ORIGINAL ARTICLE

REVISTA ENFERMAGEM ATUAL IN DERME

FACTORS INVOLVED IN WOMEN'S CHOICE FOR PLANNED HOME BIRTH IN THE CONTEXT OF THE COVID-19 PANDEMIC

FACTORES IMPLICADOS EN LA ELECCIÓN DE LAS MUJERES POR UN PARTO DOMICILIARIO PLANIFICADO EN EL CONTEXTO DE PANDEMIA COVID-19

FATORES ENVOLVIDOS NA ESCOLHA DAS MULHERES PELO PARTO DOMICILIAR PLANEJADO EM CONTEXTO DE PANDEMIA COVID-19

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RESUMO

Objetivo: compreender os aspectos envolvidos na escolha das mulheres pelo parto domiciliar planejado como opção de nascimento no contexto da pandemia. **Método:** pesquisa qualitativa do tipo descritivo, com dez mulheres que tiveram partos domiciliares após a COVID-19 ser caracterizada uma pandemia. As entrevistas on-line foram realizadas em domicílio, por meio da plataforma de videoconferência. Após a transcrição das entrevistas, foi feita a análise de conteúdo temática. **Resultados:** identificaram-se os sentimentos de solidão, medo e incerteza; as motivações para esta modalidade de nascimento, que perpassaram os princípios pessoais que valorizam a essencialidade feminina, mas também de preocupações sobre o risco de contaminação e a privação da participação de familiares. Ainda, caracterizou-se a assistência pelas enfermeiras obstétricas, pautada por diretrizes de segurança e humanização. **Conclusão:** este estudo possibilitou conhecer o gestar e parir em um contexto de pandemia e trazer subsídios para a atuação das enfermeiras obstétricas no ambiente domiciliar.

Palavras-chave: COVID-19; Enfermagem Obstétrica; Pandemias; Parto Domiciliar; Parto Humanizado.

ABSTRACT

Objective: to understand the aspects involved in women's choice of planned home birth as na option in the context of the pandemic. **Method:** qualitative descriptive research, with ten women who had home births after COVID-19 was characterized as a pandemic. The online interviews were conducted at home, via a videoconferencing platform. After the interviews were transcribed, thematic content analysis was performed. **Results:** feelings of loneliness, fear and uncertainty were identified; the motivations for this type of birth, which encompassed personal principles that value feminine essence, but also concerns about contamination risk and the deprivation of family participation. Furthermore, care provided by obstetric nurses was characterized by safety and humanization guidelines. **Conclusion:** this study made it possible to understand pregnancy and childbirth in a pandemic context and provide support for the work of obstetric nurses in the home environment.

Keywords: COVID-19; Obstetric Nursing; Pandemics; Home Childbirth; Humanizing Delivery.

RESUMEN

Objetivo: comprender los aspectos implicados en la opción de las mujeres por el parto domiciliario planificado como alternativa de parto en el contexto de la pandemia. **Método:** investigación descriptiva cualitativa, con diez mujeres que tuvieron partos domiciliarios después de que el COVID-19 se caracterizara como pandemia. Las entrevistas *online* se realizaron en el domicilio, utilizando la plataforma de videoconferencia. Después de la transcripción de las entrevistas, se realizó un análisis de contenido temático. **Resultados:** se identificaron sentimientos de soledad, miedo e incertidumbre; las motivaciones para este tipo de parto, que permearon principios personales que valoran la esencialidad femenina, aunque también se detectaron preocupaciones por el riesgo de contaminación y la privación de participación familiar. Además, se caracterizó la asistencia brindada por enfermeros obstétricos, orientada por directrices de seguridad y humanización. **Conclusión:** este estudio permitió comprender el proceso de gestar y parir en contexto de pandemia, además de brindar apoyo a la gestión de las enfermeras obstétricas en el ámbito domiciliario.

Palabras clave: COVID-19; Enfermería Obstétrica; Pandemias; Parto Domiciliario; Parto Humanizado.

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INTRODUCTION

In recent decades, pregnancy and childbirth have come to be regarded as events of medical interest, which contributed to the acceptance of this occurrence, previously considered a family matter, as a hospital-based model, treated as a mechanical process with its physiology largely disregarded[1-2].

Given this scenario, women have been questioning this practice while advocating for the appreciation of physiological processes and female autonomy during pregnancy and birth, which are central to alternative care models such as Planned Home Birth (PHB). This model restores female protagonism, reflected in greater knowledge and control over one's body, and ensures that the birth event places the woman at the center of care organization, supported by qualified and safe obstetric practices [2,3]. Consequently, when compared to hospital-based care, PHB constitutes a birth model associated with fewer interventions[4-6].

Revisiting the context of the COVID-19 pandemic, which began on March 11, 2020, following an outbreak of respiratory illness caused by the Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV-2), first identified in December 2019 in Wuhan, China[7]. In the field of women's health, given the extreme circumstances and the classification of pregnant and postpartum women as high-risk groups, specific care pathways and clinical-care actions were established for managing these women in primary and hospital health services[8].

Thus, with the advent of new hospital protocols and routines aimed at controlling exposure to the novel coronavirus, pregnant women might feel apprehensive about the possibility of experiencing childbirth alone. This could occur due to restrictions on the presence of companions of their choice during labor. Additionally, they may experience feelings of apprehension, fear, and uncertainty regarding the severity of the disease and the maternal-fetal repercussions of potential infection[9]. A similar phenomenon observed in some countries, such as the United States and the United Kingdom, led to an increased demand for PHB in response to women's perception of hospitals as unsafe environments regarding disease transmission[1,10-11].

In this context, PHB was already a desired birth model for some pregnant women due to their prior conceptions about traditional hospital-based obstetric care. Furthermore, it is viewed as a safe alternative during the COVID-19 pandemic, according to the reflections and professional experience in this field of one of the authors.

Therefore, this study investigated whether the restrictive measures adopted by health institutions and the curtailment of pregnant women's rights at the time of delivery, combined with the fear of potential COVID-19 infection in hospital settings, contributed to the choice of PHB as a birth option.

The study aimed to understand the factors involved in women's choice of planned home

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birth as a birth option within the pandemic context.

METHODS

This was a descriptive and exploratory study with a qualitative approach, which met the criteria defined by the Consolidated Criteria for Reporting Qualitative Research (COREQ) to ensure rigor and quality in the research conducted.

Data collection was carried out in the residential setting as the space for information production, through online interviews via the Zoom videoconferencing platform, with ten women who met the inclusion criterion: having experienced PHB during the pandemic. The exclusion criterion considered those residing outside the state of Rio de Janeiro, given that each state in the federation adopted its own restrictive measures regarding social isolation. It should be noted that there were no refusals to participate.

For participant selection, the Snowball Sampling recruitment method was used. The seed was identified, an individual whose purpose is to locate some people with the necessary profile for the research within the general population, thereby bringing the researcher closer to the group to be studied[12]. Thus, the first participant was referred by one of the researchers who was already working with a home birth group; and successively, a growing set of potential contacts meeting the eligibility criteria for study participation was established. This ongoing data collection process was concluded after ten (10) interviews, when theoretical saturation was reached, as no new elements were being added that would deepen the theorization of the study object.

After each seed referral, the researcher contacted the potential participant, with whom there was no prior contact, personal or professional relationship, via messaging application, in order to explain the research objectives and formalize the invitation to participate. Subsequently, interviews were scheduled according to participants' availability and took place remotely, at the participant's own residence, in a room chosen by her to ensure privacy, confidentiality, and minimal interruptions.

The initial step involved receiving, via WhatsApp, the Informed Consent Form as a digital file, scanned with the participant's signature. It should be noted that a copy of the document was digitally archived by the participant. To ensure confidentiality and anonymity of the interview, an alphanumeric code was applied, identifying participants by the letter P for Participant, followed by an Arabic numeral indicating the order in which interviews were conducted, such as P1, P2, P3, ..., P10.

This was followed by a semi-structured interview, guided by a script composed of closed sociodemographic questions and five open-ended questions: "How did you feel during the COVID-19 pandemic throughout your pregnancy, childbirth, and postpartum period?"; "How did you perceive the restrictions imposed by the

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pandemic on your pregnancy, childbirth, and postpartum period?"; "Did the pandemic influence your choice of PHB as a birth option?"; "At what point during the pandemic did you become certain that PHB would be the best option?"; "Tell us about your experience with PHB and how you perceived the care provided by the obstetric nurse during your delivery." It is worth noting that data collection was conducted by a single interviewer, who was at the time a resident in obstetric nursing, and who was appropriately guided by the principal investigator, who holds a doctoral degree and has experience in interview techniques.

Interviews took place from October 2021 to April 2022, with an average duration of forty-five minutes. At times, the interviewer needed to pause the interview due to the brief presence of other people in the room chosen by the woman for this stage. After confirming the participant's privacy, the interview was resumed.

Each interview was conducted only once per participant, recorded via audio/video using the videoconferencing platform's built-in feature, and shared with participants for validation within two days. Subsequently, participants returned confirmation of their recorded statements. Additionally, it should be noted that field notes were not used as an additional resource for data collection.

The narratives, transcribed in full, constituted the corpus submitted to thematic content analysis[13], comprising three stages: 1) pre-analysis of testimonies; 2) exploration of material and treatment of results; and 3) inference and interpretation. Thus, after floating reading of the accounts, the technique of marking registration units was applied, using the “Text Highlight Color” tool in Microsoft Word to begin decoding these narratives. At the end of this process, 124 registration units were obtained. that is, phrases that stand out for representing the motivations behind opinions, attitudes, values, and tendencies which were grouped by proximity of meaning and gave rise to four thematic nuclei: “Perceptions about home birth”; “Perceptions about hospital birth”; “Influence of the pandemic on pregnancy”; and “Team safety protocols.” Immediately afterward, interpretations and interrelations by similarity were performed, which allowed the structuring of three categories: “The experience of being pregnant and giving birth during the pandemic”; “Why give birth at home?”; and “Care during PHB in the pandemic.”

It should be noted that the research began after submission and approval by the Ethics Committee of the National Institute of Women's, Children's, and Adolescents' Health Fernandes Figueira/IFF-Fiocruz under CAAE No. 50231221.9.0000.5269, in accordance with Resolution No. 466/2012, which establishes guidelines for research involving human subjects.

RESULTS

The age range of the women participating in the study is 28 to 41 years. Regarding education level, most women have completed

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higher education (n=8). Concerning marital status, the majority live in stable unions or are married (n=9). Monthly family income corresponds to more than ten minimum wages for most of the families represented (n=7). Regarding obstetric profile, they are multiparous (n=7) and had previous hospital birth experiences (n=6).

The experience of being pregnant and giving birth during the pandemic

The COVID-19 pandemic imposed social isolation on society as a measure to reduce physical contact between people and the risk of infection. This public health measure affected the feelings experienced by pregnant women, causing loneliness, diminished support networks, and deprivation of traditional family social events.

> *We were very isolated; family members did not participate in my pregnancy; people did not see me pregnant [...] I consider that my pregnancy was not fully enjoyed, mainly due to the lack of social contact* (P2).

> *My pregnancy was completely isolated the entire time. [...] And so, no one saw me pregnant. None of my friends have a photo with me pregnant; my mother barely saw me pregnant either. It was very difficult.* (P5).

> *But when you are physically present with people who care about you, you end up being pampered. [...], so I felt that I lost that affection, that moment when the family gives you special attention. [...]. We went through it alone.* (P10).

Through the narratives, participants expressed fear, insecurity, and conflicting information resulting from the unknown potential repercussions of COVID-19 on pregnancy and the fetus, given that pregnant women were classified as a high-risk group by the Ministry of Health. A frightening scenario, due to uncertainties regarding the progression of COVID-19.

> *We started to see the hospital situation worsen significantly, and then we felt quite unprotected, insecure* (P1).

> *Everything was a cause for concern. the fear of getting COVID, of having complications. Also, the research I read and heard about regarding the consequences of COVID for pregnant women* (P2).

> *The fear was greater because I kept thinking: "What if I get severe COVID now?" So, while everyone was wearing cloth masks, I was wearing an N95* (P10).

Given this context, due to uncertainties regarding the progression of COVID-19, information about vaccine development and the prioritization of this immunization measure in international policies to control the pandemic's advance created great expectations for these women, who began to envision better days.

> *I had the opportunity to get vaccinated early and I did, so I felt a bit more at ease about it. I would go out for appointments and occasionally to open spaces, just to breathe more freely* (P3).

> *I received my first vaccine dose while pregnant. I was the first pregnant woman at the health center to get vaccinated [...]. "I'm only leaving here vaccinated," and then they vaccinated me. When my baby*

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> *turned three months old, I received my second vaccine dose* (P5).

> *The vaccination campaign began, and I was waiting anxiously to get out of this pandemic situation. That's when I really started organizing my life; even choosing the name and accepting the pregnancy took a while* (P8).

With the start of vaccination for at-risk populations, pregnant women resumed their planning and the possibility of experiencing all the feelings and moments related to the pregnancy process, accompanied by their loved ones.

Why give birth at home?

The choice of PHB occurs for different reasons, motivations, and justifications defined by the couple. However, with the advent of the pandemic, COVID-19 became an important driver for choosing PHB, although it does not represent the main reason for this choice for the women, as indicated by the participants.

> *It was the pandemic that determined our decision, because of this friend of mine who had to be hospitalized at 28 weeks and ended up getting COVID [...]. This made me very apprehensive, and we saw how much the pregnant woman was at risk* (P1).

> *The pandemic was not a determining factor, but it was one of the factors; thinking about a hospital environment to give birth has always seemed strange to me, and now thinking about being in the hospital with the risk of COVID infection* (P2).

> *I already had this desire to have a humanized birth, with or without the pandemic, but knowing that we were in a pandemic and that everything was very new really reinforced it* (P6).

The COVID-19 pandemic imposed new requirements on hospital institutions and the reorganization of workflows and work processes to avoid crowding and increased circulation of people in enclosed environments. Control measures resulted in patient and staff screening, COVID testing for patients, strict visitation policies in maternity wards, rules for the presence of companions, and isolation of suspected or infected patients. Thus, the excerpts below reveal a fear of being alone or without their support network at the time of delivery, which was considered by the interviewees as another determining factor for choosing PHB.

> *For me, childbirth has always been a family event; I never gave birth alone. In my other pregnancies, I had my husband, my mother, and sisters accompanying me, and I wanted to have this experience again. I think it provides security; it's comfort and support* (P1).

> *We even visited hospitals and were informed that I would not be able to have visitors, that I would not be able to have my mother with me, that I could not switch companions, so we opted for PHB* (P8).

Furthermore, through their statements, these women demonstrated knowledge and awareness of their capacity to give birth, considering female physiology and the freedom to make choices regarding their bodies and the birth of their child. This awareness strongly contributed to the choice of PHB, since this positioning ran counter to most obstetric practices present in the hospital environment.

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> *I am a woman, healthy, conscious; I took care of myself during pregnancy. Physically, emotionally, mentally. What should I fear in my delivery? [...] For me, it is intuitive. Once I understood that there is no better place to be born than one's own nest* (P4).

> *People may suggest one thing or another, but my body speaks and I follow; no one interferes!* (P7).

> *I prepared myself emotionally; I was also very confident in myself, in my body; I knew the pain would come, and I knew I was capable* (P9).

Some women belong to a privileged group in society regarding information and knowledge about options for the place of birth; but also regarding a more meaningful and personal experience that considers the greatness of female nature, resulting from the choice of professional practices in this birth modality.

Care during PHB in the pandemic

Care in PHB is culturally associated with informality, intimacy, closeness, and the creation of affectionate interpersonal relationships, with bonding and trust, uniting the pregnant woman, the family, and the obstetric nurse. However, given the pandemic context, it became necessary to adapt this care to comply with distancing protocols and the use of personal protective equipment, in order to provide quality care with the safety required by the pandemic.

> *All preventive measures were taken; the nurses [...] wore masks the entire time* (P3).

> *And they followed all protocols, handwashing, mask use during consultations and delivery. They would see me out here, which is the open space I have; we didn't stay inside the house either* (P5).

> *At all times, they were concerned with keeping me informed, updating me about their testing* (P8).

In this context, although it was necessary to adopt all required safety measures, obstetric nurses maintained their profile of home-based care: through the importance of understanding the couple's reality, emotional support for the woman and her family, offering support and security in the decisions made by the pregnant woman, and their own technical care grounded in scientific knowledge, as represented in the testimonies below.

> *What really caught my attention was the obstetric nurse's perspective, because it is truly different from the medical view, [...] because they position themselves as protagonists, and with the nurses I felt a big difference, they really placed me as the protagonist. [...] all the thorough and careful assessment, but at the same time, allowing us to experience that moment as a family* (P2).

> *The idea is that we build a relationship through prenatal care and seeing each other, precisely so that at the time of delivery there is trust with those people. [...] And they respected me; I questioned many things, but they explained the reasons to me. I respected them and was respected. It was a really great relationship* (P4).

> *I remember that during labor, due to the time and pressure, one of the nurses told me that I had edema [...]. She told me to stay calm, that we would do some maneuvers. I said "Okay, I trust you," and we did it* (P8).

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Thus, the limitations imposed by new work processes and care pathways determined by the COVID-19 pandemic were incorporated into the specialized and individualized care of the obstetric nurse, bringing quality and safety to obstetric care, and a unique experience of humanized birth.

DISCUSSION

In this investigation, women expressed their experiences of pregnancy during the COVID-19 pandemic. Physical distancing as one of the public health measures was a primary recommendation to inhibit or delay the spread of the virus, preventing the emergence of new cases. However, this distancing caused psychological impacts on society, evidenced by studies indicating that 16.5% to 35.2% of the general population exhibited symptoms of sadness or depression, and 28.8% to 41.3% manifested symptoms of anxiety, particularly among women[14].

Experiencing this in a solitary manner and a certain fragility of feelings due to social isolation had repercussions on the pregnancy process. It hindered the construction of the identity of being pregnant, since the support of the family system and social sharing are essential for the woman to embrace this new role[15].

Concerns arose with the progression of COVID-19. In the case of pregnant women, it was observed that initially the number of infected pregnant women was lower than in the general population. However, when infected, pregnant women proved vulnerable to more aggressive manifestations of the disease, with negative perinatal outcomes[7,16], which justified the classification of this population group as high-risk[8]. As a result of such complications, a 70% increase in the maternal mortality rate was recorded in the months of March to May 2021, compared to previous years[17]. Thus, these factors, reported daily by the media, emerged as concerns for these women and their families regarding potential infection from hospitalization and the impact on maternal-fetal health.

COVID-19 vaccination became a worldwide expectation for confronting the pandemic. From March 2021, due to the observed increase in mortality, pregnant and postpartum women, with or without comorbidities, became a priority group for vaccination, confirmed after an individualized assessment of the risk-benefit profile[8]. In this scenario, vaccination brought feelings of hope for resuming daily life and the possibility of the reunions longed for by the women in this study, who understand that pregnancy should be experienced within family and social life.

Faced with this obscure context of health crisis for health systems, their users, and the public, participants in this study considered PHB as an important alternative for childbirth. A similar phenomenon was observed internationally[1,10,11], and in Brazil, an online survey in April 2020 indicated that 52.7% of respondents reported that their birth plans had been altered, and 28.2% stated they would feel safer if delivery occurred at home[18].

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In light of this, the growing movement of women toward PHB, as a consequence of the pandemic, corroborated recommendations from some international organizations, including the International Confederation of Midwives. This organization published an official document on the need for countries to adopt out-of-hospital births as a safer proposal compared to the hospital environment, through care provided by qualified obstetric nurses[19]. In Brazil, however, the Ministry of Health, during the pandemic, expressed opposition to home births or births in Birth Centers for women suspected or confirmed for SARS-CoV-2, recommending care in reference centers and hospitals due to the potential for symptom worsening[20].

The onset of the pandemic was accompanied by restrictions on practices and behaviors in maternity wards, aimed at limiting the risk of cross-contamination. For pregnant and postpartum women who did not test positive for COVID-19, it was established that the presence of a companion would be accepted; however, rotations and hospital visits were suspended to minimize the circulation of people in the hospital environment[8,20].

These measures impacted the human rights of women and their babies, reduced the psychological and physiological benefits of this care, and were accompanied by over-medicalization[21], practices that compromise woman-centered care and the provision of safe, quality care.

Such practices may interfere with the birth plan and with feelings such as distress, anxiety, and insecurity for those who were counting on the presence of more than one companion and family support[14,22]. It should be noted that, although it loses prestige with the institutionalization of childbirth, the family network provides physical and emotional support, contributing to the humanization of the birth experience.

In this and other investigations, higher levels of education and monthly family income among participants reveal a population with certain socioeconomic conditions, with private resources to fund a private PHB care team[2,3,5]. They make this choice because they understand that professionals who practice PHB implement best practices in obstetrics, consider expectations and wishes, value listening and welcoming, and believe in women's capacity to give birth naturally[2,5,23].

Thus, these women choose a counterpoint to hospital care, which disregards existing scientific evidence and maintains practices that reproduce depersonalized care, adhering to inflexible norms and routines and imposing procedures that ignore dialogue and maternal decision-making[2].

On the other hand, women with low education and income levels, users of the Unified Health System (SUS), experienced the restrictions imposed by the pandemic during their delivery, due to the necessary reorganization of work processes. Research revealed that these women had some of their rights taken away, such as the presence of a companion during labor, delivery, and the

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postpartum period, and the compromised bonding established in the first days of life with their baby. This occurred due to the separation of the mother-infant dyad in cases of COVID-19 positivity[24].

The absence of care protocols for COVID-19 in home-based care for pregnant women was noted, which led to the adaptation of official obstetric protocols to the home environment, such as: sanitization of the workspace and equipment, alternating between in-person and online modalities for prenatal consultations, and restriction on the number of people present at the birth scene, recommending the presence of a doula and one companion of the woman's choice[1,25]. New measures were implemented to prevent exposure of obstetric nurses, their clients, and family members.

The new safety-oriented practices required by the pandemic were integrated with the knowledge and experience of obstetric nurses, who consider the home as their work environment. These professionals, despite the reconfiguration of practices and the distancing required by COVID-19, were still able to establish a relationship of trust, security, and bonding with the woman, through an interaction that goes beyond verbal communication. This interaction is also expressed through touch and eye contact[23,25], considered significant factors in the choice of this type of birth selected by the participants.

In view of this, with the intention of helping women experience the potential of PHB, obstetric nurses align the principles of respect and safety with scientific propositions for best obstetric practices in their care.[2,5] Therefore, they succeed in establishing humanized birth in the home environment by considering shared decision-making and the abolition of interventionist practices, measures that ensure beneficial outcomes for maternal-infant health, quality of care, and women's satisfaction.

FINAL CONSIDERATIONS

This research made it possible to understand the aspects involved in being pregnant and giving birth in the home environment within the pandemic context. The feelings experienced by them involved loneliness and frustrations from not sharing the pregnancy with family members and people in their social circle due to the imposed social distancing, as well as anxiety and fear about infection with the virus and its repercussions for maternal-fetal health.

The women's motivations for choosing PHB encompassed distrust in hospital-based obstetric care, heightened by the potential for SARS-CoV-2 infection in the hospital environment and by restrictions on the presence of family members considered vital in planning their delivery.

Thus, women who experienced pregnancy and childbirth in this pandemic context perceive that their question "where and how should delivery occur" was affected by the pandemic and positively determined the decision to choose PHB as the place of birth. Therefore,

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this research contributed to obstetric nurses working in the home environment by helping them understand the determinants for the decision to choose PHB. This includes the specific health care context imposed by COVID-19, enabling the empowerment of pregnant women who wish to reclaim their female essence, based on their principles and conceptions about humanized birth and the place of birth.

The conceptions arising from this experience have limitations as they represent a snapshot that may reveal territorial differences. Furthermore, the use of the online modality for data collection may have affected the participant's confidentiality and privacy, a necessary aspect in the environment, which was mitigated by the interviewer by pausing the dialogue when family members were perceived to be present in the room.

REFERENCES

1. Floyd RD, Gutschow K, A Schwartz DA. Pregnancy, Birth and the COVID-19 Pandemic in the United States. Med Anthropol. 2020; 39(5):413-27. doi: https://doi.org/10.1080/01459740.2020.1761804

2. Prates LA, Timm MS, Wilhelm LA, Cremonese L, Oliveira G, Schimith MD et al. Being born at home is natural: care rituals for home birth. Rev. Bras. Enferm. 2018; 71 (Suppl 3):1324-34. doi: https://doi.org/10.1590/0034-7167-2017-0541

3. Volpato F, Costa R, Lima MM, Verdi MIM, Gomes IEM, Scapin SQ. Planned home birth in the contexto of covid 19: information for decision making. SciELO Preprints. 2020. doi: https://doi.org/10.1590/SciELOPreprints.496

4. Reitsma A, Simioni J, Brunton G, Kaufman K, Hutton EK. Maternal outcomes and birth interventions among women who begin labour intending to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: a systematic review and meta-analyses. E Clinical Medicine. 2020; 21:100319. doi: http://dx.doi.org/10.1016/j.eclinm.2020.100319

5. Koetler JG, Bruggemann OM, Freita PF, Riesco MLG, Costa R. Obstetric practices in planned home birth assisted in Brazil. Rev. esc. enferm. USP. 2018; 52:e-03371. doi: https://doi.org/10.1590/S1980-220X2017034003371

6. Hutton EK, Reitsma A, Simioni J, Brunton G, Kaufman K. Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: a systematic review and meta-analyses. E Clinical Medicine. 2019; 14:59-70. doi: https://doi.org/10.1016/j.eclinm.2019.07.005

7. Ministério da Saúde (BR). Secretaria de Vigilância em Saúde. Guia de vigilância epidemiológica: emergência de saúde pública de importância nacional pela doença pelo coronavírus 2019 – covid-19. Brasília-DF: Ministério da Saúde; 2022.

8. Ministério da Saúde (BR). Secretaria de Atenção Primária à Saúde. Departamento de Ações Programáticas e Estratégicas. Manual de recomendações para a assistência à gestante e puérpera frente à pandemia de Covid-19. Brasília-DF: Ministério da Saúde; 2021.

9. Estrela FM, Silva KKA, Cruz MA, Gomes NP. Gestantes no contexto da pandemia Covid-19: reflexões e desafios. Physis: Rev Saúde Coletiva. 2020; 30(2): e300215. doi:

https://doi.org/10.1590/S0103-73312020300215

10. Cheng RFJ, Fisher AC, Nicholson SC. Interest in Home Birth During the COVID-19 Pandemic: Analysis of Google Trends Data. J Midwifery Womens Health. 2022;67(4):427-34. doi: https://doi.org/10.1111/jmwh.13341

11. Romanis EC, Nelson A. Homebirthing in the United Kingdom during COVID-19. Medical Law International. 2020; 20(3):183-200. doi: https://doi.org/10.1177/0968533220955224

12. Vinuto J. A amostragem em bola de neve na pesquisa qualitativa: um debate em aberto. Temat. 2014; 22(44):203-20. doi: https://doi.org/10.20396/tematicas.v22i44.10977

13. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2016.

14. Malta DC, Gomes CS, Szwarcwald CL, Barros MBA, Silva AG, Prates EJS et al. Distanciamento social, sentimento de tristeza e estilos de vida da população brasileira durante a pandemia de Covid-19. Saúde Debate. 2020; 44(4):177-90. doi: https://doi.org/10.1590/0103-11042020E411

15. Paixao JN, Campos LM, Carneiro JB, Fraga CDS. Maternal solitude before the new guidelines in SARS-COV-2 times: a Brazilian cutting. Rev. Gaúcha Enferm. 2021; 42 (spe):e-20200165. doi: https://doi.org/10.1590/1983-1447.2021.20200165

16. Mascarenhas VHA, Becker AC, Venâncio KCMP, Baraldi NG, Durkin AC, Riesco MLG. COVID-19 and the production of knowledge regarding recommendations during pregnancy: a scoping review. Rev. Latino-Am. Enfermagem. 2020; 28:e-3348. doi: https://doi.org/10.1590/1518-8345.4523.3348

17. Orellana J, Jacques N, Leventhal DGP, Marrero L, Duarte LSM. Excesse maternal mortality in Brazil: Regional inequalities and trajectories during the COVID-19 epidemic. PLoS One. 2022; 17(10): e0275333. doi: https://doi.org/ 10.1371/journal.pone.027533

18. Santana NM. As gestantes em meio à pandemia de Covid-19. Le Monde Diplomatique Brasil [Internet]. Brasília-DF: 2020 [acesso 2025 Maio 13]. Disponível em: https://diplomatique.org.br/as-gestantes-em-meio-a-pandemia-de-covid-19/

19. International Confederation of Midwives (ICM). Women's rights in childbirth must be upheld during the coronavirus pandemic. Países Baixos: 2020.

20. Ministério da Saúde (BR). Secretaria de Atenção Primária à Saúde. Departamento de Ações Programáticas Estratégicas. Nota Técnica Nº 9/2020-COSMU/CGCIVI/DAPES/SAPS/MS. Recomendações para o trabalho de parto, parto e puerpério durante a pandemia da COVID-19. Brasília (DF): Ministério da Saúde; 2020.

21. Renfrew MJ, Cheyne H, Craig J, Duf E, Dykes F, Hunter B et al. Sustaining quality midwifery care in a pandemic and beyond. Midwifery. 2020; 88:102759. doi: https://doi.org/10.1016/j.midw.2020.102759

22. Aydin E, Glasgow KA, Weiss SM, Khan Z, Austin T, Johnson MT et al. Giving birth in a pandemic: women's birth experiences in England during COVID-19. BMC Pregnancy and Childbirth. 2022; 22:304. doi: https://doi.org/10.1186/s12884-022-04637-8

23. Cursino TP, Benincasa M. Parto domiciliar planejado no Brasil: uma revisão sistemática nacional. Ciênc. Saúde Colet. 2020; 25(4):1433-1443. doi: https://doi.org/10.1590/1413-81232020254.13582018

24. Leal CA, Lima MM, Sonaglio BB, Costa R, Wilhelm LA, Drews MP. Atenção ao

parto e puerpério durante a pandemia de COVID-19: implicações na humanização do cuidado. Rev. Eletr. Enferm. 2023; 25:73786. doi: https:/doi.org/10.5216/ree.v25.73786

25. Webler N, Almeida LCG, Carneiro JB, Campos LM, Glaeser TA, Santos MC et al. Planned home birth assistance: challenges during the COVID-19 pandemic. Rev. Bras. Enferm. 2022; 75 (Suppl 1):e-20210083. doi: https://www.scielo.br/j/reben/a/FL98mVkPHhy9pGPHdsQRxKq/?lang=en

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