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Wanting to give birth naturally: women's perspective on planned homebirth with a nurse midwife

Desejando parir naturalmente: perspectiva de mulheres sobre o parto domiciliar planejado com uma enfermeira obstétrica

Deseando parir naturalmente: perspectiva de mujeres sobre el parto domiciliario planificado con una enfermera obstétrica

Octavio Muniz da Costa Vargens[I]; *Siw Alehagen*[II]; *Alexandra Celento Vasconcellos da Silva*[I]
[I]*Universidade do Estado do Rio de Janeiro;* [II]*Linköping University*

ABSTRACT
Objective: to describe the choice of planned homebirth attended by a nurse midwife in a large urban centre, from the perspective of Brazilian women. **Methods:** in this Grounded Theory study, ten women aged 20 to 41 years, who had a planned homebirth accompanied by a nurse midwife, were interviewed. Participants were recruited through a social network by accessing a group of women who wrote about their homebirth. **Results**: two categories emerged: seeing no possibility of giving birth naturally in the hospital environment; and thinking about the safety of a planned homebirth. Hospital represented several unfavourable aspects, such as unnecessary interventions and loneliness. Women thought of home as a safe place to give birth, connected with nurse midwife care. **Conclusion:** there are women who do not wish to give birth in hospital, but prefer to give birth at home and, from the point of view of human rights and de-medicalized care, nurse midwives should support women in their decision.
Descriptors: Women's Health; Nurse Midwives; Natural Childbirth; Home Childbirth.

RESUMO
Objetivo: descrever a escolha do parto domiciliar planejado acompanhado por enfermeira obstétrica em um centro urbano de grande porte, na perspectiva de mulheres brasileiras. **Métodos:** estudo qualitativo guiado pela *Grounded Theory*. Foram entrevistadas dez mulheres com idade entre 20 e 41 anos que tiveram parto domiciliar planejado acompanhadas por enfermeiras obstétricas. As participantes foram recrutadas por meio de rede social, acessando um grupo de mulheres que escreveram sobre seu parto domiciliar. **Resultados:** Emergiram duas categorias: Não vendo possibilidade de parir naturalmente no ambiente hospitalar e Pensando na segurança do parto domiciliar planejado. O hospital representou vários aspectos desfavoráveis como intervenções desnecessárias e solidão. As mulheres consideravam o lar um lugar seguro para parir, conectado aos cuidados de enfermeiras obstétricas**. Conclusão:** há mulheres que não desejam parir no hospital, preferindo parir em casa e do ponto de vista dos direitos humanos e dos cuidados desmedicalizados, as enfermeiras obstétricas devem apoiar as mulheres nessa sua decisão.
Descritores: Saúde da Mulher; Enfermeiras Obstétricas; Parto Normal; Parto Domiciliar.

RESUMEN
Objetivo: describir la elección del parto domiciliario planificado con enfermera obstétrica en un gran centro urbano, desde la perspectiva de mujeres brasileñas. **Métodos:** estudio cualitativo guiado por la *Grounded Theory*. Se entrevistó a diez mujeres entre 20 y 41 años que tuvieron parto domiciliario planificado, siendo acompañadas de enfermeras obstétricas. Las participantes fueron reclutadas a través de red social, accediendo a un grupo de mujeres que escribieron sobre su parto en domicilio. **Resultados:** surgieron dos categorías: las que no veían posibilidad de dar a luz naturalmente en el hospital y las que pensaron en la seguridad del parto domiciliario planificado. El hospital representó varios aspectos desfavorables como intervenciones innecesarias y soledad. Las mujeres consideraban que el hogar era un ambiente seguro para dar a luz, vinculado al cuidado de enfermeras obstétricas. **Conclusión:** hay mujeres que no desean dar a luz en el hospital, prefieren hacerlo en casa y, desde el punto de vista de los derechos humanos y de los cuidados sin la intervención de un médico, las enfermeras obstétricas deben apoyarlas en esa decisión.
Descriptores: Salud de las Mujeres; Enfermeras Obstetrices; Parto Normal; Parto Domiciliário.

INTRODUCTION

In Brazil, homebirths are commonly accepted when women have no access to a hospital, either for living in isolated areas or for lacking economic resources[1]. Over 98% of the births take place in health institutions. Caesarean rates reached a mean of over 85 percent in private institutions in 2019[2]. Approximately 80% of the Brazilian women want to give birth normally. However, during pregnancy, the physicians usually tried to convince them to renounce to their thoughts and only 30% gave birth normally[1]. In addition, a combination of factors such as indiscriminate use of invasive procedures and routine interventions, even without scientific support, constitute a potentially risky

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Corresponding author: Octavio Muniz da Costa Vargens. E-mail: omcvargens@uol.com.br
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practice for both women's and their new-borns' health[3,4]. This stems from the hegemony of a technocratic and medicalized care model in Brazil[3].

Most women in high- and middle-income countries give birth in hospitals as the cultural norm. Nonetheless, there are women who demand the opportunity for a planned homebirth[5,6]. In most industrialised Western countries, less than 1% of the women give birth at their homes; yet, there are differences across the countries. For example, around 2% of the women in the UK in 2019[7], 12.9% in the Netherlands in 2019[8] and 3.4% in New Zealand in 2017[9], gave birth at their homes.

Women's wish to choose where to give birth is handled in different ways in different countries. In Australia, publicly-funded homebirth models designed to make it easier for midwives working in hospitals to provide homebirth care have been in place for the past twenty years[10].

Socioeconomic factors seem to exert an influence, as women who want homebirths have higher socioeconomic status than those who give birth in hospitals[11]. One reason for giving birth at home is the differences between home and hospital care. Some women mention that the reasons why they mistrust hospital care include unnecessary interventions and adverse experiences[5], whereas the home is an alternative environment where a woman can feel safe with a nurse-midwife she has come to know during pregnancy[12]. Wanting to have a homebirth also seems to be connected to being in a familiar place where the woman can relax, as compared to the unknown and sometimes frightening hospital environment[5].

This study addresses the decision for a planned homebirth in a large urban centre in Brazil, where women are usually supposed to give birth in hospitals. The objective was to describe the choice of planned homebirth assisted by a nurse-midwife in a large urban centre, from the perspective of Brazilian women.

METHOD

This qualitative study, based on the Grounded Theory[13] was conducted in Rio de Janeiro, Brazil, from May to November/2017. Ten women, aged from 20 to 41 years old, were interviewed. As an initial inclusion criterion, the women should have had a homebirth monitored by nurse-midwives. As required by the methodology[13], and following new criteria originating from the comparative analysis, four sample groups of participants were gradually being selected and included in the study:

G 1. *Women whose first and only childbirth was at their homes and assisted bynurse-midwives*. The comparative analysis of these interviews pointed to the possibility of different meanings attributed to the situation if the women had previous homebirth experiences assisted by nurse-midwives. They could compare their own experiences in previous and present childbirths, and that guided the choice for the next group.

G 2. *Women who had given birth more than once, always at their homes and assisted by nurse-midwives*. The comparative analysis of these data raised some concerns/hypotheses related to previous experiences of giving birth in a hospital and led to the third and fourth groups.

G 3. *Women whose second or third childbirth was at their homes, assisted by anurse-midwife, and who had given birth at least once previously, in a hospital, also monitored by a nurse-midwife*.

G 4. *Women whose second or third childbirth was at their homes assisted by a nurse-midwife and who had given birth at least once previously in a hospital and assisted by a physician*.

Regarding the third and fourth groups, it is important to highlight that, in Brazil, few women who give birth in hospitals are assisted by midwives and most of them are attended to by physicians. Therefore, the women who were seen by physicians in previous hospital childbirths were included.

The data were collected through semi-structured interviews with open-ended questions such as “How did you come to the decision for a planned homebirth?”. Two pilot interviews were conducted to ascertain the appropriate strategy for approaching the participants. These were not included in data analysis.

The participants were recruited through the Facebook social network. Once a woman was identified, the first contact was made through the same social network, inviting her to participate in the study. In the event of initial acceptance, a meeting was scheduled at the date, time and place of the participant's choice. Before the interview was initiated, the women gave their written consent. The interview session lasted 30-50 minutes. Saturation was reached after 10 interviews were analysed, i.e., when no new categories emerged from the data.

The interviews were recorded using digital MP3 equipment, and transcribed verbatim. Subsequently, they were re-read to ensure accuracy of the information. Numerical codes were used to conceal the participants' identities: names

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were replaced by an alphanumeric code comprising the letter "I" followed by the interview number (I1). The sample group was identified by the letter "G" followed by the number of each group (G1).

Data analysis was based on the Grounded Theory[13]. In the first step of the analysis, the interview was transcribed by the interviewer immediately after its conclusion. The transcription was read by the researcher while listening to the recording in order to adequately transform spoken language into written language. The second step was vertical distribution, which consisted in separating each sentence of the transcription. This was made in order to analyse them one by one. In the third step, open coding was performed to assign meaning to each text unit, i.e., each sentence of the vertical distribution. The next step was to group the related codes, trying to find an expression that could represent the idea or meanings contained in each constituted group, provisional categories. This step is a result of the comparative constant analysis where the open codes were compared one by one in each interview as well as among the group of interviews already conducted. The next step was to continue the comparative analysis proceeding to the organization, densification and reduction of the provisional categories culminating in the definition of the effective categories and, as an unfolding, the integration and correlation between the categories. During the last step, the examination of the categories lead to the emergence of the core category representative of the phenomenon targeted by this study, the high point of the interpretation[13]. In the process of comparative analysis, attempts were made regarding the schematic representation of the process. This was performed through the articulation and integration of the subcategories, in order to express the phenomenon in its conditions and context, the decision and subsequent action, as well as the search for its validation by comparisons with the data.

To ensure the criteria for the Grounded Theory, all authors were involved in data analysis. The researchers conducted a selective literature search guided by the comparative analysis of the data[13], aiming to validate the theoretical model proposed.

In compliance with Brazilian and international agreements on research ethics, the study was approved by the Research Ethics Board (CAAE 66687617.9.0000.5282, report No. 2,087,496, in 05/29/2017).

RESULTS

Data analysis identified two categories: Seeing no possibility of giving birth naturally in the hospital environment and Thinking about safety in a planned homebirth. These categories led to the core category: Wanting to give birth naturally and safe - Deciding on a planned homebirth with a nurse-midwife.

Seeing no possibility of giving birth naturally in the hospital environment

Women consider that childbirth is a normal life event and, therefore, not a condition to be medically treated. They expressed a desire to give birth naturally, with the minimum of or without interventions. They stated that they feared protocols and procedures which, even though presented as interests for safety, would force them to a not normal process of giving birth, i.e., a caesarean section.

> *You don't need a super hospital. It's such a natural thing; you don't really need to leave home. (I2G4)*
>
> *When the obstetrician started talking about the caesarean because it was much easier and more modern, I started to distrust… it didn't make sense to me. (I1G1)*

The hospital environment was seen as unfamiliar and frightening. Many women had negative experiences of hospitals and the normal event of childbirth does not fit into the hospital's impersonal environment. Being in an unfamiliar environment would not facilitate handling their fear of pain and the unique and unknown process of giving birth.

> *I never liked the hospital environment because of the smell of ether, it always gives me dread. (I1G1)*
>
> *I think there is always that fear of the unknown. I didn't know what it was like, so I was afraid. (I3G1)*

The women stated that what they have heard that giving birth in a hospital was about being abandoned. Their main concern in that situation was not childbirth itself nor pain, but the fear of being alone away from the family. Some women mentioned the fear of leaving the children home while they were going to the hospital.

An important dimension of childbirth is that it raises awareness of being responsible for a child and of lifelong motherhood. Some women mentioned fear of this transition occurring in an environment other than their homes, even if it was seen as a naturally process.

> *There was fear in the fact that my baby was being born. It was motherhood. Now I was going to be a mother, I was going to be responsible for a child. (I1G1)*

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Thinking about safety in a planned homebirth

Women have their own thoughts on safety and some of them have to deal with comments regarding safety from family members and significant others. To the people around them, safety in childbirth is connected to the hospital environment, equipment, procedures and health team that are supposed to be available. Then, giving birth out of the hospital is unsafe.

> *Everyone asks if there will be an ambulance at the door, then you have to explain that you don't need one, and people think that's absurd. They think you're putting the baby at risk. (I2G4)*

However, even if these women understand these safety aspects, they also saw other unwanted aspects of giving birth in hospitals. Looking around themselves, they realize that some significant others were born at home in a safe manner, and that strengthens them in thinking about childbirth as a natural event.

> *When my family came to ask me why I wanted a homebirth and whether it wasn't risky, I said, 'You were all born at home. Do you have any health problem because of that?' (I1G4)*
>
> *My husband was born at home in 1979; his mother had a natural homebirth. (I3G1)*

For these women, safety is not only connected to childbirth as a biological or medical phenomenon, and not a matter of resources available in a hospital. Safety is also about feeling comfortable, being together with their relatives, feeling themselves as the protagonist and powerful to give birth and becoming a mother.

> *At home it is much safer, you're welcomed, and you know that the team that is with you is evidence-based, so no one is going to do any nonsense. No one is going to let go of a possible safety limit. I trust very much in the nurse-midwife and it is much safer, much more human, much more dignified and respectful. (I1G2)*

Regarding safety, women acknowledge that it is not so easy to decide how and where to give birth naturally. It generates fear; a feeling of something happening to the baby and to themselves, the fear of an unknown and uncontrolled process.

> *I had seen a delivery and the child put his head out and it took some time. That impressed me. (I2G1)*
>
> *There is always that fear of the unknown. I didn't know what it was like, so I was afraid of something happening. (I3G1)*

Concerning decision-making, despite their doubts about the environment and/or safety, they stated that trust was a main factor. They trust the homebirth assistance team (nurse-midwives) that would be with them in a homebirth.

> *I trust very, very much in the nurses and it is much safer, much more human, much more dignified and respectful, both for the mother and for the baby.(I1G2)*

Wanting to give birth naturally and safe: Deciding on a planned homebirth with a nurse-midwife

The interpretation and integration of the categories led to this core category. The women presented doubts in relation to what they wanted, but were sure about what they did not want as regards giving birth. In their minds, there were a number of negative aspects to the hospital environment, such as unnecessary interventions, a threatening environment, being alone and leaving their next of kin. Deep inside, they knew that this was not what they wanted when giving birth.

The women wanted a natural childbirth in a familiar and unthreatening environment, and the home was the place that could guarantee so. They wanted to be close to their family and also to be supported by a skilled nurse-midwife. Planned homebirth was a way of handling the fear of pain, keeping children at home and, for those giving birth for the first time, facilitate the transition to motherhood.

The women thought about the meaning of safety as related to the technocratic resources available in a hospital. At the same time, they believed that giving birth was a natural phenomenon of women's lives and that they should not need these resources. They believed that they needed an environment other than a hospital. Home was where they had felt safe in so many situations, so why not when giving birth too? They knew people who had experienced homebirths, and everything had gone well. For these women, safety took on a new meaning based on a close and trusting relationship with those who were to take care of them at home: nurse-midwives.

Thus, after thinking and rethinking about the advantages and disadvantages of homebirth as compared with childbirth in hospitals, these women came to the conclusion that they wanted to give birth naturally, without any medical invasive procedures. Despite everything, they decided to give birth at their homes, assisted by a nurse-midwife (Figure 1).

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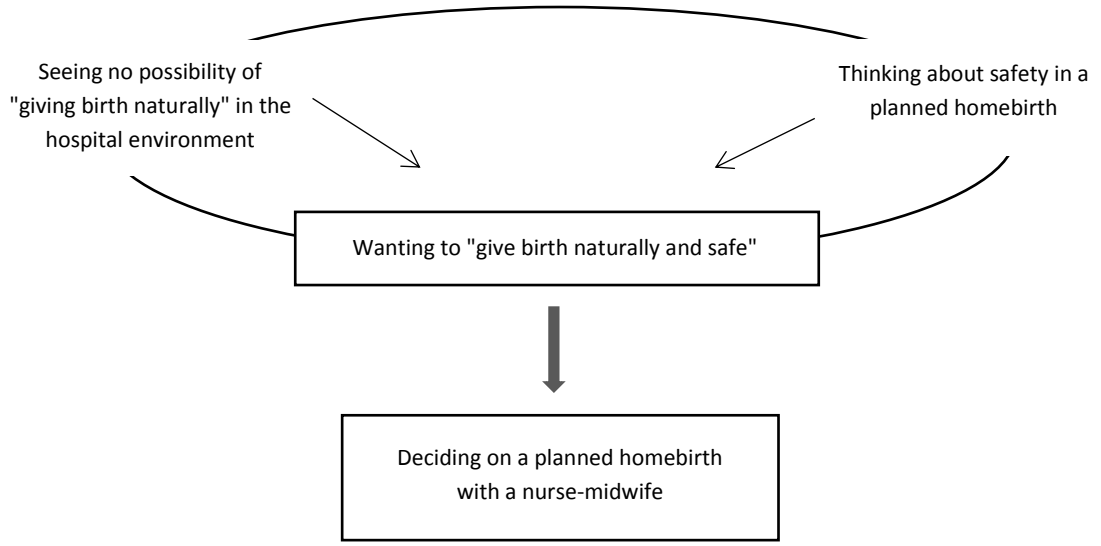

FIGURE 1: Diagram representing the theoretical model: Wanting to give birth naturally and safe. Rio de Janeiro, Brazil, 2017.

DISCUSSION

Safety when giving birth is strongly related to the technocratic resources available in the hospital, including a team of professionals qualified from the perspective of medicalized technocracy.

By giving voice to the women who experienced homebirths monitored by nurse-midwives, this study contrasts with this common thought about safety in some essential aspects. First, the women did not relate childbirth safety to the availability of hospital resources, adding important subjective and affective dimensions, which are striking in the home environment. At the same time, they rejected the exaggerated and unnecessary interventions that are a routine in the hospital environment. They also pointed out the unmedicalized, individualized and competent performance of the nurse-midwife as a major factor for safety in childbirth. This is in accordance with a newly published study from Australia[14].

Our study shows that women's decision for a planned homebirth was a process involving factors from different dimensions: environment, fear, safety and the professional who would take care of them. The women compared and balanced these dimensions and concluded that they wanted to give birth naturally, deciding for a planned homebirth assisted by anurse-midwife.

Safety was a crucial dimension in this process. Reiterating common sense, in medical-hospital environments, as well as in society at large, the idea of childbirth safety is related to the support of sophisticated equipment[13,15-17]. However, if childbirth is seen as a natural event, medical intervention is not necessary. The women feared early intervention in response to slow cervical dilation and that the delivery process would end in a caesarean section. If it is not possible for a woman to give birth naturally in the hospital, planned homebirth becomes the choice for some of them, and this corroborates with another study showing women's preference for planned homebirths[5,14].

Fear was also connected with the prospect of handling pain and the unknown, uncontrollable process of childbirth, especially in an environment that is frightening by itself. The delivery room has been described as a place and experience that can instil fear[18].

The transition to motherhood was also a cause for fear. If the place of birth is familiar, this makes it easier for women to feel connected to their child while giving birth[5,14].

The women in this study considered safety as crucial in a planned homebirth. They mentioned that others had given birth at their homes and that this had not ended up in problems. If others had done it, why couldn't they give birth at their own homes? This can be related to self-efficacy, a person's confidence in their own ability to cope with a given situation[19]. Women who prefer homebirth trust in their ability to give birth[20]. Vicarious reference to others' experiences is one of the sources of individual self-efficacy. Other sources identified are outcomes of earlier experiences, verbal persuasion and emotional arousal[19]. Their self-efficacy was certainly increased by the

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stimuli offered by the nurse-midwives who cared for them during pregnancy and whom they trusted to assist in their homebirth[20].

Confidence in the nurse-midwife was important for the decision of wanting a planned homebirth. One way of understanding this trust may be that the nurse-midwife supported their efforts to gain greater control over the process of giving birth. This has also been reported in a Finish study[6]. Comparing the sense of control among the women who had planned homebirths and those who underwent elective caesarean sections, those with planned homebirths reported being more in control of the situation[16,17]

In a concept analysis of control in childbirth, some critical attributes were shown to be decision-making, access to information, personal safety and physical functioning[21]. In the context of planned home childbirth, these attributes can be used to understand the sense of control experienced by the women. One-to-one care and a familiar environment facilitate an active role in decision-making and access to information. Personal safety rests on the women's identifying their homes as safe places for giving birth. The physical function can be facilitated at home by the familiar environment where women have greater sense of control of their bodies, emotions and pain. This is in agreement with other studies reporting that women who preferred or had planned homebirths were more likely to feel in control, as they could choose the place of birth and actively participate in decision-making about the care provided[6,21].

In this sense, as regards the nurse-midwives' role in the decision in favour of a homebirth, the women recognize certain distinctive attributes in these professionals' practice. It was how the nurse-midwives acted encouraging them to deal with their fear of pain and to experience giving birth naturally[21]. Strategies to avoid negative experiences, as well as fear, during childbirth must offer women emotional and existential safety when in labour[18].

The results showed that negative aspects of the hospital environment are factors that strongly influence the decision in favour of a homebirth. While understanding the many reasons why the hospital environment is the way it is and how difficult it is to set up one-to-one care, the influence of the medical-technocratic model is evidenced, with the medicalization of birth[22], hegemonic in Brazil[23]. However, several negative aspects pointed out by the women in this study relate much more directly to the hospital staff behaviour than to the physical environment itself. Nurse-midwives should change the way they behave, so as to work in the hospital environment with a woman-centred focus, the way they do in homebirths[24].

Limitations

A limitation can be that only ten women participated in the study. However, the theoretical sample of four groups with some differing characteristics can be seen as a strength of the method. This strategy yielded a wealth of data for constant comparative analysis. As a strength to be mentioned, this study was carried out from the perspective of the women's narratives, which configures its uniqueness and importance.

CONCLUSION

In this study, it was found that women's decisions in favour of a planned homebirth resulted from a process of comparing and balancing several aspects. They did not consider the hospital environment as necessary for the natural process of giving birth. Motherhood and having to leave home and their children to go to a hospital were other important factors, as well as the fear of an unknown situation.

Confidence, including feeling safe with a skilled nurse-midwife and one-to-one care, was a central condition in their decision for a planned homebirth.

For women who had a homebirth, the experience of one-to-one care, with the trust and confidence it engenders, could be introduced in hospitals in order to reduce the negative impacts of hospital birth on women. Nurse-midwives are fundamental in this change. Even so, there are women who would prefer to give birth at their homes. From the perspective of human rights and de-medicalized care, nurse-midwives should offer this option and support women in their decision.

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