women who opted for a water birth is visible (Figure 3).

It is emphasized that episiotomy was undertaken in only one parturient woman, and that the rate of intact perineum was 27.3%. In relation to the perineal lacerations, none were of the third or fourth degree, all being exclusively of the first or second degree, it being the case that of the women who presented perineal laceration, almost half did not need perineal suturing. The fetal heart beat remained normal in most of the cases monitored.

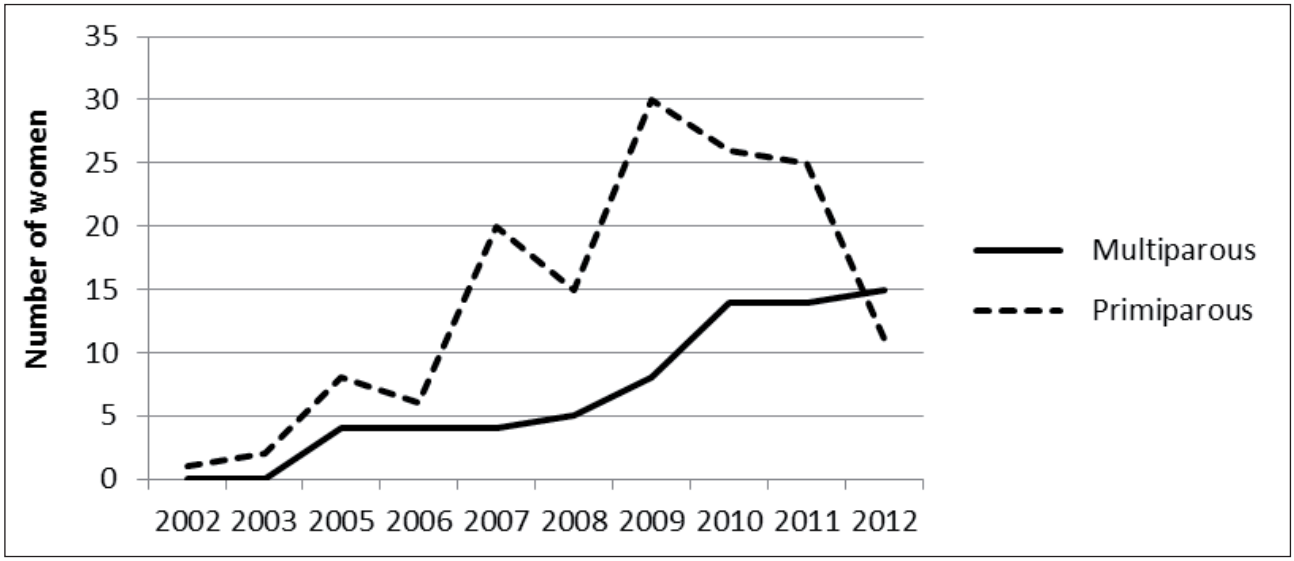

Figure 2 – Parity of the women assisted by the Hanami Team. Santa Catarina, 2002-2012. (n=212)

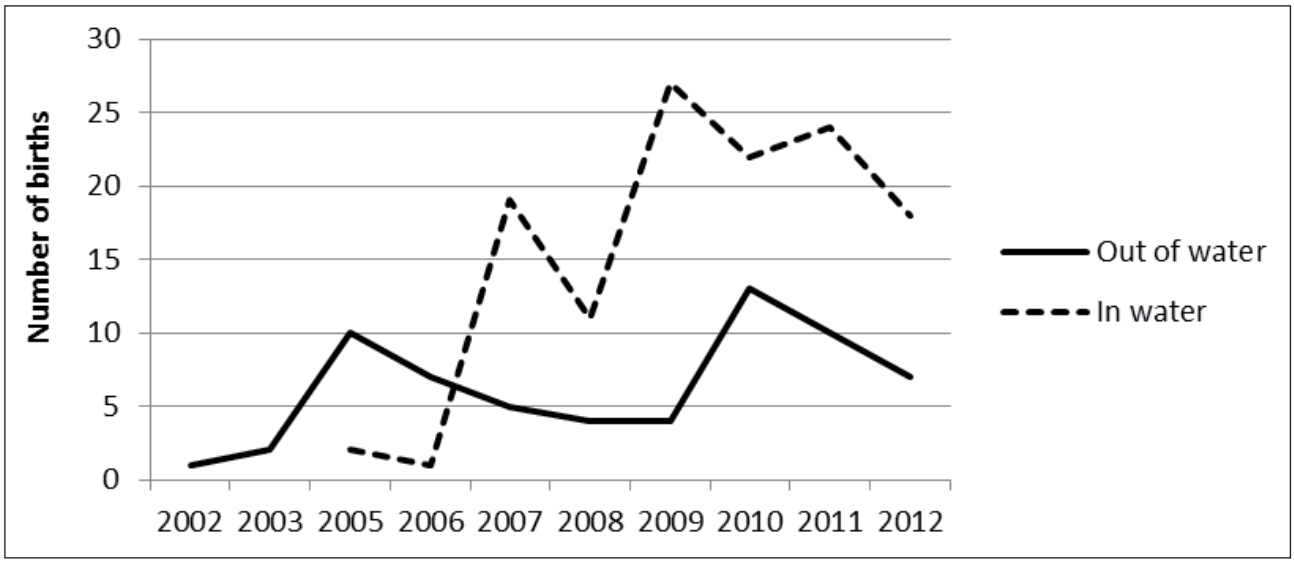

Figure 3 - Distribution of the home births assisted in and out of water by the Hanami Team. Santa Catarina, 2002–2012. (n=187)

The rate of maternal transfer during the pregnancy was 4.7%, and in labor was 7.4%, there being no transfer after the birth. Among the causes of maternal transfer during labor, emphasis is placed on: arrest of cervical dilatation and arrest of fetal descent.

Of the women's complications in the postpartum period, the most frequent was delayed or prolonged expulsion of the placenta; however, no puerperal woman needed to be transferred because of this complication.

Table 2 - Distribution of the variables for attendance in the home, from the prenatal care to the postpartum period, by the Hanami Team, in Santa Catarina, 2002 – 2012. (n=212)

Variable	n	%	CI 95%
Parity			
Primiparous	144	67.9	61.6 – 74.2
Multiparous	68	32.1	25.8 – 38.4
Previous home birth	22	10.4	6.3 – 14.5
Transfers in the prenatal period	10	4.7	1.9 – 7.5
Normal fetal heartbeat (n=202)	190	94.0	90.7 – 97.3
Amniotomy (n=202)	20	9.9	5.9 – 13.9
Clear amniotic fluid (n=202)	192	95.0	92.0 – 98
Transfers during labor (n=202)	15	7.4	3.8 – 11.0
Birth at home (n=187)			
Out of water	64	34.2	27.4 – 41.0
In water	123	65.8	59.0 – 72.6
Perineal conditions (n= 187)			
Intact perineum	51	27.3	20.9 – 33.7
Episiotomy	1	0.5	0.0 – 1.5
Perineal laceration (n=135)	135	72.2	65.8 – 78.6
Laceration – first degree	119	72.1	65.6 – 78.6
Laceration – second degree	13	7.9	4.0 – 11.8
Laceration – third or fourth degree	0	0	
Perineal suturing (of those who had laceration)	98	59.4	52.3 – 66.5
Data not provided	3		
Postpartum complications (n=187)			
Prolonged expulsion of placenta	63	33.7	26.9-40.5

Variable	n	%	CI 95%
Hemorrhage	12	6.4	2.9-9.9
Others	6	3.2	0.7-5.7
Means of childbirth in the hospital (n=25)			
Cesarean	21	84.0	69.6-98.4
Vaginal birth	4	16.0	1.6-30.4

DISCUSSION

The results indicate that the number of women who choose to give birth at home through the Hanami Team is increasing, and that complications, the need for transfer and cesarean are low. The majority of the findings are similar to those already published in studies undertaken in Brazil and other, developed, countries.[4,6,10,12-13, 23-26]

One of the limitations for discussing the present study's findings is the meager publication of quantitative Brazilian data regarding assistance at home so as to compare the results obtained.[10-11,19]

In relation to the sociodemographic characteristics, the age range of the majority of the women was below that found in the international studies (between 30 and 34 years old)[26-30] and in another Brazilian study (30–35 years old).[10] The high educational level is in consonance with another Brazilian study, in which 62.8% of the women assisted at home had a higher education,[10] and with one international study.[23] Women with a high educational level tend to have more access to information and knowledge, which allows them to question the currently-dominant model of health and opt for a different locale to give birth to their children, as they believe the home to be an intimate, familiar and safe place, as well as seeking professionals who are trained and qualified for this care.[31]

Due to this mode of care being private, it was to be expected that the majority of the women would undertake paid activity, as this involves the payment of the costs. International studies have also demonstrated that it is women with higher socioeconomic status who opt for this place to give birth.[3-4,24,29,32] In Brazil, only a small number of home births are attended through the Unified Health System (SUS), being undertaken by the team from the Sofia Feldman Hospital.[33] Other countries support this type of attendance as an integral part of their Health Systems, as is the case with Holland,[4] Australia,[26] Canada,[5] New Zealand[30] and the United Kingdom.[29]

In the present study, the majority of women who chose this place to give birth were primigravidas, which seems to be a Brazilian tendency,[10-11] diverging from studies undertaken in other countries, in which it was multiparous women who most opted for home birth.[3-4,6,12,23-24,26-30,32,34] However, one can observe an increase in the number of multiparous women who opted for home birth (Figure 2), which may result from the satisfaction with the previous experience of birth at home, and from the dissatisfaction of women who gave birth for the first time in hospital.

The increase in the number of home births in this study is in consonance with the worldwide tendency[12-13] and with the data presented in the Live Births Information System (*Sistema de Informação sobre Nascidos Vivos* - SINASC), referent to the growth in the number of home births recorded in some Brazilian cities, such as Florianópolis, São Paulo, Rio de Janeiro and Campinas.[37] This rise may result from the WHO recommendations, which were widely publicized in Brazil, which describe that women's decisions should be respected regarding choice of the place to give birth.[8] It may also be related to other factors, such as the greater search for autonomy, privacy, individualized attendance, possibility for a higher number of companions, the possibility for early and continuous skin-to-skin contact with the NB, and not to be subjected to unnecessary interventions, given that these are some of the main reasons which motivate women to choose to give birth at home in a planned way.[38-41]

The findings regarding the obstetric behaviors showed that in the home birth, the interventions are reduced and the beneficent practices are implemented, emphasis being placed on water births which, in the hospital ambit, are not frequent. This result differs from the Brazilian obstetric context, as the data from the "Being born in Brazil" study (a hospital-based investigation undertaken in all the regions of Brazil, with a sample of 23,894 puerperal women), revealed that only 5.6% of the women with normal risk and who gave birth vaginally were not subjected to obstetric interventions during labor and birth, that the lithotomy position was widely used in institutions, passing 90.0%, and that the Kristeller maneuver was undertaken in 36.1% of the women.[17]

The data demonstrate few changes in fetal well-being, a result evidenced by the stability of the normality of the cardiac frequency during labor over the years. It is important to emphasize that no

woman in the study was transferred as a result of change in the fetal heartbeat, which differs from some publications[10,45-46] in which the nonreassuring fetal status was the reason for the transfer.

The respect for the physiology from labor through to birth, and the restricted use of obstetric interventions, may have contributed to the fetal well-being and, consequently, to the high rate of clear amniotic fluid. The presence of meconium in the amniotic fluid is discussed little in the studies; however, in one study which compared this variable in different contexts, a rate of meconium in home births of 1.5% was found, while in hospital, it was 6.4%.[29]

It should be emphasized that preserving the integrity of the membranes may also have favored the fetal well-being and the continuance of the clear color of the amniotic fluid. The rate of amniotomy was similar to that found in international studies, which varied between 5.0% and 22.4%;[3,5-6,12,34] however, it was below that found in Brazilian normal birth centers[47] and in the "Being born in Brazil" study, in which 40.7% of the women with normal risk are subjected to this intervention during labor.[17]

It is important to stress that no woman had a laceration of the third or fourth degree, as there were no lacerations which compromised the urethral and/or anal sphincter, a data which differs from those of the international studies, in which these lacerations varied from 0.4% to 7.1% among women assisted in the home.[5-6,26-28,48] Emphasis is also placed on the fact that almost half of the women who had a laceration did not need perineal suturing and that the rate of intact perineum was similar to that found in another Brazilian study (34.8%)[10] and above that found in an international study (14.3% in nulliparous women).[48]

The undertaking of the episiotomy in just one parturient woman shows that assistance in the home is based in scientific evidence, this being similar to another Brazilian study.[10] This rate is lower than that found in other countries, where it varies from 2.1% to 15.0%[3,5-6,12,26,29,45,48] and is totally discrepant from the hospital environment in Brazil, in which approximately 60.0% of 'normal risk' women are subjected to episiotomy.[17]

This study indicates a low rate of maternal transfer to hospital, both during pregnancy and during labor, even though the sample is made up of a high number of primiparous women, resembling the case in other countries. This outcome may result from the rigorous protocol for inclusion of pregnant women for attendance by the team. In one systematic review, published in 2014, the rates of transfer varied from 9.9% to 31.9%, it being the case that among primiparous women this number reached 45.4%, and in the multiparous women, 12.0%, occurring with greater frequency in labor (8.2% to 24.1%), due to slow progression (5.2% to 9.8%).[25]

Regarding complications after birth, delayed expulsion of the placenta was the most common, but no woman needed to be transferred for this reason. Generally speaking, the studies do not present this data. Some indicate the rate of manual removal of the placenta as being between 1.0% and 1.6%,[6,12,24] making it necessary to investigate this issue in the home context.

Hemorrhage was the second-most common complication, and although it occurred in less than 7.0%, it is important to foresee this risk and have medications available so as to contain it, given that, in Brazil, in 2007, in accordance with the International Classification of Diseases, it was the third most common cause of maternal death (8.0%), losing only to the hypertensive diseases (23.0%) and to sepsis (10.0%).[49] One study undertaken in the United Kingdom indicated that the risk of hemorrhage in the postpartum period of women attended in the home is two-and-a-half times less than that of women assisted in hospital.[50] Other studies present rates which vary from 0.2% to 9.3%.[5,-6,12,29] Hemorrhage in the postpartum period is one of the urgent reasons for transfer,[45] however, in the present investigation, no puerperal woman was transferred due to this complication, differing from some studies which found a rate varying from 1.0% to 1.5% of transfers.[3,28] The systematic review published in 2014, on the other hand, found even lower rates of transfer (0% to 0.2%).[25]

Attention is called to the low percentage of cesareans (9.9%) in the total of the sample studied (212) when compared with the Brazilian rate cited above, and with the WHO recommendations that this rate should be below 15%.[51] This finding was similar to that of a study undertaken in Canada, in which 12.0% of the primiparous women, and 1.6% of the multiparous women underwent cesarean section.[5] The other studies, which do not present the data referent to parity, indicated a rate of cesareans between 2.8% and 9.2%.[3,6,12,26-29] The rates of cesareans found for pregnant women without obstetric complications in hospital births in Brazil (2011 – 2012) were 20.7% in the SUS and 85.7% in the private sector,[18] a mode of care which included the majority of the women in this study.

This study was limited to women attended by a team of autonomous nurses, and the sample refers exclusively to the women who wished to have

home births. This is, therefore, the group of women who tend to have a privileged socioeconomic status, women with normal obstetric risk, and with specific care (one-to-one) in the prenatal period and during childbirth, which may hinder the generalization of the results to other care contexts.

Among this study's limitations, emphasis is placed on the retrospective data collection, as the failure to completely fill out the medical records limited the analysis of some variables.

CONCLUSION

There was an increase in the number of attendances over the years. The sample presented a higher proportion of primiparous women, with a high educational level, who undertook paid activity.

The obstetric interventions during labor and birth were rare (particularly episiotomy and amniotomy), and water birth was frequent. Few cases of changes in fetal heartbeat and/or meconial amniotic fluid were observed. The rates of maternal transfer were low and consistent with the literature, few complications were observed in the postpartum period, and no woman needed to be transferred for these reasons. The percentage of cesareans in the samples was 9.9%, far below that observed for women with similar characteristics in Brazil in general.

The assistance provided seeks to respect the principle of comprehensiveness, but fails to meet the principles of fairness and universality of health practices. It is hoped that the results presented constitute evidence for the safety and effectiveness of home birth, and that this may serve as a basis such that this mode of care may be offered to more families, including through the SUS.

The study contributes to the knowledge of some maternal results regarding assistance with home births, as well as of the characteristics of the women who opt for this attendance. Based on these findings, it is considered that planned home births, attended by professionals who are qualified and who have a transfer plan, is a viable option for women who do not wish to give birth in hospital.

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