ORIGINAL ARTICLE

WOMEN'S MOTIVATIONS FOR PLANNED HOME BIRTHS FOLLOWING A VAGINAL HOSPITAL DELIVERY

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Highlights: Women report trauma and obstetric violence in hospital births. (2) Previous negative experiences motivated the choice for Planned Home Birth. (3) Home birth offers greater autonomy and respect for women's choices. (4) Reports highlight the search for safety and humanized care during childbirth. (5) Need to review hospital practices to reduce obstetric violence.

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WOMEN'S MOTIVATIONS FOR PLANNED HOME BIRTHS FOLLOWING A VAGINAL HOSPITAL DELIVERY

ABSTRACT

Objective: to analyze the experiences that motivated women's choice for planned home birth after a previous hospital vaginal delivery. **Method:** this is a qualitative study with a descriptive and exploratory design, conducted in the western region of Santa Catarina, southern Brazil, with women who had a planned home birth after a previous hospital vaginal delivery. Data were collected from September to December 2022, using triangulation, through semi-structured interviews, information obtained from prenatal records, and records from the teams that attended the births. Thematic Content Analysis was used, culminating in the theme "Previous hospital experiences". **Results:** eleven women participated in the study and reported previous negative hospital experiences, including various forms of obstetric and neonatal violence, as the main motivations for choosing home birth. The reports revealed trauma and dissatisfaction with hospital care, highlighting unnecessary interventions, lack of privacy, and disrespect for personal preferences during labor and in the postpartum period, which led women to seek a more respectful and personalized environment in subsequent pregnancies. **Conclusion:** the choice of planned home birth reflects women's search for greater autonomy and safety in the childbirth process, with care that emphasizes respect and is centered on the quality of care provided to the mother–baby dyad. The need to review hospital practices and promote humanized care that values the protagonism and physiology of the parturient is highlighted.

Palavra-chaves: Obstetric Nursing. Home childbirth. Humanized childbirth. Obstetric Violence.

INTRODUCTION

The prevailing obstetric model in Brazil is predominantly medicalized and institutionalized within the hospital network, guided by biomedical and interventionist care, in which the physiological process of childbirth has been transformed into a practice that, in most cases, does not respect women's autonomy and their choices. Furthermore, historically, a structural shift in the childbirth care model can be observed, as this practice moved from the home setting, assisted by midwives, to the hospital environment, accounting for approximately 98% of births occurring in hospitals out of the total number of births in Brazil[1].

Thus, many women who have had hospital experiences report dissatisfaction and trauma associated with this moment, generating significant discomfort and insecurity regarding the possibility of being exposed to various forms of obstetric violence and interventions. Faced

with uncertainties and fears related to childbirth, women have sought alternatives to experience the childbirth process respectfully, opting for Planned Home Birth (PHB)[2].

PHB is understood as the care provided to women during pregnancy, childbirth, and the immediate postpartum period, in the home environment, carried out by a qualified professional, freely chosen by the woman, and registered with their professional regulatory body[3]. The World Health Organization (WHO) recognizes physicians, obstetric nurses, and/or doulas as qualified and trained professionals to conduct PHB, in addition to the participation of individuals and professionals chosen by the woman, such as friends, family members, doulas, among others[4]. Furthermore, Resolution No. 737, of February 2024, issued by the Federal Nursing Council (COFEN), regulates the practice of obstetric nurses and midwives in PHB care, establishing that these duly registered and qualified professionals are responsible for conducting this model of childbirth care in accordance with specific protocols[5].

In this context, PHB is an option consistent with the principles of humanized care, in which women regain their protagonism in the childbirth process, strengthening family bonds and their autonomy[6]. Additionally, care provided at home promotes greater well-being for the mother–baby dyad, as it occurs in the least invasive manner possible, ensuring a welcoming environment for the parturient, freedom of position according to the woman's preference, combined with the use of complementary therapeutic practices, as well as minimal interventions with the newborn (NB), ensuring effective and prolonged skin-to-skin contact between mother and baby[7].

Given the above, this study was guided by the following research questions: how were the experiences of women who had a previous hospital vaginal delivery, and what were the motivations related to the prior childbirth process that led them to choose PHB? Therefore, the objective was to analyze the experiences that motivated women's choice of PHB after a hospital vaginal delivery.

METHOD

This is a qualitative study with a descriptive and exploratory design, conducted in six municipalities in the western region of the state of Santa Catarina, with women who chose PHB after a previous hospital vaginal delivery. Inclusion criteria were: women over 18 years of age, who had a previous hospital vaginal delivery before PHB, and who were attended by obstetric nurses in the western region of Santa Catarina. Exclusion criteria were: primiparous women,

women for whom PHB was contraindicated according to eligibility criteria, and those who were transferred to the hospital during the childbirth process.

Participants were identified from contact lists provided by obstetric nurses who work with PHB care in the western region of Santa Catarina, containing women's names and phone numbers. Initial contact was made via WhatsApp, through text messages explaining this study's objectives and inviting them to participate intentionally, considering the inclusion criteria. The study consisted of three stages developed through an electronic form (Google Forms), sent after agreement to participate. Completion of the form constituted the woman's consent to participate in the study. The first section corresponded to the formal invitation to participate in the study, its objectives, and justification. The second section presented information on the Free and Informed Consent Term (FICT), as well as the participant's agreement and authorization to record the interview. Finally, in the third section, participants were asked about the most suitable days and times for conducting the interview.

To understand the phenomenon under study in its complexity, data production employed triangulation of sources of evidence[8], namely: conducting semi-structured interviews; collecting information from prenatal records; and collecting data from PHB team records regarding the care provided. Interviews were conducted online using videoconferencing platforms such as Google Meet and WhatsApp and were guided by a structured script including participant characterization and identification, as well as sociodemographic data.

The interview script included questions related to prenatal care, labor, childbirth, and the immediate postpartum period. Regarding prenatal care and childbirth, questions included the number of consultations, place and date of birth, who was present, gestational age, duration of the active phase, conditions of the amniotic sac, birth environment, birth position, time of placental expulsion, and the use of substances or techniques to induce labor. Concerning the immediate postpartum period in PHB, aspects explored included the condition of the perineum, need for suturing, the newborn's Apgar score, complications during labor, childbirth or postpartum, and, finally, descriptive questions about the motivations for choosing PHB, including reasons for this decision, influence of other people, reactions to the choice, the experience of PHB, and previous hospital birth experiences.

Data collection was carried out by two undergraduate Nursing students, at the time of the study, under the guidance and supervision of the lead researcher, a university professor and nurse specialized in obstetrics, with experience in conducting qualitative research. All

interviews were audio-recorded for subsequent transcription and data analysis and were conducted between October and December 2022, with an average duration of 30 minutes. The criterion of theoretical saturation was adopted for the inclusion of new participants, and data collection was discontinued when no new elements and/or information emerged to support the theoretical discussion[9] regarding the investigated phenomenon. The interviews were transcribed manually and in full by the students, without any use of automatic transcription software, and organized into Microsoft Word® files.

There was no prior relationship between the interviewers and the participants, there were no refusals among the invited women, and no third parties were present during the interviews, except, occasionally, the participants' own children. No field notes were taken, and no subsequent validation of the transcripts by the participants was carried out.

The collected data were submitted to thematic content analysis[10], following the stages of pre-analysis, material exploration, treatment of results, inference, and interpretation, all conducted manually, without the use of qualitative analysis software. In the pre-analysis stage, the transcribed interviews were organized in chronological order into digital folders, followed by floating reading of the transcripts, revisiting the study objectives, and familiarization with the material, identifying relevant meaning units. During material exploration, the statements were coded into enumerated recording units and grouped according to thematic similarity and color coding. This strategy allowed the grouping of recording units with convergent meanings, facilitating the progressive construction of subcategories and, subsequently, thematic categories.

In the final stage, the findings were articulated with the theoretical framework, allowing the understanding of the meanings attributed by participants to their experiences. At the end of the process, 772 recording units were identified, organized into 22 subcategories, which gave rise to three themes, among which, in this study, the theme "Previous hospital experiences" will be addressed, with categories related to the medicalization of childbirth, obstetric violence, immediate postpartum period, neonatal violence, and the Golden Hour.

This study is part of a larger research project entitled "*Motivações de mulheres frente à tomada de decisão pelo Parto Domiciliar Planejado na pandemia de COVID-19*" and followed legal and ethical guidelines, receiving ethical approval in December 2021 under opinion number 5,170,967 and CAAE number 2930121.1.0000.5564.

All participants received and completed the Free and Informed Consent Term (FICT) and the consent term for the use of image and/or voice via a Google Forms link. No unforeseen events or situations that could place participants at risk were observed during the interviews. To preserve the identity of the women included in the study, each participant's name was replaced by the letter P (for participant), followed by an increasing ordinal number (P1, P2, P3…), according to the interviews' order. The study followed the recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ).

RESULTS

Eleven women participated in the study who chose PHB after a previous hospital vaginal delivery. Their ages ranged from 30 to 43 years, with a mean of 35 years; all were married, and ten had completed higher education and/or postgraduate studies. Regarding religion, seven participants were Catholic, five had a family income higher than seven minimum wages, and the others had an income lower than five minimum wages.

When analyzing the experiences that motivated women's choice for planned home birth after a hospital vaginal delivery, the following theme emerged: "Previous hospital experiences" as a motivating factor in this process.

In this context, participant P2 reported that the decision to choose PHB arose immediately after the birth of her first child.

> [...] the decision to have a home birth came the moment my first labor ended. When my daughter was born, I looked at my husband and said, "The next one will be at home!" Without even thinking twice (laughs). That's when I understood what it was about and realized what had been missing, what I had wanted in my first birth, and I decided the second would be at home. (P2)

Another participant stated that her choice for PHB was influenced by aspects related to the environment of the healthcare service where she had her first birth. The hospital setting, described as impersonal, cold, and lacking privacy, contributed to feelings of discomfort and emotional distance, leading her to choose a more welcoming, intimate, and respectful experience.

> [...] the hospital birth was what most pushed me toward having a home birth, because I didn't like it, even though the care was good, I didn't like being in that environment. It's not really an environment, hospitals are for sick people. (P4)

Similarly, previous negative experiences of some participants were associated with various negative feelings that ultimately created barriers related to the hospital experience. These situations contributed to women distancing themselves from the institutionalized childbirth model, leading them to seek alternatives that would provide greater support and autonomy during birth.

> [...] the experience I had in the hospital left me afraid of having to go back there again. I was terrified at the thought of ending up in a hospital again to give birth, that's how I felt. (P6)

> [...] both of my hospital births were bad experiences. The second birth itself wasn't, but the postpartum period was really bad. (P8)

> [...] there was obstetric violence, a lot of unpleasant situations, and that's what motivated me, in my second pregnancy, to stay at home for the whole labor and birth. (P11)

In the context of obstetric violence, some participants reported being subjected to unnecessary and repeated vaginal examinations, as well as episiotomy without consent during the childbirth process. These reports highlight invasive and distressing situations, generating feelings of helplessness, pain, and violation of their rights as women and parturients.

> [...] and then he [the doctor] called the nurse, and they didn't wait, they didn't even ask. One grabbed one of my arms, the nurse grabbed the other, and they forced me onto the bed, the guy did a vaginal exam on me, I had never felt so much pain in my life. I think it hurt more than the birth itself, because he was extremely rough, I was screaming in pain. (P8)

> [...] for me, the worst part was the episiotomy. I see it as a form of violence, I was never asked or consulted at any point. (P9)

> [...] I had an episiotomy during my hospital birth, and that actually bothered me from the moment it happened. (P10)

Still regarding obstetric violence, one participant reported that she was threatened by the professional who assisted her during childbirth and experienced psychological pressure to accept a certain procedure. This occurred through arguments that made her feel fearful and vulnerable, as they involved aspects that, according to the professional, could be harmful to her baby.

> [...] the doctor threatened me, called me stubborn, said it wasn't about me anymore, that it was about my baby's health, because she wanted me to lie down so she could perform an episiotomy. (P11)

Other recurrent practices observed in the interviews included directed pushing (instructing the woman to push the baby out), as well as restricting certain positions or imposing unwanted positions for childbirth. These practices also represent limitations on the parturient's autonomy, especially as they disregard the physiology of childbirth and respect for the female body.

> [...] the doctor kept saying: "Push, you need to help yourself". And the nurses were like: "Come onnn". And you're like "uhhn, uhhn" [groaning and straining]. (P1)

> [...] I thought I had freely chosen the position to give birth, but actually I was encouraged to sit on the birthing stool. And there was directed pushing in my first birth, which was something I didn't want. (P2)

> [...] I remember a nursing assistant pulling me so I would move further up [participant gestures by leaning her body forward], so I could push the "right way", because the first

> time I pushed the “wrong way”, right (ironic laugh), and I ended up with a lot of burst blood vessels. (P7)

The Kristeller maneuver was another type of intervention identified in one of the reports, illustrating care marked by coercive and dehumanized practices. This conduct, recognized as a form of obstetric violence, highlights the persistence of a care model centered on professional authority and intervention on the female body, in contrast to the proposal of humanization and respect for women’s autonomy in the childbirth process.

> [...] someone climbing on top, getting on top of you to push the baby out. How can that even happen? These are absurd things, we wouldn’t even do that to animals, imagine doing that to a person, it’s shameful. (P4)

Another account revealed disrespect for the companion law, which, in addition to violating women’s rights, contributes to increased vulnerability and a sense of loneliness at a time that requires physical and emotional support.

> [...] my first birth was really difficult. My labor lasted, in total, over 30 hours, and I went through it alone in the hospital [...] I spent the early morning, the whole night alone, and the morning alone, my husband was only allowed to come in during visiting hours. (P9)

Another relevant issue mentioned was the restriction of food and fluid intake imposed on some participants by the professionals who assisted their births in the hospital setting, which left them feeling very distressed and uncomfortable. This practice, still present in some services, goes against current recommendations from health organizations, which recognize the importance of women’s freedom of movement and choice of food as part of humane and safe care.

> [...] I was admitted at eight in the morning, and she was born at four-thirty in the afternoon. What I remember the most is begging the nurse for water, and they wouldn’t give it to me, so I felt extremely hungry and thirsty, it was awful. (P8)

> [...] I went without food during the time I was hospitalized. (...) nowadays people talk a lot about episiotomy as violence, but I think not being allowed to eat is also a form of violence. (P9)

Unpleasant situations were also related to the immediate postpartum period, such as lack of privacy, disrespect, and unnecessary attitudes and remarks toward one of the interviewees. These experiences reveal the persistence of invasive and unempathetic practices in postpartum care, contributing to feelings of vulnerability and discomfort during this already sensitive period.

> [...] a lot of unnecessary interventions, especially in the postpartum, right, and a lack of privacy. The staff was very invasive, because I had just given birth, I think they're not used to women giving birth [participant smiles ironically]. That kind of thing, like a nurse coming in and saying: "I heard you had a 4.5 kg baby, can I see how the tear looks?" (P6)

Still regarding the postpartum period, numerous interventions performed on NBs were highlighted, as they became the focus of healthcare professionals and pre-established routines in hospital institutions. These practices, often carried out without maternal consent or proper explanation, generated feelings of helplessness and separation between mother and baby, reinforcing the perception of dehumanized care.

> [...] so their service was really embarrassing, and what they did to my son as well. (P6)

> [...] he was born, he was fine, but then he was immediately taken for a bath, all that typical hospital routine, I don't know if they used silver [nitrate] in his eyes, I don't know what they used, and my husband was able to follow that part, the nurse bathing him and getting him dressed, but he had to watch through a glass window. (P9)

In this postpartum context, the Golden Hour stands out, referring to the first hour after birth, when skin-to-skin contact with the mother and early breastfeeding take place, promoting bonding, thermal stability, and other health benefits for the NB. Regarding this moment, most

participants reported that they did not experience it with their NB at the time of hospital birth, which resulted in emotional and psychological distress due to being separated from their babies and witnessing them undergo multiple unnecessary procedures.

> [...] I believed we had had prolonged skin-to-skin contact, but later I found out she stayed in my arms for five minutes, and then they took her away, took her to be weighed and measured, and then brought her back to me. So she stayed with me for five minutes, then for ten minutes she was taken away from me, and then she was placed back (on my lap). Later I realized that those ten minutes when she was taken away from me in those first moments were very impactful and very significant. (P2)

> [...] I feel like my first hour with my baby was stolen, they left the baby crying, alone in the nursery, for two and a half hours. He only came to my chest because the doula left my side and went to get him, he was crying so much that everyone could hear him. (P6)

> [...] so here's what I say: “Why wasn’t he brought to me?” He was fine, he didn’t need oxygen, he didn’t need anything. He went through all the routine interventions they do in hospitals, my husband was shocked watching it, because he followed everything, he even asked one of the staff if that was normal, because he wasn’t close, he was far away. (P7)

> [...] I just kept looking at the clock on the wall, I stayed there for an hour, one whole hour (participant emphasizes in an indignant tone), and my baby had only breastfed a little, so I kind of missed out on that hour… (pauses to reflect). (P8)

It was also observed that many NBs were not placed at their mothers’ breasts during the first hour of life and were not encouraged to breastfeed, often receiving infant formula instead. This practice of supplementing the babies’ diet with infant formula after birth was reported by participants, who stated that their babies were taken away by the staff for routine care and returned to the room already supplemented.

> [...] them giving formula, because we know it takes a while for the milk to come in, but colostrum is enough to feed the baby, so that was mainly why I chose not to give birth in the hospital (again). (P3)

> [...] they gave formula without my consent, and my breasts were like this (participant gestures as full with her hands), seriously, I had so much milk… I was like: "Why would you give formula to the baby?" For me, that was devastating. The baby is born, the woman is there with milk, why would they go and give that stuff to the baby? (P4)

Beyond the examples highlighted regarding interventions performed on NBs, many of these experiences served as motivations for women to choose PHB in a subsequent pregnancy. This choice reflects the desire to experience a more humanized birth, in which they could exercise their autonomy, protagonism, and trust in a team that respected their pace and decisions.

> [...] I think the main reason was to avoid interventions on my baby in the hospital. (P3)

> [...] I didn't want my daughter to go through all those interventions that I know my [first child] went through unnecessarily. (P7)

> [...] I didn't want to go through everything I went through in the hospital with my daughter, with my first daughter. (P8)

Finally, some participants reported that the perception of having experienced negative childbirth care in the hospital setting only became evident during the PHB experience, when the shortcomings and interventions that occurred in the hospital stood out in contrast to the practices experienced at home. In this context, a statement from P2 highlighted the respect for timing and the physiological processes during PHB, elements that were not respected in the healthcare institution where she was assisted during her previous pregnancy.

> [...] in my first labor, I believed it had been very humanized, that it had been respectful, but later I realized there were several flaws, several pseudo-humanized practices,

> attitudes that were not what I wanted for my child's birth (...) delayed cord clamping, which I thought: "Wow, it was respected and very delayed". They only waited for it to stop pulsating and then clamped it right away (...) the birth of my placenta in the first delivery was not gentle, it was not natural. My cord was pulled so that the placenta would come out. Even though everything turned out fine, I later found out that it was a procedure that carried a lot of risk and that it might not have gone well. (P2)

Thus, considering the aspects mentioned, numerous reports of unpleasant situations and unnecessary interventions performed on women and/or newborns were identified, in addition to accounts of various episodes of obstetric and neonatal violence. Therefore, it is important to discuss these findings in light of existing literature.

DISCUSSION

The analysis of participants' previous experiences with hospital vaginal births demonstrated a close relationship with the motivations for choosing PHB. In this same vein, all participants reported that their hospital experiences were motivating factors in choosing this mode of childbirth.

Furthermore, many interviewees mentioned aspects they would have liked in hospital birth that did not occur, in addition to raising several issues regarding the environment and differences between the hospital and their home. In this sense, it is important to highlight that the home environment has a positive impact on the childbirth experience, as the setting and the professionals assisting the birth are determining factors for a humanized process, ensuring respect, safety, and the sense of comfort that the home represents for women, as well as greater autonomy over their bodies and respect for the physiology of birth[11].

From this perspective, it was observed that participants developed barriers toward the hospital environment after their previous experiences, expressing negative feelings such as fear, panic, apprehension, and insecurity, especially when considering the possibility of experiencing another birth in that same context of care. In line with this, a recent international review, consistent with this study, showed that traumatic experiences in previous hospital births and the desire for a physiological birth are decisive factors leading many women to choose planned home birth[12].

Furthermore, it is important to emphasize that studies have shown that numerous interventions are used within the medicalized model, involving practices and procedures that distance women from the protagonism expected at this moment[13]. There is also evidence of professionals who discourage vaginal birth and contradict women's preferences expressed during prenatal care. Therefore, preparing pregnant women and seeking high-quality information are essential factors for ensuring confidence and informed decision-making in situations that may arise throughout prenatal care. In this context, access to reliable information emerges as a key resource to reduce the uncertainty surrounding pregnancy and childbirth, whether related to fear, insecurity, or perceived risk[14].

The process of seeking information not only reduces negative feelings but also helps transform emotional perceptions of childbirth, strengthening women's confidence in themselves and in their decisions throughout prenatal care[12-14]. Thus, the active pursuit of information functions as an empowerment strategy that reinforces professional recommendations, supports previously expressed preferences, and strengthens the understanding that childbirth can be a positive and safe experience, in contrast to the medicalized view that associates it with pain and suffering[14].

Among the unpleasant experiences reported by participants in this study, many situations were consistent with obstetric violence. Conceptually, this type of violence is characterized by acts committed in relation to women's sexual and reproductive health, carried out by healthcare professionals, public servants, technical-administrative staff of public and private institutions, or any other person who has contact with the woman before, during, or after the provision of healthcare services[14]. In this context, obstetric violence has been categorized in the Brazilian framework into several aspects, which may overlap, including physical, psychological, sexual, institutional, material, and media-related forms[15].

Some accounts also highlighted situations in which repeated vaginal examinations were performed and/or conducted by different professionals without the participants' consent, characterizing obstetric violence of a sexual nature[15]. Therefore, it is recommended that repetitive vaginal examinations, performed by different healthcare professionals either at the same time or at different moments, be avoided[16].

Other aspects mentioned in several interviews relate to the performance of episiotomy and episiorrhaphy, the former defined as a surgical incision made in the woman's perineum, including the skin, muscle, and vaginal mucosa, to enlarge the birth canal during the expulsive

phase, and the latter consisting of the suturing of the episiotomy[16]. In this context, if the woman is not consulted about these interventions or does not authorize them, this constitutes a violation of her rights as a form of obstetric violence of a sexual nature. Even in cases where authorization is given by the woman, such procedures are often unnecessary and should not be performed without proper justification[15].

Beyond these aspects, another classification of obstetric violence is psychological violence, related to cruel treatment of women, including verbal and discriminatory aggression, and even omission of information. Similarly, another study contextualizes that obstetric violence violates human rights in different ways, including other forms of humiliation such as socioeconomic and racial discrimination against parturients[18].

Furthermore, obstetric violence was also identified through the performance of the Kristeller maneuver (the act of applying pressure to the uterine fundus during labor or childbirth), an intervention that is still frequently performed and causes pain and discomfort to the parturient, as mentioned by one of the study participants, and is considered a form of physical violence. In addition, the use of this maneuver may negatively impact fetal vitality, as it disrupts uterine contractility and involves several risks, such as uterine rupture, perineal injuries, birth trauma, and risk of hemorrhage. Moreover, this maneuver may also lead to fetal or neonatal asphyxia and death[17].

In agreement, a study that analyzed maternal outcomes related to interventions during labor revealed that women who underwent the Kristeller maneuver during the expulsive phase had a ninefold increase in the likelihood of complications during childbirth compared to those who did not undergo the procedure[19]. These findings once again highlight the urgent need to review and reform hospital childbirth care practices, aiming to minimize risks and respect the rights of parturients, their safety, and their protagonism, as evidenced by the participants in this study.

Another important point mentioned by one of the participants concerns the Companion Law No. 11.108, enacted in 2005, which requires health services within the Unified Health System (SUS) to allow the presence of at least one companion chosen by the parturient during labor, childbirth, and the immediate postpartum period[20]. This represents an important legal milestone in Brazil aimed at improving care during the childbirth process and a major achievement in women’s and children’s health, as the presence of a partner or family member

during labor and postpartum tends to reduce the likelihood of obstetric violence and unnecessary interventions.

Likewise, high-quality perinatal education strengthens women and their support networks, promoting safer decision-making for the mother–baby dyad. In this way, the parturient is better able to intervene in outdated practices, such as the imposition of specific birth positions and other forms of violence that frequently occur within hospital institutions. In agreement, another study showed that access to scientific information increases women's sense of security during the gestational and childbirth periods, helping them understand their rights and make more informed decisions[21].

Restriction of fluid and food intake was also identified in the interviews, as many participants reported episodes in which healthcare professionals denied them food and liquids for several hours before and after childbirth, leaving them feeling distressed and uncomfortable. In contrast, although this restriction remains a common practice in many Brazilian maternity settings, the Ministry of Health recommends oral intake of fluids and food during labor for low-risk parturients, since with current techniques, rates of general anesthesia in obstetrics are very low and aspiration of gastric contents is a rare event[16]. Furthermore, other studies have shown that keeping parturients fasting during hospital labor contributes to a reduction in the likelihood of vaginal birth[19].

Other complaints mentioned refer to the immediate postpartum period, in which many parturients reported unpleasant situations, mainly related to disrespectful attitudes by healthcare professionals, which further hinder recovery and the overall childbirth experience in the hospital setting.

Another negative aspect observed in the hospital postpartum period concerns the numerous interventions performed on NBs, driven by pre-established routines of healthcare professionals and institutions. This was also highlighted in international studies that emphasize the negative effects of separation between mother and NB in the immediate postpartum period[22]. Even brief separations can generate maternal distress and insecurity, reinforcing the need for healthcare teams responsible for maternal and child care to act collaboratively, recognizing that such practices may lead to short- and long-term harm to the dyad[22]. International guidelines, such as those adopted in Sweden, explicitly recommend that care be provided without separating mother and baby. However, structural barriers and hospital

routines still perpetuate practices that distance the newborn from the mother, reducing essential opportunities for skin-to-skin contact and early breastfeeding[23].

From this perspective, the importance of the Golden Hour for bonding within the mother–baby dyad, the initiation of breastfeeding, and many other benefits for the newborn is highlighted, which can be ensured by delaying certain routine procedures, such as the physical examination. In the context studied, many participants did not experience the Golden Hour with their babies during hospital birth, which hindered several of these aspects. Similarly, a study that developed an assessment questionnaire on breastfeeding quality in neonates, observing proper latch, swallowing sounds, and other aspects, demonstrated the importance of skin-to-skin contact in the first hour of life. Babies and mothers who experienced the Golden Hour achieved higher scores on the questionnaire, a finding that also associates the Golden Hour with reduced neonatal and infant mortality rates[24].

Given the numerous unnecessary practices performed on the participants and/or their NBs during hospitalization, women felt motivated to avoid this setting in future childbirth experiences in order not to relive uncomfortable and/or violent situations. Thus, women who were aware of the possibility of being exposed again to unnecessary interventions and manipulations, both directed at themselves and their NBs, chose alternative ways of experiencing childbirth, opting for PHB.

It is also noteworthy that having previous hospital experiences enabled participants to identify errors and shortcomings in the care they had received, motivating them to establish priorities for subsequent births. In this sense, childbirth in the home setting represented, for these women, a new opportunity to experience the process as a physiological and humanized event, with active participation and genuine protagonism.

Finally, it is believed that this study made a significant contribution by demonstrating that previous negative experiences, unnecessary interventions, and obstetric and neonatal violence drove the choice of PHB, expanding the understanding of women’s desire for more respectful care centered on their preferences and needs. The study reinforces the importance of revisiting hospital practices and promotes discussion on the humanization of childbirth care. This study's limitation is the participants' memory bias, which may influence the completeness of the reported information.

CONCLUSION

In light of the results and analyses presented, it was found that the study participants carry many negative memories, traumas, and fears resulting from previous hospital childbirth experiences. These negative experiences were the main motivation for choosing PHB in subsequent pregnancies, due to the numerous interventions they underwent and reports of dissatisfaction with the care received in the hospital setting, directed not only at the woman but also at her newborn, characterizing situations of obstetric and neonatal violence.

Therefore, it can be concluded that the humanization of childbirth care has a significant impact on women's experiences and should be incorporated from prenatal care onward, including discussions about childbirth possibilities and available options, to ensure the highest possible quality of care for the mother–baby dyad. In this same context, the increasing demand for and choice of PHB reflects this scenario, in which women seek an experience in which they are protagonists and can make decisions in partnership with the professionals who assist them, within a context of safety and trust in the care team.

This study's results point to the need to strengthen the role of obstetric nurses at all levels of care, including in PHB assistance. The importance of woman-centered practices that value support, attentive listening, and respect for maternal choices is highlighted, contributing to the reduction of unnecessary interventions and situations of obstetric violence. It is also recommended to promote continuing education programs and ongoing training for nursing and other healthcare professionals, focused on the humanization of childbirth, empathetic communication, and ethical practice in addressing women's vulnerabilities.

Healthcare managers and policymakers must review institutional protocols that still support medicalized and interventionist models, encouraging the implementation of best obstetric practices and expanding access to woman-centered care. It is also suggested that topics such as the humanization of childbirth and obstetric violence be included in academic curricula and continuing health education.

Finally, the development of further research exploring maternal and neonatal outcomes across different childbirth models is recommended, contributing to strengthening the scientific evidence base that supports clinical and policy decisions aimed at promoting safer, more respectful, and humanized childbirth experiences.

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WOMEN'S MOTIVATIONS FOR PLANNED HOME BIRTHS FOLLOWING A VAGINAL HOSPITAL DELIVERY

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