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Social support network of Brazilian Amazonian women to subsidise the decision-making power of planned home birth: a qualitative study

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ABSTRACT

Objective To understand the social support network of Amazonian women when making decisions about planned home births.

Method Descriptive, exploratory, qualitative research.

Setting Planned home birth care, accompanied by obstetric nurses, in the state of Pará, Brazil.

Participants 20 women who had a planned home birth in the metropolitan region of the state of Pará, Brazil. These women were surveyed by a team of obstetric nurses working in home birth care. In-depth semistructured interviews were conducted at the women's homes between August 2021 and February 2022, with the audio captured on an mp3 device. The data were analysed at the same time as the data collection. Each interview was transcribed and content analysis was used to process the data.

Results The social support network shares experiences and knowledge between women in order to guarantee knowledge and not perpetuate traumatic episodes during childbirth. This network is a link to women's power of choice in relation to their own birth, which culminates in successful experiences in the birth process.

Final considerations Understanding the social support network for women's decision-making during planned home births is central to guaranteeing rights and expectations regarding the place of birth. Social support networks need to be expanded by non-governmental groups and by the Unified Health System itself, especially in primary healthcare.

Descriptors Women; home childbirth; social support; access to information and nursing.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ This study is the first to investigate home birth among Amazonian women, with its characteristics identified.
⇒ This study supports the description of women's social support network when making the decision to give birth at home.
⇒ The information obtained from the study participants may be subject to memory bias.
⇒ The limitation of the study was not using triangulation of methods, such as the technique of participant observation of home births.

INTRODUCTION

Childbirth is a unique moment in many women's lives. During this period, these women need a social support network to ensure that they can make informed, qualified and safe decisions. An effective support network helps to mobilise the decision-making power of the planned home birth experienced by these women. Thus, this network is a system structured by various social objects and guides an inter-relationship between individuals with a system of exchanges and reciprocities; it is a key element of interlocution such as emotional and instrumental support, whether intrafamilial or extrafamilial, or on the part of institutions and health professionals.[1 2] This relationship aims to guarantee all the knowledge that is capable of supporting the decision to have a home birth.

While the social support network is established in each individual's life, it constitutes systems of people or institutions aimed at social interaction, with the focus of meeting individual needs, with protective, emotional, financial and knowledge resources.[3] This network can also be established when overcoming crises, constituting a protective factor and also helping with possible decisions.

Currently, social support must be established in this relationship, providing protection to instrumentalise women's decision-making, promoting stability in the face of crises (seeking support to decide) and producing self-esteem and emotional stability.[2 4] These connections between women and other people, whether intrafamilial or extrafamilial, effectively contribute to supporting women in their decision-making power for planned home births.

Historically, the hospital has been synonymous with safety for the health of women and newborns. However, in many cases, the high number of interventions such as episiotomy, Kristeller's manoeuvre, amniotomy and elective caesarean section[5–7] has demonstrated (in) safety during the birth process in the context of Brazilian public health.

In this way, planned home birth, when assisted by qualified professionals such as obstetric nurses, obstetricians and midwives, is an alternative and a process of escape from experiencing interventions that are currently considered unnecessary during institutional care.

In Brazil, the demand for home births has been growing. However, universality and equity, which are guidelines of the Brazilian Unified Health System (SUS), are far from being realised,[8] as is the guarantee of their right to a successful birth and to professionals who base their conduct and guidance on up-to-date scientific evidence. It is, therefore, necessary to break away from the hegemonic model of obstetric care, transforming settings such as the home environment for low-risk women. This can be transformed into a social support network for obstetric health and guarantee decision-making for women. It will demystify all the aspects surrounding planned home births, such as their safety, thus contributing to a drastic reduction in obstetric interventions and obstetric violence, which has become increasingly common in obstetric care.[5]

The safety of home births[9–14] and the support of professional and non-governmental organisations, as well as the WHO, express the real need for support for women,[9] in order to guarantee informed decision-making about planned home births. Home births assisted by trained professionals for women at low obstetric risk are as safe as hospital births, and this has already been demonstrated in specialised literature.[10–14] The safety of home births shows that there are no differences between fetal and early neonatal death, risk of haemorrhage and maternal mortality in relation to the place of birth. It also shows that home birth has a lower risk of obstetric interventions, such as episiotomy, severe lacerations and caesarean section or instrumental delivery.[5 7–14] Thus, the social support network is a foundation for women to consciously and safely establish their decision-making power when they are provided with support for this decision with a home birth assisted by professionals trained to assist women at low obstetric risk.

In this context, there is a need for as much of a social support network for these Amazonian women, which also takes the form of promoting public policies to guarantee women's decision-making in home births.[15] Because the high cost is a major barrier to childbirth, given that there is no recommendation in the country for planned home births in both the private and public healthcare spheres, as the Ministry of Health has established that hospitals are the safest place for childbirth. Because of these many issues, women do not have a social support network, which can also be financial, to subsidise the planned home birth if the woman decides to do so.

This interlocution of knowledge by the social support network in obstetric health allows an exchange with their support network of women, where they show their experience of home birth, and this knowledge and connections between these women become effective for decision-making for the planned home birth. Based on this argument, the study had the following guiding question: What is the dimension of the social support network of Amazonian women for home birth decision-making?

The study of planned home births in the Amazon context is the first with this panorama[8 13 16] in the different realities of the Brazilian context. Home births in the Amazon region are cultural, especially in places with limited infrastructure, which often have a traditional midwife, whether in communities with traditional populations such as riverside dwellers, quilombolas or indigenous peoples. Culturally, childbirth is provided with maternal care for these women and the research, which took place in urban centres in the region, has better conditions for health system services and infrastructure. The study's object of investigation is to observe this type of birth and also how information relates to the power of choice for Amazonian women.

The social support network of Amazonian parturients and women is made up of the women themselves, who are central figures in this sharing of childbirth. In this way, the relationship between Amazonian women and home birth is perennial, and therefore, being established in their history and social context, their network is established in care and sharing knowledge.

The aim of the study was to understand the social support network of Amazonian women when making decisions about planned home births.

METHODS

Study design

This was a descriptive, exploratory, qualitative study, guided by the Consolidated criteria for Reporting Qualitative research (COREQ).[17] This research approach was established to guide the experience of social support for women's decision-making in home birth. The COREQ report is available in online supplemental material III.[18] The study involved 20 women who had a planned home birth in the Amazon region, state of Pará, Brazil.

Study setting and study participants

First, a search was made for health professionals who provided planned home birth care in the region, and the Naiá Parto Domiciliar Obstetric Nursing team was found to be the only team providing home birth care. Thus, the

home births of the women taking part in this study were attended by obstetric nurses, who are technical professionals, trained and specialised in planned home births.

It is important to mention that in the state of Pará-Brazil, during the period in which this study was carried out, only obstetric nurses were providing home birth care. Professionals such as obstetricians, midwives and obstetricians were not involved in this type of care.

It is worth noting that in Brazil, the professional practice of nurses, obstetricians and midwives is regulated by Law No. 7.498/1986.[19] At the moment, traditional midwives, professionals with no technical or specialised training, work in communities with difficult access to health professionals. An obstetrician is a professional with a degree in obstetrics, who exclusively provides care for the pregnancy-puerperal cycle. The obstetric nurse, on the other hand, is a health professional with a degree in nursing, who needs a specialisation course in obstetric nursing to work during labour, birth and the puerperium. In terms of level of care, the professionals mentioned are qualified to assist women during the reproductive period, including the performance of low-risk normal childbirth.

Through contact with the obstetric nurses, the women's emails and telephone contacts were made available.

After the respective contacts were passed on, an initial invitation was sent via WhatsApp to each potential participant, following the eligibility criteria: participants over 18 years of age; planned home birth in the metropolitan region of the state of Pará (northern region of Brazil) between 2020 and 2022; not transferred to a hospital unit. Women who had an intercurrence during the period of home birth care were excluded, characterising discontinuity of the care process. It should be noted that no participants refused to take part in the research.

A pilot study was carried out with three women who were not actual participants in the data, in order to evaluate the instrument and make possible adjustments, which did not need to be made.

A total of 30 invitations were sent out and 20 participants returned them. Data collection ended at theoretical saturation when there was a similarity of meanings as the data collection techniques were carried out, thus ending the collection.

Data collection procedure

The participants who responded were scheduled for data collection. The instrument used was an individual, face-to-face semistructured interview, which took place at a location of the woman's choice, in most cases, her home environment. This instrument was developed by the researchers specifically for use in this study, finalising the data collection techniques. There was no initial relationship prior to the data collection stage, which only began on the day of the scheduled interview.

The interviews took place only in the presence of the interviewer and the participant, without the presence of third parties, guaranteeing privacy in each interview. Before the data were collected, the participants were asked to sign an informed consent form, which guarantees their right to anonymity, using an alphanumeric code, P (participant), followed by a numeral, according to the order in which the interviews were carried out (P_1, P_2, P_3, …, P_{20}).

In the interviews, the woman was approached with data on her age, marital status, ethnicity, level of schooling, family income, type of home, number of births, desired/unwanted pregnancies, the place of birth of her mother and her birth, and the occurrence of transfer to a hospital unit. Once these data had been collected, the following questions were asked: Tell us about the support you received for your planned home birth? What was your home birth support network like? Did your support network help you with your decision? Tell us about this process? What was the decision to have a home birth like for you? The research terms are provided in online supplemental material IV,[18] as is the interview script used. No field notes were taken during the interviews.

Each interview lasted an average of 120 min and took place between August 2021 and February 2022. This process used Mp3 recording, which was authorised by the participants, which was submitted to full transcription and later data processing. After data collection, the participants were sent a transcript of the material for validation and feedback on their statements, in accordance with COREQ guidelines.

It should be noted that the researcher who collected the data was female, had no conflict of interest and had no personal or professional acquaintance with the team of obstetric nurses and the women taking part. The participants were aware of the reasons for carrying out the research, which was explained to them during the recruitment process.

At the time of data collection, the researcher had specialist training and an ongoing master's degree in nursing as her credentials, as well as being a postgraduate nursing student. She obtained training from professors with doctoral degrees, who are part of the research team, to carry out the data collection instruments, as well as previous experience in studies carried out using research instruments.

Patient and public involvement

Patients or the public were not involved in the design, or conduct, or reporting, or dissemination plans of our research.

Data analysis

The data were processed using content analysis.[20] The analysis takes place in three distinct moments: (1) preanalysis, with the organisation of the transcribed material and floating and exhaustive reading to formulate either hypotheses or objectives with the scientific literature, with knowledge of the material; (2) exploration of the material and treatment of the results, coding and categorisation, with the cutting out of the units of meaning, arising from the frequency of repetition of meanings, through

the following units of records: influence of other women; participation in women's/childbirth and birth groups; restriction of information on the choice of planned home birth; orientation and knowledge about the team of obstetric nurses; assertiveness, reliability, safety and preparation of this team and (3) inference and interpretation, the last stage of the analytical process, which constitutes the interpretation of the results, based on inference and the support of constructive elements for the units of meaning.[20]

This analysis allowed for non-aprioristic categorisation, which resulted in the following unit of meaning: Support and information for home birth, which formed the basis of two categories: (1) social support network underpinning women's decision-making for planned home birth and (2) social support network for women's decision-making for planned home birth.

It should be noted that the study did not use software to support data analysis but was carried out manually by the research team. The themes were identified not through software coding, but through the process of identifying the themes by colourimetry, which allows the themes to be identified by creating a legend with the assimilation of colour, thus following the entire process, with the creation of registration units and their codes, following the stages of the analytical process of content analysis.

It should be noted that the authors did not include their professional experiences and possible motivations in the interpretation of the study data. They were only responsible for structuring the research, applying the data collection and analysis technique, describing and interpreting the results from a theoretical point of view. The analysis used the conceptual dimension of the social support network to support the discussion of the results and studies of planned home births, public policies in Brazil and international recommendations.

RESULTS

Regarding the characterisation of the twenty Amazonian women, there was a predominance of participants aged between 30 and 40, with a marital status of married or in a stable union. They were of brown ethnicity, had completed higher education, had a family income of between 4 and 10 minimum wages in Brazil (R$1412.00) and owned their own home, making them middle and upper-middle class in the country.

As for the number of births, there was a predominance of primiparous women, with planned and desired pregnancies. The participants in this study gave birth at home, assisted by obstetric nurses. They were not transferred and did not have any complications, participating fully in home birth care.

Social network support underpinning women's decision-making for planned home births

Amazonian women have a social support network to influence their choice of planned home birth—the experiences of other women who have given birth at home. This social support from woman to woman provides important emotional support for the shared experiences of planned home birth, supporting the decision to have a home birth. These experiences of a positive birth in the Amazon region guarantee women's right to information for their home birth experience.

> But I talked to this friend of mine who had a baby and she told me about it, she told me about the nurses she met, she told me about her delivery. A normal birth, she had it at home too. And she told me about the nurses and everything, but the point that made her decide to have a home birth. She said: if you can, go for a normal birth, but we didn't know how it would be, if it would be at home, but she said: go for a normal birth. So, I went to the nurses, my first contact, and it was essential. (P2)

> We did a lot of research, then I already had people very close to me, friends who had had home births and they recommended the team, the people I could talk to in order to get it done. (P9)

> This started after I was sure it would be safe, because our [couple's] biggest concern is this: to look for quality information from someone who will give you quality information. So I thought: why not home-based? Then I opened my mind to this and started researching more, and I chose to have it at home. (P10)

> But the support we had from the team of nurses was very reassuring and, without a doubt, guaranteed 100% peace of mind and safety. We knew that they were very competent and that they would be there for anything that might happen, they passed on all the information and I felt safe to have my home birth. (P18)

The meeting with the social network of Amazonian women is an important strategy for social support, with the dissemination of exchanges of experiences and knowledge that contributed to the decision to have a planned home birth. These exchanges of knowledge constitute a constant movement of links and relationships with other women, in order to guarantee the (de)mythification of home birth.

> At some meetings here in Belém of the women's group I had, I met the girls, I met a colleague, I met the girls and we would exchange our experiences. And at that time, it wasn't a very strong movement, it was still at the beginning of the group, but we were sure that, after a while, I began to be sure that home birth was the best choice for my son. (P1)

> Oh, all the women in the women's group, for example, were a group that helped a lot and it was basically them. My partner was a bit hesitant, he didn't really believe me, my ex partner, my mother too, my family was a bit indecisive, but I went anyway. It was basically women who supported me. (P20)

Previous negative experiences of childbirth, with traumatic experiences for Amazonian women, encouraged the participants to use their social support network to make the decision to give birth at home. This is a way for them not to experience the same traumas and to change the way women look at birth, especially with regard to unnecessary childbirth interventions, disrespect and obstetric violence.

> I was always very afraid and it didn't work out, so I ended up giving birth in a hospital, my first birth. And the birth of my first son was very bad, I suffered obstetric violence, the nurse pushed my belly to get him out, I had an episiotomy, I had all the right stuff, I was very, very ill after he was born. With my second child and the others, I said I wasn't going to do it anymore, so I chose to give birth at home so I wouldn't be disrespected. I had it at home so I wouldn't be raped. (P11)

> Regarding my son's first doctor, I decided not to keep him because, during labor, he denied the touch twice and, on those two occasions, he did the touch, and also ordered me to stay in a chest-up position. I didn't want that position because it hurt too much and he did something on my cervix that ended up tearing my cervix! So, I decided I wouldn't be him and I'd have my son in other circumstances, outside the hospital. (P17)

In this way, the social support network is a central point for the support of Amazonian women and its positive influence on the decision to have a home birth.

The social support network for women's decision to have a planned home birth

The initiative of Amazonian women themselves and other women to seek out information about home birth was a continuous and crucial process that made it possible to guarantee the decision to have a planned home birth.

> We organized and prepared for this birth, I read a lot, I took part in online forums, in short, I did a lot of mental preparation so that I could really live. It was a birth, even though the pregnancy had been planned and I couldn't afford it, but I planned this birth, I sought out all kinds of information, of my own volition and that of my colleagues in the group. I really worked hard to make it work. (P6)

> And it was such an overwhelming experience that I started looking for knowledge about it, even more than I had done as a pregnant woman, because I was doing my master's degree at the time, I lived in Recife, so I started researching scientific articles in depth. I became very attached to evidence-based medicine, which is now very much on the agenda, with the recent history of obstetrics, and this was great and when shared by others, it helped a lot. (P19)

The social support network through the media, such as films, specialised websites, women's blogs, social networks such as Facebook and Instagram, was important strategies for disseminating knowledge and for discussing home birth and pregnancy itself, providing a link for Amazonian women when it came to making the decision to have a planned home birth.

> So, I didn't really look. I used to look more in specific places, like blogs and the internet, on the websites of researchers in the field, just to get more qualified information and not just guess, my child. (P4)

> I watched the video, I watched that documentary Rebirth of Childbirth, it was something that influenced the decision, it strengthened the decision to have a normal birth and also the issue of home birth, it opened up the idea of home birth. (P8)

> I had already seen some reports on the subject and I saw her [colleague] post something about [the Internet]. That's when I got in touch with my colleague on the network, saying that I'd seen it, I wanted to know a bit more and that's when she [friend on the network] started to explain how it worked, her experience. It grew and grew and I looked for more and more information. It was studying, looking for some articles, a few that I found talking about it, videos about it, and then they helped me with books, with reports of humanized births, both at home and in hospital. As far as information was concerned, it was really through reports, videos and books, and it was really the team that guided me in relation to books and some articles that I read looking for, that I don't even know I still have, that talked a bit about it. But my main focus was the videos themselves, looking for people who had done it, what it was like, and that was it. (P9)

The social support network of women, with the recommendation of a specialised team of obstetric nurses, who provide qualified support throughout the prenatal process, based on scientific evidence. This constitutes a valuable support network for Amazonian women when it comes to making decisions and experiencing a planned home birth. This support from the nurse throughout prenatal care represents an important step for women as a way of guaranteeing their rights to home birth, accessed by seeking out teams for the home birth process.

> My husband and I aren't ones to make decisions without thinking about the risks and everything else. So, we thought about all the issues and the nurses who accompanied us were also very concerned, they surrounded us with all the care and information, which gave us a lot of security, a lot. Otherwise, I wouldn't have embarked. Which was totally different to my first birth. Their support and the information were essential to my choice. (P2)

> So, meeting the nurses, having the information they [the nurses] passed on at that moment, was a watershed, that's when I met them. So I got a lot of reciprocity from the nurses, even though we hadn't planned to have a home birth. Was there a possibility?

Yes, because I'd had a series of follow-ups during my pregnancy that made it possible to have a home birth. (P7)

The social support network by different means is one of the strategies to help guarantee decision-making and their rights as Amazonian women in planned home births.

DISCUSSION

On the road to the right to a planned home birth, the social support network in the field of health is a milestone for the appropriation of healthcare, especially obstetric care. This network constitutes an interlocution with the sharing of various forms of knowledge between people, family members and Amazonian women, either individually or collectively, and this exchange gives women the opportunity to make decisions, either by sharing the positive experience of home birth or the traumatic experience of hospital care.[1 2 8 21] The network is a combination of social knowledge exchange to provide information and empower women's decision-making, empowering women who decide how to give birth and how they want to go through childbirth. In this way, the socialisation and sharing of these successful experiences through the social support network becomes valuable and brings a sense of reality closer to these women, as well as confirming the safety and professionalism involved in the process of carrying out a home birth.

The empowerment of Amazonian women is a process that goes through their social support network, which gives them the self-confidence to make decisions and control over their lives, such as psychological, biological, social, financial and political.[22] In this sense, this network is a milestone for the empowerment of Amazonian women to make sexual and reproductive health decisions, since the Brazilian historical context has always been one of curtailment of women's autonomy and rights, and this social support allows these women to make decisions.

Recognising women's knowledge when it comes to making decisions is the driving force behind organising the right to their bodies. The social support network in obstetric health is based on values related to the emotional and bodily experiences of birth, evoking and deepening the meanings that these experiences represent for each woman.[23] In this transmutation of knowledge, possibilities are enhanced and built that guarantee rights based on social support as a safe source mechanism. It also includes women seeking professional information and (re)knowledge of the team of obstetric nurses working in the region as a potential foundation for guaranteeing choice. Information is made available so that each woman is given the opportunity to choose.

The Health Care and Clinical Excellence guideline states that it is important for women to receive the information they need when deciding where to have their baby, so that they can make a fully informed decision, in other words, social support is an important guideline for guaranteeing decision-making. In this network, the provision of information on the rates of interventions, transfer and perinatal outcomes of home birth and possible risks are important points for the empowerment of Amazonian women and for informed decision-making. This is especially the case given the high level of schooling of these women, as seen in other studies, which enables them to make decisions.[5 8 12 15] There is a gap in the social support network for women's decision-making regarding the place of delivery.[24] In addition to this social support, the search for professional information should be based on scientific recommendations and care data, in order to support women's decision-making, as determined by the scientific literature.[23–25]

The exchange of knowledge in this social support network from woman to woman also reveals the vulnerability interpreted from the care provided in hospital units, which, because they belong to an institutional culture, represent obstacles to connecting with one's own body during the labour and birth process. In this way, the hospital is synonymous with a place that is interventionist, patriarchal and based on the hegemonic model of obstetrics, which does not take into account the particularities of women, with their needs, be they personal, social or cultural during childbirth.[23] There is a narrative of the risk of childbirth, which means that birth must take place in hospital units and with the presence of a medical professional, showing that home birth is not a safe way to give birth. This fact contributes significantly to blaming women in the event of any complications, with the aim of restricting their decision-making.[26]

The consequences of these disconnections are violations of women's rights that emerge in narratives of previous negative experiences, whether their own or those of others. In this sharing of knowledge and the transmutation of knowledge between women, there are not only narratives of successful home birth experiences but also of violations, power relations, cohesion and violence that are conditioning factors for the decline of giving birth in hospitals. The literature[4 5 27] corroborates the claim that the hospital becomes a space of fear, especially because of the caesarean section, obstetric interventions and violence. This social support network pushes women to resist the hegemonic model and to seek out information that provides a link of trust for their empowerment and decision-making regarding the place of birth.

In a study,[28] it was shown that only 9% of women choose home birth, and they do so due to a previous traumatic hospital experience, motivated by negative childbirth experiences or apprehension with the conventional maternity care model. In this way, the social support network perpetuates its sharing and enables a flight by Amazonian women from experiencing traumatic childbirth and the hegemonic model of obstetrics. For, many times, this experience involves routine interventions and a widespread lack of respect for women's autonomy and decision-making, nullifying their desires and rights.

Despite the advances in the field of childbirth and delivery, which include the contribution of scientific

knowledge, the topic of planned home birth requires greater dissemination of knowledge. Indeed, there is a gap in the scientific production of home birth and the social support network in the field of decision-making. Home childbirth needs guidelines/regulation in the Brazilian healthcare system, especially regarding the confrontation between professional classes in search of fields of activity and market.[8] In the quest for knowledge about planned home birth, there is an association with the initiative of the women themselves, as observed in studies[23 24 26–29] since women tend to seek the necessary knowledge to support their own decision-making through various sources of information, such as scientific events, articles, books, the internet, films and interactions with healthcare professionals. This social support is relevant in ensuring an informed decision. This means of information needs to be further explored on how it enables, based on its content, women's decision-making in light of the information conveyed through the internet. However, the provision of scientific channels by nurses positively contributes to women's decision-making.

In this context, the popularisation of the internet has enhanced the search for information through specialised websites, articles and events, a fact that facilitates access to a greater quantity of qualified information, an essential variable for informed decision-making.[8] In addition to the support of qualified professionals crucial for directing and refining information, there is a construction of knowledge through a social support network propagated by the internet, with continuous development of information means to subsidise the decision-making of Amazonian women in planned home births. Well, as information is provided, there is greater self-confidence to be aware of the determination of the birth location. In this way, the internet constitutes a social support network for women to filter the information received and establish the timely knowledge for the decision of home birth.

The media, particularly the internet, provide a large volume of information that can quickly and globally put women in conflict with interests and needs. And with the dissemination of groups and social networks, such as Instagram and Facebook, it contributed to the mobilisation of policies and innovative information among individuals, taking on an important role in health education for childbirth and birth, and therefore, for the autonomy and empowerment of users and professionals.[30]

A study[31] demonstrated that internal motivation is a key element in the decision-making process for planned home births. Highlighting, furthermore, that in planned home births, psychological and emotional issues are also particularly important factors, as well as the relationship with the midwife/obstetric nurse, who, by providing care to women, enhances successful experiences in meeting birth expectations, representing greater satisfaction for Amazonian women. But, which was only achieved through the search for information as a form of knowledge and exchange of experience with the social support network, with information about professionals for planned home births. The social support network for home birth is a foundation for the guarantee of their rights and empowerment.

The study was limited by the research technique employed, as the researchers did not participate in the home births reported by the women, and other techniques such as observation and field diary were not used for records on home births. Moreover, the restricted and localised sample of participants does not allow for the generalisation of the results of this study.

Final considerations

The study provides support for social support as an articulator for women's decision-making in planned home births. Where there is a need for political articulation to guarantee an equitable choice of home birth for Brazilian women, especially in the northern region of Brazil.

The need for new studies that investigate and delve deeper into home childbirth is highlighted, especially in the northern region of the country, due to a real limitation of studies in this region and a concentration of investigations in the southern and southeastern regions. Thus, studies on the social support network and information through channels such as the internet in obstetric health, which are articulated for the decision-making of planned home births, and thus subsidise policies and guidelines for the maternal and child care network in Brazil.

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