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Planned home births in Joinville: epidemiological profile of women and maternal and neonatal outcomes

Partos domiciliares planejados ocorridos em Joinville: perfil epidemiológico das mulheres e desfechos maternos e neonatais

Partos domiciliarios planificados ocurridos en Joinville: perfil epidemiológico de la mujer y resultados maternos y neonatales

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ABSTRACT

Objective: To identify the epidemiological profile of women who opted for planned home birth in a city in the north of Santa Catarina and to present the main maternal and neonatal outcomes.

Method: Quantitative, cross-sectional research, with retrospective and documentary data collection carried out in 66 medical records of women who had planned home births from January 2012 to March 2020, in Joinville. The data were organized in tables and analyzed in a descriptive way.

Results: The women who opted for planned home birth have a mean age of 31 years, are mostly white, married, with higher education, multiparous, planned pregnancy and performed prenatal care properly. Maternal and neonatal outcomes were positive, with low transfer rates, none being neonatal, and no cases of maternal morbidity.

Conclusion: The evidence found proved to be satisfactory for the implementation of a new model of health care for women and children.

Keywords: Home childbirth. Humanizing delivery. Obstetric nursing. Evidence-based nursing. Maternal and child health.

RESUMO

Objetivo: Identificar o perfil epidemiológico de mulheres que optaram pelo parto domiciliar planejado em um município localizado no norte de Santa Catarina e apresentar os principais desfechos maternos e neonatais.

Método: Pesquisa quantitativa, transversal, com coleta de dados retrospectiva e documental, realizada em 66 prontuários de mulheres que tiveram parto domiciliar planejado de janeiro de 2012 a março de 2020, em Joinville. Os dados foram organizados em tabelas e analisados de maneira descritiva.

Resultados: As mulheres que optaram pelo parto domiciliar planejado têm média de 31 anos de idade, são, majoritariamente, brancas, casadas, com ensino superior completo, multigestas, planejaram a gestação e realizaram o pré-natal adequadamente. Os desfechos maternos e neonatais foram positivos, com baixa taxa de transferência, sendo nenhuma neonatal, e nenhum caso de morbidade materna.

Conclusão: As evidências constatadas demonstraram-se satisfatórias para a implementação de um novo modelo de atenção à saúde da mulher e da criança.

Palavras-chave: Parto domiciliar. Parto humanizado. Enfermagem obstétrica. Enfermagem baseada em evidências. Saúde materno-infantil.

RESUMEN

Objetivo: Identificar el perfil epidemiológico de las mujeres que optaron por el parto domiciliario planificado en un municipio del norte de Santa Catarina y presentar los principales desenlaces maternos y neonatales.

Método: Investigación cuantitativa, de corte transversal, con recolección de datos retrospectiva y documental, realizada en 66 historias clínicas de mujeres que tenían parto domiciliario planeado de enero de 2012 a marzo de 2020, en Joinville. Los datos fueron organizados en tablas y analizados de forma descriptiva.

Resultados: Las mujeres que optaron por el parto domiciliario planificado tienen una edad promedio de 31 años, son en su mayoría blancas, casadas, con estudios superiores, multiparidad, embarazo planificado y realizaron el control prenatal adecuadamente. Los resultados maternos y neonatales fueron positivos, con bajas tasas de transferencia, ninguna neonatal y ningún caso de morbilidad materna.

Conclusión: La evidencia encontrada resultó satisfactoria para la implementación de un nuevo modelo de atención a la salud de la mujer y el niño.

Palabras clave: Parto domiciliario. Parto humanizado. Enfermería obstétrica. Enfermería basada en la evidencia. Salud materno-infantil.

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INTRODUCTION

The labor and birth process has long been considered a personal event, surrounded by people the pregnant woman trusts, such as family members and midwives. With the advent of medicine and scientific transformations, this care was modified and, gradually, replaced by a technocratic model of care, in which the woman's body came to be seen as an object and childbirth as a dangerous and pathological event. This model resulted in the institutionalization of childbirth, with the use of intervention practices, often performed without criteria and/or scientific indication, transforming the obstetric context into a scenario of violence[1].

Childbirth began to be offered in hospital institutions with the aim of reducing maternal and neonatal deaths, in addition to providing greater hygiene and practical learning for medical professionals who were starting in obstetric care[2]. However, the abusive and unnecessary use of procedures and technologies, violent obstetric care and the alarming increase in cesarean section rates have contributed to unwanted maternal and neonatal outcomes. In this context, in order to change this scenario, actions to humanize childbirth emerged, supported and encouraged by the Ministry of Health (MH)[1].

One of these initiatives was marked by the creation of Stork Network (*Rede Cegonha*), whose main objective was to reduce maternal and infant mortality, through the implementation of a new model of health care for women and children, focusing on childbirth, delivery, growth and development from zero to 24 months of age; ensuring access, reception, and resolution. Thus, ensuring women the right to reproductive planning and humanized care during pregnancy, childbirth and the postpartum period, and guaranteeing children the right to a safe birth and healthy growth and development[3].

In this context, the insertion of Obstetric Nursing in care emerged after understanding the irrational use of technologies, through social movements and health institutions, in the 1980s, with the objective of transforming childbirth care into a woman-centered model, in its leading role and autonomy, with the use of practices based on scientific and beneficial evidence. It should be noted that obstetrical nurses are considered qualified professionals to provide normal delivery[1,4].

In view of the above, the importance of scientific and technological advances in recent years is recognized, however reflection is needed to rescue the historical model of parturition and birth, considering the home environment as appropriate for physiological delivery. The obstetric nurse emerged, then, in this scenario, assisting in the rise of planned home birth (PHB), which came to be as a concrete option to rescue natural childbirth, in view of the recognition of a competent professional performance[1].

The PHB is a mode of delivery and birth that takes place in the home environment, in a planned and intentional manner, based on care provided by qualified professionals who use several appropriate material resources[2], unlike the delivery that takes place accidentally and unassisted.

In this environment of care, obstetric nurses use techniques that favor the physiological evolution of labor and delivery, apply non-pharmacological measures for pain relief in parturient women and consider the humanization practices recommended by the World Health Organization (WHO). These professionals have been playing a fundamental role in labor and birth care, using the Good Practices in Labor and Birth Care, as well as respect for common practices adopted in the conduct of normal delivery, developed by the WHO, since 1996[1] and to this day widespread in the context of the humanization of labor and birth.

However, despite the national and international movements and the WHO MSe initiatives, there is a predominance of interventions in labor and birth care with the occurrence of violence in hospital maternity, mischaracterization of women, disregard of their autonomy, with consequent high rates of cesarean sections and maternal and perinatal morbidity and mortality[5]. In view of this and seeking respectful and individualized care, many women have opted for the PHB as an alternative and possibility of care that eases their leading role. In this care model, childbirth takes place at the pregnant woman's home and is performed by qualified professionals, who are usually obstetric nurses. However, in a country where 98% of births take place in hospitals, PHB is often mistakenly associated with lack of economic resources and women's difficulty in accessing health services[6].

This mode of delivery and birth is considered recent and, due to myths and challenges that permeate the humanization of care, national production is limited in this area[7]. In developed countries, the prevalence of PHB varies, reaching 11.3% in New Zealand, 2.8% in England and 1% in Australia. In the Netherlands, 62.7% of women planned their deliveries at home[8]. Reason why the international scope has more studies published on the subject, with evidence that support the safety of the PHB.

In Brazil, the PHB is expanding and the best environment for childbirth is where woman feels safe. The refusal to submit to interventionist and violent obstetric care has led to the choice of home as the appropriate place for labor and birth. Women and their partners have made efforts to defend this right to choose and have their wishes and needs respected and, often, due to the lack of guidelines on the subject in our country, couples feel isolated and helpless and are treated as

clandestine[6]. These facts strongly corroborate the need of emphasizing the importance of this type of labor and birth, as well advance and give visibility to the theme, investing in more studies and research to demystify the PHB and qualify direct and indirect assistance to labor and birth[2].

Moreover, it should be noted that the PHB is a reality for few in Brazil, but the existing studies related to the subject point out to positive results when compared to other forms of care, besides unanimous satisfaction[7] of women who experience it. At home, this public usually has high rates of normal delivery, freedom of choice regarding the position, low levels of obstetric interventions and transfers before and after childbirth[8].

Aiming to learn more about this type of home care, the following research question arose: who are the women who opt for PHB and what were the outcomes of their labor and births? The objective of this research was to identify the epidemiological profile of women who opted for PHB in a northern city of Santa Catarina and to present the main maternal and neonatal outcomes.

METHOD

This is a quantitative, cross-sectional study, with retrospective and documentary data collection, conducted in Obstetric Nursing care records, from June to November 2021.

The inclusion criteria were women who opted for the PHB in the city of Joinville, Santa Catarina, from January 2012 to March 2020. This collection period was due to the time of operation of the two teams that made the medical records available for the research. Exclusion criteria were women who did not had labor under the supervision of the teams and women transferred to the hospital setting before delivery.

The collected data were provided by two teams that perform PHB in Joinville, a city located in the southern region of Brazil, in the north of the state of Santa Catarina. One of the teams has been active since 2012 until today in the region. The other team started providing care in 2016 and ended its activities in 2020. Both are composed of obstetric nurses and have their own structured records, which are stored in physical format, under the responsibility of each one.

It should be highlighted that sample calculation was not performed, since all the records of deliveries that occurred in Joinville and from the period in which the two teams were active were included in the study.

The medical records of the still active team consist of prenatal follow-up form, postpartum follow-up form, history of the newborn (NB), history of delivery and modified partogram of the Latin American Center for Perinatology (*Centro Latino Americano de Perinatologia* - CLAP). The medical records of the other team consist of prenatal form, prenatal follow-up history for home birth, history of labor, informed consent form for PHB and modified CLAP partogram.

The prenatal follow-up forms contain the pregnant woman's personal data, family history, her own health history, obstetric data, data on the current pregnancy, laboratory tests and the results of obstetric ultrasound.

The history of labor has data related to arrival at home, such as: date, time, who attended, conditions of the pregnant woman and people present. It also contains information about the pregnant woman's hydration, nutrition, and waste eliminations, as well as notes from the physical examination performed, including characteristics of the nipples, abdomen, upper and lower limbs. There are data on the obstetric examination and vaginal losses such as mucus plug, ruptured bag, characteristics of the amniotic fluid, the cervix, the fetal presentation and the De Lee plan. It also presents the painful and emotional perceptions of the pregnant woman, such as pain and anxiety and the nursing care provided during labor and birth. This part of the medical record also has information related to the delivery, such as date and time, if the parturient was referred to the hospital and the reason, the position of delivery, presence or not of laceration and degree, if there was a suture, if the expulsive period was prolonged and whether there was a nuchal cord.

The partogram presents information regarding the parturient identification, date and time of its opening, woman's age, parity, last menstrual period (LMP), gestational age (GA), uterine dynamics, cervical dilation, non-pharmacological methods for pain relief, vital signs, and fetal heart rate (FHR).

Data related to placental delivery consider time of placental expulsion, mechanism of detachment, its weight, length and insertion of the umbilical cord, cord pulsation time, presence of the Pinard safety globe, uterine tone, location of the uterus in relation to the umbilical scar and characteristics of lochia. There are also notes related to vital signs, blood pressure, heart rate, respiratory rate and maternal temperature.

The newborn files contain information about their name and mother's name, day and time of birth, Apgar scale, first attachment to the breast, suction and breastfeeding soon after birth, duration of breastfeeding, type of attachment, anthropometric measurements, vital signs, results of the first physical examination and the somatic Capurro.

The postpartum follow-up forms have the identification of the puerperal woman, the father and the NB, as well as information regarding the visits carried out on the first, third and tenth day postpartum, namely: date, time, nurses who performed the visit, main complaints of the puerperal woman, general condition and vital signs, evaluation of the breasts, breastfeeding, perineum and lochia, general state

of the NB and her vital signs, signs of jaundice, condition of the umbilical stump and guidance provided by the team.

After data collection from the medical records, the information was entered into the Microsoft Office Excel program, where it was tabulated and analyzed through formal measurement, resulting in the profile of the women who had PHB in Joinville, also allowing the analysis of the maternal and neonatal outcomes.

The Microsoft Office Excel spreadsheet contained the following data for analysis: woman's age, marital status, education level, number of prenatal consultations performed, parity, gestational age on the day of delivery, positions adopted during labor, non-pharmacological methods used for pain relief, degree of laceration (if any) and need for suturing; of the NB - apgar, capurro, weight, if there was a transfer to the hospital and the reason.

During the teams' work, their records underwent periods of reformulation, and for this reason, some information was not found, being signaled in the results as missing information.

All legal provisions of Resolution number 466, of December 12, 2012, which approves guidelines and regulatory standards for research involving human beings, were complied. The research project was approved by a Research Ethics Committee (REC), under CAAE number 44388721,7,0000,5363 and opinion number 4,815,183. The waiver of the Free and Informed Consent Form (FICF) was requested since the data collection was done in medical records.

RESULTS

Data were collected from 79 medical records of women who started labor at home, under the assistance of the teams. From these follow-ups, in 83.5% of the cases the birth took place at home and in 16.5% of them there was a need to be transferred to the hospital, as shown in Figure 1.

From these transfers, 26.7% (n=4) were due to woman's desire to receive labor analgesia, 26.7% (n=4) due to progression failure, 13.3% (n=2) due to cephalo-pelvic disproportion, 6.7% (n=1) due to thick meconium and 26.7% (n=4) of the medical records did not have this information.

The results of the analyses of the 66 medical records included in the sample showed that the mean age of the women was approximately 31 years old, with a minimum age of 21 years old and a maximum age of 40 years old. Other information collected from these 66 medical records is presented in Table 1 and presents data about the women, their obstetric histories, their parturition processes, and the births of their children.

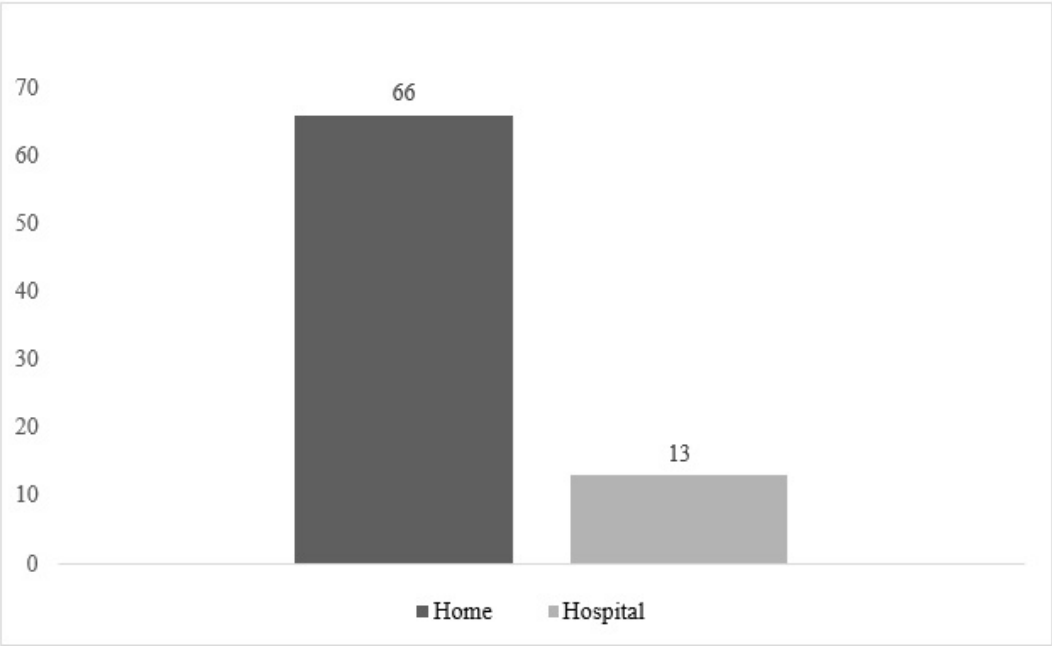

Figure 1 – Place of birth. Joinville, Santa Catarina, Brazil, 2021
Source: Prepared by the authors.

Table 1 – Characterization. Joinville, Santa Catarina, Brazil, 2021

	Medical Records (n=66) m (min-max)
Gestational age at ultrasound (weeks)	39 (37-42)
Newborns weight (grams)	3472 (2600-4550)
Newborn Gestational Age – Capurro Method (weeks)	39 (36-42)
	Medical Records n (%)
Ethnicity	
White	61 (92.4)
Brown	2 (3.0)
No information	3 (4.5)
Marital status	
Married	46 (69.7)
Single	8 (12.1)
Stable union	8 (12.1)
Divorced/Separated	4 (6.1)
Education level	
Postgraduate	2 (3.0)
Complete higher education	43 (65.2)
Incomplete higher education	9 (13.6)
Complete high school	12 (18.2)
Pregnancy	
Planned	43 (65.2)
Unplanned	9 (13.6)
Unplanned, but accepts	2 (3.0)
No information	12 (18.2)

Table 1 – Cont.

	Medical Records (n=66) m (min-max)
Parity	
Primiparous	30 (45.5)
Second birth	22 (33.3)
Third birth	7 (10.6)
Fourth birth	4 (6.1)
Fifth birth	2 (3.0)
Sixth birth	1 (1.5)
Prenatal	
Six or more consultations	64 (97.0)
Less than six appointments	1 (1.5)
No information	1 (1.5)
Birth positions	
Vertical positions (standing, kneeling, squatting)	50 (75.8)
Horizontal position	2 (3.0)
No information	14 (21.2)
Place of birth	
In the water	46 (69.7)
Out of the Water	14 (21.2)
No information	6 (9.1)
Degree of perineal laceration	
Intact perineum	13 (19.7)
Some degree of laceration	45 (68.2)
1st degree injury	24 (36.4)
2nd degree injury	21 (31.8)

Table 1 – Cont.

	Medical Records (n=66) m (min-max)
Need for suture	
Yes	31 (47.0)
No	27 (40.9)
No information	8 (12.1)
Amniotic fluid	
Clear fluid with lumps	26 (39.4)
Clear fluid	22 (33.3)
Meconium fluid	5 (7.6)
Thick meconium fluid not associated with changes in fetal heartbeat	3 (4.5)
No information	10 (15.2)
Newborn	
Female	37 (56.1)
Male	29 (43.9)
Neonatal vitality	
Apgar score ≥7 at 1st minute	62 (93.9)
Apgar score ≤7 at 1st minute	4 (6.1)
Apgar score ≥7 at 5th minute	66 (100.0)

Source: The authors.
Legend: m: mean; min: minimum; max: maximum; n: absolute frequency; %: relative frequency; ≤: less than and/or equal; ≥: greater or/and equal.

DISCUSSION

This study showed a low rate of maternal transfer for continuity of care in the hospital setting. This fact may occur due to following a strict protocol to include pregnant women in the care provided by the teams[9], such as, planning PHB care previously, inclusion of only pregnant women considered low-risk, birth that goes on physiologically, proper assessment during labor, birth and postpartum, and availability and use of appropriate materials for care[4]. It is noteworthy that none of the transfers occurred for reasons related to the non-reassuring fetal situation, while the collected data showed the permanence of normal fetal heart rate.

A research conducted in the state of Rio de Janeiro revealed that the highest percentage of women who gave birth at home were between 20 and 34 years old[10]. Another research conducted in the region of Campinas, state of São Paulo, found that the mean age of the women included in

the study was 30 years old, ranging from 18 to 40 years old[11]. Similar results to those found in the present study stated that the mean age of the women was approximately 31 years old, ranging from 21 to 40 years old.

Regarding ethnicity, the same investigation concluded that almost 50% of the women who had PHB were brown[10], a different finding from the findings of this research, where almost all (92%) of the women were white. However, it is believed that this difference was due to the existing regional differences between the two Brazilian cities and states studied.

The marital status variable also showed differences in relation to the evidence of the present study, when compared to the study conducted in the state of Rio de Janeiro. In the first case, 70% of the women included were married and, in the second, 77% of the women were single at the time of the PHB[10].

Culturally, there are those who link the PHB to lack of access to health services, lack of financial resources or misinformation. However, the data found in this research showed the opposite, corroborating the literature that indicates that women who opted for this mode of labor and birth have high education level[7,8,10,11], access to information and adequate adherence to the prenatal care[8].

The PHB has been the option of many women and their families in large urban centers, where there is a sufficient supply of obstetric beds. Often, women who decide for the PHB are from middle social strata and have already experienced hospital births previously. Such facts lead to reflect on the choice for this place of birth. Furthermore, a qualitative study conducted with couples concluded that the reasons that led them to opt for the PHB mainly considered dissatisfaction with the care provided in hospitals, since, in these scenarios, care is usually provided routinely and with often violent and outdated techniques. This same study brought as an incentive for decision-making by the PHB the possibility of women having their autonomy respected[6].

In this context, the MH points out in its guidelines that, in the Brazilian context, one should not discourage the planning of home births, with safety criteria that must be respected, such as timely and opportune access to hospital care, in case of need for transfer and care provided by a qualified professional. However, this body does not support the PHB as a recommendation, claiming that this service is unavailable in the Unified Health System (*Sistema Único de Saúde* - SUS) [4,12]. It is highlighted that in Brazil, the PHB has been offered by teams that work privately and autonomously[2].

Moreover, and considering regulations in Santa Catarina, the state where the present study was developed, a technical opinion issued by the Regional Council of Nursing points out several inclusion and exclusion criteria for PHB care. In the meantime, the inclusion criteria for the PHB are: pregnant women classified at low-risk or habitual obstetric risk at prenatal care; single pregnancy; cephalic fetal presentation; gestational age greater than or equal to 37 weeks and less than 42 weeks and couple according to the Free and Informed Consent Form[13].

Unlike to what the results of studies conducted in Brazil show, in which the highest percentage of pregnant women who opted for the PHB were primiparous[9], in this study, due to a small difference, the highest percentage of women who opted for the PHB was multiparous women, a trend found in international studies and which may be linked to satisfaction with the previous childbirth experience at home, as well as unsatisfactory childbirth experience previously experienced in the hospital setting[9].

The almost absolute number of women who had six or more prenatal consultations was in line with what is recommended by the MH[14] and with what was found in a study conducted in Rio de Janeiro[10].

There is evidence that shows a decrease in the gestational age pattern for "early term", which encompasses from 37 weeks of pregnancy to 38 weeks and 6 days of pregnancy. This fact has been observed, mainly, in the private network, due to the high rate of elective cesarean sections. In SUS, "term" pregnancy (39 to 40 weeks and 6 days) prevails[15]. The present study showed that, at home, gestational age was equivalent to existing data, considering also that planned home births are spontaneous and result from a pregnancy that is classified as low risk.

In this research there were no cases of maternal morbidity, postpartum hemorrhage or severe lacerations (3rd and 4th degree). Scientific studies have proven that the freedom to choose the maternal position during labor and the expulsive period should be encouraged, since it can reduce the painful feeling, in addition to not causing harm to both the woman and the newborn[16,17].

A study that analyzed 160 medical records of women who had PHB in Campinas, São Paulo, showed that most were using the bathtub or swimming pool at the time of delivery and that they gave birth in vertical positions[11], similar findings to those found in the present research.

The perineal outcomes found in this research corroborate the evidence of a study that also demonstrated a higher incidence of 1st and 2nd degree lacerations, considered of low severity[7]. Considering that most of the positions adopted by the women included were vertical, the findings respect what the WHO and the MH indicate regarding the freedom to choose the position for childbirth[18]. They also show that Obstetric Nursing care is based on current scientific recommendations, considering the importance and

maternal need to take control of their bodies and, consequently, their deliveries[7].

Considering that the apgar score reflects the birth condition of the NB and that a score above seven indicates great conditions[19], this study demonstrated positive neonatal outcomes in the PHB, since, in the fifth minute of life, all newborns had a score equal to or greater than seven.

Considering the weight of newborns, research conducted in Campinas, São Paulo, found that most of them (about 80% of cases) weighed between 2500 grams and 3400 grams[10]. The mean weight of the NB in this study was 3472 grams, a value close to the findings of the mentioned research.

The positive outcomes of women and NB sustained in this research showed the quality of care provided, as well as the safety of the PHB provided by qualified teams. Other studies have shown that assisted childbirth at home, by qualified teams, does not increase the risk of mortality and hospitalization in a neonatal unit[7], that care is considered of low intervention and that the rates of complications and maternal transfers are low[9]. Aiming at qualifying this model of care, it is extremely important to guarantee an established referral system, with professionals who recognize the PHB as a safe option and a women's right, with availability to continue the care started in the home context with dignity to those who need it.

CONCLUSION

This study demonstrated that the women who opted for the PHB in Joinville, Santa Catarina, are, on average, 31 years old and are mostly white, married, with high education level, multiparous, planned the pregnancy and underwent prenatal care. More than that, the research findings showed positive maternal and neonatal outcomes, with a low transfer rate, none being neonatal, and no case of maternal morbidity.

The results highlighted that the PHB, in the investigated context, presented low intervention during care, corroborating with the reduction of maternal and infant mortality. Thus, the evidence found in this study proved to be satisfactory for the implementation of a new model of health care for women and children, sustaining that the home is set as a safe place for labor and birth.

This modality of labor and birth has been gaining visibility and more followers in Brazil and has demonstrated beneficial quantitative and qualitative assessments, contributing to the demystification of the choice for the PHB.

Despite this, it is recommended that further investigations be conducted on this topic in order to support the choice of women and their families/partners with scientific information, as a way of ease their access to PHB, naturally and respectfully, with respect to the place where they feel most protected and welcomed.

This research has the potential to assist future Nursing professionals to work in the context of the PHB, in addition to supporting actions regarding the important role that obstetrical nurses have on maternal and child health as agents of change in the Brazilian obstetric reality.

As a limitation of the study, is the fact that data collection included only one region of the state of Santa Catarina. However, it is believed that the results showed here are important to support future research, stimulating actions that contribute to teaching, research, management and/or care in Nursing and health.

REFERENCES

1. Silva TPR, Dumont-Pena E, Sousa AMM, Amorim T, Tavares LC, Nascimento DCP, et al. Obstetric nursing in best practices of labor and delivery care. Rev Bras Enferm. 2019;72(Suppl 3):235-42. doi: http://doi.org/10.1590/0034-7167-2018-0561
2. Denipote AGM, Lacerda MR, Selleti JDN, Tonin L, Souza SRRK. Parto domiciliar planejado no Brasil: onde estamos e para onde vamos? Res Soc Dev. 2020;9(8):e837986628. doi: http://doi.org/10.33448/rsd-v9i8.6628
3. Ministério da Saúde (BR). Gabinete do Ministro. Portaria nº. 1.459, de 24 de junho de 2011. Institui, no âmbito do Sistema Único de Saúde - SUS - a Rede Cegonha. Diário Oficial União. 2011 jun 27 [cited 2022 Apr 05];48(121 Seção 1):109-11. Available from: https://pesquisa.in.gov.br/imprensa/jsp/visualiza/index.jsp?data=27/06/2011&jornal=1&pagina=109&totalArquivos=184
4. Santos LM, Mata JAL, Vaccari A, Sanfelice CFO. Trajectories of obstetric nurses in the care of planned home childbirth: oral history. Rev Gaúcha Enferm. 2021;42(spe):e20200191. doi: https://doi.org/10.1590/1983-1447.2021.20200191
5. Valinho PB, Zveiter M, Mouta RJO, Seibert SL, Marques SC. As dificuldades do parto domiciliar planejado no Brasil: uma revisão sistemática. Res Soc Dev. 2021;10(7):e45910716540. doi: http://doi.org/10.33448/rsd-v10i7.16540
6. Castro CM, Azevedo AFP. Narrativas sobre parto domiciliar planejado após parto hospitalar. Rev Fam Ciclos Vida Saúde Contexto Soc. 2018 [cited 2022 Apr 05];6(1):53-62. Available from: https://www.redalyc.org/articulo.oa?id=497955422008
7. Cursino TP, Benincasa M. Parto domiciliar planejado no Brasil: uma revisão sistemática nacional. Cien Saude Colet. 2020;25(4):1433-43. doi: https://doi.org/10.1590/1413-81232020254.13582018
8. Koettker JG, Bruggemann OM, Freitas PF, Riesco MLG, Costa R. Obstetric practices in planned home births assisted in Brazil. Rev Esc Enferm USP. 2018;52:e03371. doi: http://doi.org/10.1590/S1980-220X2017034003371
9. Koettker JG, Brüggemann OM, Knobel R. Maternal results from planned home births assisted by nurses from the hanami team in the south of Brazil, 2002-2012. Texto Contexto Enferm. 2017;26(1):e3110015. doi: http://doi.org/10.1590/0104-07072017003110015

10. Chaves WB, Mota CP, Silva JLL, Mouta RJO, Silva TC, Dias Filho JC, et al. Sociodemographic profile of women who had homebirth in the municipality of Rio de Janeiro, from 2010 to 2017. Res Soc Dev. 2022;11(3):e22011326382. doi: https://doi.org/10.33448/rsd-v11i3.26382
11. Silveira FA, Mello AL, Castro CC, Baptista A, Barros AFF, Nunez SC, et al. Planned home births in the region of Campinas from 2013 to 2017. Res Soc Dev. 2021;10(12):e234101220358. doi: https://doi.org/10.33448/rsd-v10i12.20358
12. Ministério da Saúde (BR), Secretaria de Ciência. Tecnologia e Insumos Estratégicos. Departamento de Gestão e Incorporação de Tecnologias em Saúde. Diretrizes nacionais de assistência ao parto normal: versão resumida [Internet]. Brasília, DF: Ministério da Saúde; 2017 [cited 2022 Apr 05]. Available from: https://bvsms.saude.gov.br/bvs/publicacoes/diretrizes_nacionais_assistencia_parto_normal.pdf
13. Conselho Regional de Enfermagem de Santa Catarina. Parecer Técnico COREN/SC n° 023/CT/2016 - Assunto: Parto Domiciliar Planejado [Internet]. Florianópolis: COREN/SC; 2016 [cited 2022 Apr 05]. Available from: http://www.corensc.gov.br/wp-content/uploads/2017/01/PT-023-2016-Parto-Domiciliar-Planejado.pdf
14. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Cadernos de atenção básica: atenção ao pré-natal de baixo risco [Internet]. Brasília: Ministério da Saúde; 2012 [cited 2022 Apr 05]. Available from: https://bvsms.saude.gov.br/bvs/publicacoes/cadernos_atencao_basica_32_prenatal.pdf
15. Leal MC, Bittencourt SA, Esteves-Pereira AP, Ayres BVS, Silva LBRAA, Thomaz EBAF, et al. Avanços na assistência ao parto no Brasil: resultados preliminares de dois estudos avaliativos. Cad Saude Publica. 2019;35(7):e00223018. doi: http://doi.org/10.1590/0102-311X00223018
16. Ministério da Saúde (BR). Boas práticas de atenção ao parto e nascimento [Internet]. Brasília, DF: Ministério da Saúde; 2014 [cited 2022 Apr 05]. Available from: http://www.as.saude.ms.gov.br/wp-content/uploads/2016/07/Boas-Pr%C3%A1ticas-ao-Parto-e-Nascimento-1.pdf
17. Aasheim V, Nilsen ABV, Reinar LM, Lukasse M. Perineal techniques during the second stage of labour for reducing perineal trauma. Cochrane Database Syst Rev. 2017;6(6):CD006672. doi: http://doi.org/10.1002/14651858.CD006672.pub3
18. World Health Organization. WHO recommendations: intrapartum care for a positive childbirth experience. Geneva: WHO; 2018 [cited 2022 Apr 05]. Available from: http://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf;jsessionid=CD77DB8EE949CF372E16D439566A084E?sequence=1
19. Secretaria de Estado da Saúde do Paraná. Caderno de atenção à saúde da criança: recém-nascido de risco. Paraná: Secretaria de Estado da Saúde; 2020 [cited 2022 Apr 05]. Available from: https://www.saude.pr.gov.br/sites/default/arquivos_restritos/files/documento/2020-07/pdf1.pdf

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