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Original Article

Experience of women in the transfer from planned home birth to hospital

Experiência de mulheres na transferência do parto domiciliar planejado para hospital

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Special Call 1 - Maternal and Obstetric Health

ABSTRACT

Objective: to describe the experiences of women in the transfer from planned home birth to the hospital. **Methods:** qualitative research, subsidized by Thematic Oral History, in which six women participated, attended by the home birth team and transferred to a maternity ward, during the parturition process. The semi-structured interview script with oral history generated five categories. **Results:** five thematic categories emerged: Motivating factors for choosing planned home birth; Positive experiences on intrapartum care in the home environment; Indications of hospital transfer; Feelings experienced during and after hospital transfer; Obstetric violence during hospitalization. **Conclusion:** the motivations for choosing planned home birth favored the positive experience of the parturition process, while hospitalization reflected obstetric violence.

Descriptors: Perception; Women; Home Childbirth; Humanizing Delivery; Obstetric Nursing.

RESUMO

Objetivo: descrever as experiências vivenciadas por mulheres na transferência do parto domiciliar planejado para hospital. **Métodos:** pesquisa qualitativa, subsidiada pela História Oral Temática, em que participaram seis mulheres, atendidas pela equipe de parto domiciliar e transferidas para maternidade, durante o processo de parturição. O roteiro semiestruturado de entrevista com história oral gerou cinco categorias. **Resultados:** emergiram cinco categorias temáticas: Fatores motivadores à escolha pelo parto domiciliar planejado; Experiências positivas sobre o cuidado intraparto em ambiente domiciliar; Indicações da transferência hospitalar; Sentimentos vivenciados durante e após transferência hospitalar; Violência obstétrica durante a internação hospitalar. **Conclusão:** as motivações para escolha do parto domiciliar planejado favoreceram a experiência positiva do processo parturitivo, ao passo que a internação hospitalar refletiu a violência obstétrica.

Descritores: Percepção; Mulheres; Parto Domiciliar; Parto Humanizado; Enfermagem Obstétrica.

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Introduction

Planned home birth has been an alternative resource for women with healthy pregnancies who seek a positive experience in a welcoming environment, free from unnecessary interventions and humanized care from prenatal to the puerperium[1]. Current World Health Organization obstetric recommendations indicate that women have the right to choose the place of delivery, whose desire is in line with the reduction of perinatal risks[2].

At the international level, the rate of adhesion to home births varies from 13% in the Netherlands to 0.3% in Australia[3]. The American College of Obstetricians and Gynecologists reports that, in the United States, 0.9% of births per year occur in the home environment, whose women need to be with healthy pregnancy, with no apparent risk, monitored during prenatal care and previously informed about risks and benefits[4].

For this purpose, longitudinal research, with the objective of mapping the trajectories of births during thirteen years of investigation, showed that 98% of babies at home had a positive perinatal outcome and 2% needed care in neonatal intensive care. As for planned births in a hospital environment, 62% occurred via a normal vaginal route and 38% required instrumental or surgical intervention. Of the children born via normal vaginal delivery, 8.0% went for intensive postpartum treatment, that is, prevalence four times higher than the children planned for home birth[5].

From this perspective, a meta-analysis with 500,000 births identified that there was no statistical difference on the risk of perinatal or neonatal mortality, when comparing the results of births resulting from home or hospital planning. Even so, the literature points to a scarcity of randomized population-based clinical studies that favor the standardization of home birth[6].

It is noteworthy that for birth at home for women of habitual risk, the guidelines indicate the presence of a certified midwife, licensed obstetric nurse, properly trained or obstetrician, as well as ready access to transportation, timely to nearby hospitals, according to pre-defined logistics[4]. About this, data show that of 546 births planned at home, 77% were at home and 23% required hospital transfer[5].

In effect, hospital transfer is a resource that contributes to childbirth safety, being identified, in due time, by the home team, in order to favor positive outcomes. Thus, considering the planning during prenatal care for the occurrence of childbirth in the home environment and understanding the possibility of hospital support as a team commitment to provide protection for maternal and fetal well-being, the question was: what is the experience lived by women who changed the intercourse of the parturition process from the residence to the hospital? Therefore, the objective was to describe the experiences lived by women in the transfer from planned home birth to the hospital.

Methods

Qualitative research, subsidized by Thematic Oral History[7], developed with women, attended in the planned home birth, by a team of obstetric nurses, allocated in the capital of the Northeast Region of Brazil. The population consisted of seven women, accompanied by a home birth team, over a period of one year. However, the convenience sample consisted of six women, aged majority, transferred to maternity during the parturition process, in the active phase of labor. However, there was no access to just one client, justifying the final sample.

For data collection, a guiding instrument was used, a form, which included age, marital status, education, ethnicity, occupation, income; and a semi-structured interview script about the perceptions of the participating women regarding hospital transfer, whose duration varied between thirty minutes and one hour. According to the theoretical model, at each interview, the script can be made more flexible; in or-

der to incorporate or remove questions to improve the documentary corpus, with no need for a pilot test.

To build the documentary corpus, the steps were followed: pre-interview, followed by the interview and post-interview. In the pre-interview, the first contact was made, by telephone, to invite, present the objectives of the study and explain the operationalization of the interview.

The interview stage was carried out through recordings, and the term of possession was presented, previously to the participant, which legitimizes the publication of speeches and images with authorization. Data collection took place between March and May 2019, in a private environment, at the participant's residence or workplace.

The post-interview was subdivided into three phases: the first, called transcription is the full writing of both narratives in the interview; the second, textualization, questions are removed and the text's spelling is organized in a clearer and more cohesive way. In the second phase, too, the "vital tone" is pointed out, a guiding phrase reported by the interviewee who is more vigorous[7]. In the third phase, that is, the transcreation, the researcher can modify the text for chronological adjustments of speech and word semantics, so that the final product is realized and presented in an organized way and as a documentary source[7]. The thematic content analysis technique supported the creation of the categories[8].

After empirical treatment, a new meeting was scheduled to carry out a conference on the material produced, which legitimizes publication, upon authorization of the letter of assignment by the collaborator, the document being indicated by the theoretical model. It was explained to the collaborators that in order to preserve their identities, names of flowers that represent love, beauty and strength would be used, symbolizing the participating women.

From the women's statements, five thematic categories emerged: Motivating factors for the choice of planned home birth; Positive experiences on intrapartum care in the home environment; Indications of hospital transfer; Feelings experienced during and after hospital transfer; Obstetric violence during hospitalization.

The study followed the ethical procedures of research involving human beings, according to the Certificate of Presentation for Ethical Appreciation No. 04497318.4.0000.5176 and opinion No. 3,163,883/2019, with the due signatures of the terms of free and informed consent.

Results

The average age was 30 years, with a range from 31 to 38 years. Regarding the marital situation, they all lived with their partners and had college education. Regarding ethnicity, three women declared themselves dark skinned, one white and one black. With regard to paid employment, three women lived with an income of four to seven minimum wages, one with an income of one to three minimum wages, one with up to one minimum wage and one woman without pay.

Regarding the characteristics of parity and way of delivery after hospital transfer, of the three primiparous women transferred, two had normal vaginal delivery and one underwent cesarean surgery. In the case of multiparous women, the picture was reversed, that is, two had surgical intervention and one was assisted vaginally. In other words, 50.0% of the participants underwent surgery and all neonates had satisfactory extra uterine adaptation.

Motivating factors for the choice of planned home birth

Previous negative experiences of childbirth in hospital, obstetric violence and unnecessary interventions have been relevant factors in the decision making for normal and humanized childbirth in the home environment: *What made me choose planned home childbirth, first, was due to an evolution of births previous ones. My first delivery, eight years ago, was a stolen cesarean, in the traditional ce-*

sarean model (Jasmine). *My first pregnancy was cesarean due to lack of information, I trusted the obstetrician who said she was going to have a normal delivery and I didn't read it, I didn't research it, I didn't find out how we know it was needed and it ended up being a cesarean without any reason* (Daisy).

Planned home birth seeks to humanize care and encourage normal delivery and respect for the will of women, through information on risks and benefits to maternal and child health. The expressions seem to point out that women had security, confidence and knowledge when the reasons for their choices were reported: *I chose home birth planned because I knew all the benefits it has, both for the mother and the baby* (Orchid). *I knew that this way of delivery was going to help a lot in terms of birth quality and recovery* (Bromelia).

Positive experiences about intrapartum care at home

The planned home birth is a form of assistance differentiated from what is commonly received in hospital services. The team has sensitivity, training, skills and abilities to deal with parturition, in a respectful, caring and safe way: *In my house, there was nothing that I did not like. It was perfect, quiet, everything the way I expected* (Jasmine). *I would even say that sometimes the girls on the team came to examine me, but I didn't even feel their presence because I was in a trance state. I felt safe with them, measured the pressure, listened to the baby! It was like that, I didn't even feel it, I knew they were coming all the time, but there was no invasion, they respected me a lot* (Sunflower). *They made me totally safe* (Daisy).

Regarding the woman's desire, some interviewees reported that they were asked about the permission to perform specific techniques, non-pharmacological methods for pain relief and suggestibility of exercises aimed at satisfactory fetal positioning, ensuring respect for protagonism and autonomy: *They asked if they could do a spinning babies maneuver. They asked if they could do the touch* (Sunflower). *The midwife* (ON), *had already seen that he was badly positioned and suggested some exercises* (Jasmine). *I spent most of the time under the hot shower, that's where I managed to relieve the pain the most* (Jasmine). *I went to the bathroom and stayed in the shower for 6 hours straight* (Bromelia).

Indications of hospital transfer

The transfer is a situation in which it can occur by decision of the team, after a careful evaluation and based on scientific evidence or at the request of the woman herself, either due to a state of exhaustion or desire for analgesia: *After the amniotic sac break, the deal was like this kinda out of control you know, contraction every minute. It is a pain that we do not expect. As I was a little out of touch, my husband asked what she* [obstetric nurse] *thought and as always sincere, said that the baby could be born in thirty minutes, but it could take all night and still not be born, so, the way that was, she advised taking it to the hospital. We decided to go!* (Jasmine). *My contractions were very long, with very short rest. Soon, I started not to bear the pain, so I asked for it* (Orchid).

There are several reasons that result in hospital transfer, both maternal and neonatal, whose mother must be prepared and alert for this removal, in order to guarantee the continuity of the mother´s and the baby's vitality. Therefore, a non-reassuring fetal situation consists of a condition for transfer, according to the statement: *Unfortunately, the drop in the baby's heart rate was the reason for the transfer* (Daisy). In addition, the discomfort, caused by dystocia of the soft part, made the progression of labor at home unfeasible, conditioning the transfer*: Still, it continued in six cm of dilation and was beginning to develop cervical edema. So, we entered into an agreement to transfer* (Bromelia).

The team must also provide necessary support to the mother and family, committing to safety and referral to a hospital for intrapartum care by the multidisciplinary team. The increase in blood pressure can happen during labor or after delivery, although there is prenatal monitoring, with previous examinations, a hypertensive peak is an imposing element when referring the home to the maternity hospital: *When the pressure was measured, it was 17 x 10, it was high. So, they told me there would be no other way, we had to go to the hospital* (Sunflower). *My*

pressure started to get much altered, high, 16, 17, so the girls preferred to make the transfer (Dahlia).

Feelings experienced during and after hospital transfer

There were many feelings experienced, such as tension, frustration, perception of inability to give birth, not feeling exemplary as an obstetric health professional and desire to end suffering. Feelings that demonstrate the particularity of each woman, while evoking a similar sensation in each speech, indicating that sometime after delivery, the transference still affects them in a place of wounded affection and disappointment with them. Despite this, despite the feeling of frustration, the resolution of suffering comforted the process, mainly due to the trust placed in the team's commitment: *There was a certain tension. I was hoping to stay with my daughter and family at home, but suddenly, the plans were broken* (Sunflower). *When I knew I would need a transfer, I was not concerned with the baby's vitality, because I knew that I was very well evaluated and as we were very tired, I imagined it was the right time* (Daisy). *For me, it is a great conflict. And, to this day, I can't even talk about it much. It is the frustration of not being able to do it and I wish the pain would end* (Orchid). *The moment I knew I would need a transfer, I was not sad, because I knew that if they were asking to make the transfer, it was really necessary, for security reasons* (Dahlia). *What I felt at the time of the transfer is that I wanted to solve the problem. I wanted to end this, you know. Then that frustration hits, there is that feeling of not having succeeded, of having failed* (Jasmine).

The midwifery health professional has specialized information about the positive repercussions of normal birth for the mother and baby. For this reason, in addition to knowledge, there is still a perception of a moral obligation to meet individual, family and society expectations, in view of vaginal birth. Therefore, in the speech, the participant felt powerless and incapable, as if she doubted herself and the profession, due to the hospital transfer: *My first concern was that I did not want to undergo post-surgical recovery and that I as a professional in the area, as an obstetric nurse, defending childbirth, I was going to my second cesarean section, that was my thought, it was my frustration* (Bromelia).

Obstetric violence during hospitalization

For women, hospital transfer was configured as the necessary resource for intrapartum care. However, for some, this transfer brought different experiences than what they were receiving at home, mainly related to the negative judgment for the choice of planned home birth and lack of empathy in the parturition process: *I had the transfer in my mind as a very peaceful thing, because the hospital is for that. But, my naïveté! I actually spent strange situations there. In surgery, I still had to hear the anesthetist say that I, an informed person, should not fall for this childbirth bullshit at home, that this was absurd! Women died because of that ... It was really boring* (Sunflower). *I was terrified and wanted to leave for a private hospital, because there I knew I was going to have my cesarean section! And I really asked for a cesarean to escape obstetric violence* (Bromelia). *The assistance provided at home and in the hospital was completely different; the people's home is our home* (Jasmine).

Obstetric violence affects the parturient's physical and psychological state, when comments or behaviors violate respect for the right to choose the form of delivery, as well as the right to have one's own body as an individual and not a collective property, as can be seen in the interviewees' statements: *He spoke about my daughter, said that I put her at risk, that she could have developmental delay because of that, that she had to be hospitalized, because she did not know what conditions she was born, how if I had been born in filth!* (Sunflower). *I think I suffered the least that women suffer there! But, there was a joke like: Ah! But, wasn't normal delivery so good? Why isn't it so good now?* (Jasmine). *When I got to the hospital, the professional laughed on my face at my birth plan that I had printed. He laughed when he saw that I didn't want an episiotomy, said that if I didn't do it, the baby would be trapped. I was desperate* (Bromelia).

Discussion

The study had as a limitation the low adhesion to planned home birth, demonstrating that society still has vicissitudes related to the negative belief about

the unpreparedness of obstetric nurses to perform the procedure, although safety and healthy pregnancy are factors conditioning to the eligibility of delivery. In addition, there are no public policies that include free home birth in the health system, covering women in any economic-social stratification.

Contributions brought by the statements can have a positive impact for a better understanding of the possible intra-partum hospital transfer, after the decision to have home birth planned, whose outcomes should be welcomed and respected by the team that receives the woman in the maternity hospital, in addition to strengthening the performance of obstetric nursing in Brazil that has scientific and technical support for handling emergencies. The data prove to be innovative, as they point to the need for training based on scientific evidence from hospital teams and strategic planning of the public health system, in the face of planned home birth.

Regarding the sociodemographic characterization, the results were similar to that of a multicenter study carried out in Brazil, regarding schooling and the average age of women, whose births were attended at home[9]. As for the marital situation, the presence of the partner has been pointed out as an action of respect for the singularities and needs of each woman, considering that the partners are the main birth companions, witnessing the birth of the child[10].

In relation to skin color, research shows that there is no influence of ethnicity in the lack of access to planned home birth[11]. Although the planned home birth consists of a practice consistent with women of high socioeconomic status[12], there are no national guidelines on this health practice that support the service in the public system[1].

Regarding parity and post-transfer mode of delivery, in an investigation carried out in several regions of Brazil, the cesarean section rate was 9.0% of the parturient women who started home care[9]. In addition, survey in Australia has shown that vaginal birth rates were more prevalent among multiparous women[5], which are inconsistent with the findings of this study. Obviously, this research does not have robust quantitative results for comparison, considering the phenomenological nature and justifying the prevalence of the outcomes.

As for the motivating elements of planned home birth, the decision can also be influenced by information from the media about normal childbirth and its benefits, which represents a better way of delivery in healthy pregnancy, justified by the mother's shorter recovery time and decrease in maternal and neonatal mortality due to cesarean section[13].

However, for some women, the decision may be interrupted by the influence of professionals responsible for care, either during prenatal care or during labor, since Brazil still has a potential incidence for performing cesarean surgeries. Based on this, the search for professionals who respect the parturient's opinion on the type of delivery has been a motivating element for planned home births[14].

A study developed in Oregon identified that planned home births were associated with fewer interventions in the parturition process, when compared to hospital births. Despite these results, the need for randomized worldwide studies on outcomes compared between home and hospital deliveries was concluded[15].

Regarding the benefits, there are factors that improve the quality of intrapartum and childbirth care, such as the provision of a companion, free choice of birth position and immediate skin-to-skin contact[16]. These elements are offered in the planned home birth, ensuring the woman's right to dignity and humanization of childbirth and birth.

Regarding the role of women, home birth seeks to humanize care, even if at times there is a need to perform some intervention, such as the use of non-pharmacological methods for pain relief, maneuvers that favor the best positioning of the baby for descent, set the rhythm of contractions and consequent cervical dilation[17]. In this way, the team that conducts the planned home birth has an obligation to inform about the procedures and will only carry out after the

parturient's consent.

Conserning the possibility of intrapartum complications and the need for immediate intervention, a survey carried out in delivery centers in Rio de Janeiro, Brazil, showed that the second main cause of hospital transfer was altered heart beat[18], corroborating the indication for transfer in this study.

In the case of increased blood pressure, more specifically pre-eclampsia, this is the main cause of maternal mortality in Brazil[19]. Women with any manifestation of hypertensive syndrome during prenatal care are no longer candidates for planned home birth, leaving the condition of habitual risk[4], justifying the hospital transfer evidenced in this research.

Although there is social resistance regarding the performance of obstetric nursing in the parturition process, the care provided by the category was internationally identified as a protective factor against maternal mortality, which supports the competencies and skills based on obstetric safety[20].

Nevertheless, humanized childbirth activists seek to reduce vulnerabilities to obstetric violence, considered as any and all practices that have negative physical and psychological repercussions on women, during the pregnancy-puerperal cycle, being depicted as disrespect, verbal and physical aggressions, humiliations, unnecessary procedures, neglect of assistance, non-medicalization for cessation of pain, in addition to prejudice aimed at social, cultural, religious and economic conditions[17].

A systematic review study at the national level found that research on planned home birth is scarce in Brazil and that there are small samples. However, the literature points out that the profile of women who seek this service has discontent with the current obstetric model, a desire for autonomy over their own bodies and satisfaction with the care received from obstetric nurses[1].

Therefore, obstetric practices in planned home birth are an alternative to women who seek respectful physiological childbirth, with female appropriation of autonomy[9]. Therefore, through the statements obtained in this research, it is believed that, in order to avoid obstetric violence, the quality of care must go through respect, dignity, emotional support and effective communication, with positive language.

Conclusion

The experiences of women in the transfer from planned home birth to the hospital environment were described, showing that the motivation to give birth at home generated positive perceptions regarding the welcoming and technical expertise of the team, while obstetric violence was present in environments hospitals, given the need for transfer.

Collaborations

Pereira MFR and Braga LS participated in the design of the project, analysis and interpretation of data, writing of the article, relevant critical review of the intellectual content and approval of the final version. Rodrigues SS, Rodrigues MSD, Rodrigues WFG, Batista MG and Andrade SSC contributed with data analysis and interpretation, relevant critical review of the intellectual content and approval of the final version to be published.

References

1. Cursino TP, Benincasa M. Parto domiciliar planejado no Brasil: uma revisão sistemática nacional. Ciênc Saúde Coletiva. 2020; 25(4):1433-43. doi: doi.org/10.1590/1413-81232020254.13582018

2. World Health Organization. Recommendations: intrapartum care for a positive childbirth experience [Internet]. 2018 [cited Apr. 02, 2020]; 1-200. Avaliable from: https://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.f;jsessionid=B85C9B7163437EEE4452BE1BBFDB3711?sequence=1

3. Dahlen HG. Is it time to ask whether facility based birth is safe for low risk women and their babies? Lancet. 2019; 14:9-10. doi: https://doi.org/10.1016/j.eclinm.2019.08.003

4. American College of Obstetricians and Gynecologists' Committee. Comitee Opinion. Planned Home Birth. ACOG [Internet]. 2017 [cited Apr. 02, 2020]; (697):1-6. Avaliable from:https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2017/04/planned-home-birth.pdf

5. Scarf VL, Viney R, Yu S, Foureur M, Rossiter C, Dahlen H, et al. Mapping the trajectories for women and their babies from births planned at home, in a birth centre or in a hospital in New South Wales, Australia, between 2000 and 2012. BMC Pregnancy Childbirth. 2019; 19(1):513. doi: https://doi.org/10.1186/s12884-019-2584-0

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. Lancet. 2019; 14:59-70. doi: 10.1016/j.eclinm.2019.07.005

7. Meihy JCSB, Holanda F. História oral: como fazer, como pensar. São Paulo: Contexto; 2019.

8. Minayo MCS. Qualitative analysis: theory, steps and reliability. Ciênc Saúde Coletiva. 2012. 17(3):621-6. doi: 10.1590/S1413-81232012000300007

9. 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://dx.doi.org/10.1590/S1980-220X2017034003371

10. Ojelade OA, Titiloye MA, Bohren MA, Olutayo AO, Olalere AA, Akintan A, et al. The communication and emotional support needs to improve women's experience of childbirth care in health facilities in Southwest Nigeria: a qualitative study. Int J Gynecol Obstet. 2017; 139(Suppl. 1):27-37. doi: https://doi.org/10.1002/ijgo.12380

11. Aldrighi JD, Wall ML, Souza SRRK. Experience of pregnant women at an advanced age. Rev Gaúcha Enferm. 2018; 39:e2017-0112. doi: https://doi.org/10.1590/1983-1447.2018.2017-0112

12. Kyaddondo D, Mugerwa K, Byamugisha J, Oladapo OT, Bohren MA. Expectations and needs of Ugandan women for improved quality of childbirth care in health facilities: a qualitative study. Int J Gynecol Obstet. 2017; 139(Suppl 1):38-46. doi: https://doi.org/10.1002/ijgo.12405

13. Sena LM, Tesser CD. Violência obstétrica no Brasil e o ciberativismo de mulheres mães: relato de experiências. Interface. 2017; 21(60):209-20. doi: https://doi.org/10.1590/1807-57622015.0896

14. Oliveira VJ, Penna CMM. Every birth is a story: process of choosing the route of delivery. Rev Bras Enferm. 2018; 7(3):1304-12. doi: https://doi.org/10.1590/0034-7167-2016-0497

15. Snowden JM, Tilden EL, Snyder J, Quigley B, Caughey AB, Cheng YW. Planned out-of-hospital birth and birth outcomes. N Engl J Med. 2015; 373:2642-53. doi: https://www.nejm.org/doi/pdf/10.1056/NEJMsa1501738

16. Molina RL, Villar J, Reyes A, Elliott J, Begley M, Johnson M, et al. Delivery practices and care experience during implementation of an adapted safe childbirth checklist and respectful care program in Chiapas, Mexico. Int J Gynaecol Obstet. 2019; 145(1):101-9.https://doi.org/10.1002/ijgo.12771

17. Gomes SC, Teodoro LPP, Pinto AGA, Oliveira DR, Quirino GS, Pinheiro AKB. Rebirth of childbirth: reflections on medicalization of the Brazilian obstetric care. Rev Bras Enferm. 2018; 71(5):2594-8. doi: https://doi.org/10.1590/0034-7167-2017-0564

18. Oliveira TCM, Pereira ALF, Penna LHG, Rafael RMR, Pereira AV. Adequacy of prenatal assistance in birth houses and causes associated with hospital transfers. Rev Gaúcha Enferm. 2019; 40:e20180419. doi: https://doi.org/10.1590/1983-1447.2019.20180419

19. Silva JMP, Fonseca SC, Dias MAB, Izzo AS, Teixeira GP, Belfort PP. Concepts, prevalence and characteristics of severe maternal morbidity and near miss in Brazil: a systematic review. Rev Bras Saúde Mater Infant. 2018; 18(1):7-35. doi: http://dx.doi.org/10.1590/1806-93042018000100002

20. Pereira SB, Diaz CMG, Backes MTS, Ferreira CLL, Backes DS. Good practices of labor and birth care from the perspective of health professionals. Rev Bras Enferm. 2018; 71(Suppl 3):1313-9. doi: http://dx.doi.org/10.1590/0034-7167-2016-0661