



## PLANNED HOME BIRTH ASSISTED BY A MIDWIFE NURSE: MEANINGS, EXPERIENCES AND MOTIVATION FOR THIS CHOICE<sup>1</sup>

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### ABSTRACT

**Objective:** to understand the meanings and experiences of women who dealt with planned home birth assisted by a nurse midwife and the motivation (of these women) for this choice. **Methodology:** qualitative, exploratory and descriptive study, with 16 women, performed by means of semi-structured interviews and analyzed by the assumptions of thematic content analysis. **Results:** the women experienced childbirth with tranquility, autonomy and respect, and they chose the positions and people of their preference. Childbirth had a meaning of victory and liberation, whose experience was described as unforgettable, fantastic, intense and carried out by the woman. The dissatisfaction with the current model of care, the participation in a group for pregnant women, the access to information and the experience of previous obstetric violence motivated women to choose home birth. **Final considerations:** the women's experiences converge towards the exercise of autonomy and respect for individuality. The leading role of women who experienced a natural birth and free of interventions, should be highlighted. Obstetric care was focused on the parturient woman's needs, provided confidence, security, tranquility and respect for her choices. There is a need to expand childbirth care provided by nurse midwives to women who wish to have a planned home birth. Public policies for childbirth care can make this possible.

**Palavras-chave:** Nurse Midwives. Obstetric Nursing. Home Childbirth. Natural Childbirth. Humanizing Delivery.

### INTRODUCTION

Pregnancy and childbirth should be a period with positive experiences for the woman and her family. Nevertheless, it has been a risky and frightening event for some, generating dissatisfaction with the current childbirth care. This has generated a reevaluation of the birthing process as a physiological and feminine event<sup>(1)</sup>.

In former times, childbirth care was held by midwives in the home environment. They were known in society for their experience, although they did not master scientific knowledge. From the XX century on, there was an intensification of hospitalization and medicalization of childbirth in order to standardize care and reduce maternal and child mortality. Consequently, there was a loss of women's autonomy in the birthing process<sup>(2)</sup>.

The transfer of childbirth from the home to

the hospital environment was accompanied by a series of transformations. The woman and the baby assumed a passive position and lost their leading roles. Health professionals started to take control over birth, carrying out a series of interventions and changing obstetric practices<sup>(3)</sup>. Faced with this reality, giving birth at home represents the dissatisfaction of pregnant women with the hospital obstetric practice, whose care takes place in a fragmented manner. Simultaneously, it is considered a choice based on the critical analysis of information about home birth<sup>(4)</sup>.

The desire for a less interventionist delivery, the lack of autonomy and the fear of not being able to take control of the labor give rise to the need for women to seek strategies to experience childbirth in a more humane way and with the possibility of shared choices, such as planned home birth (PHB)<sup>(3)</sup>.

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The Brazilian Ministry of Health, considering the need for changes in childbirth care, has been encouraging natural childbirth since 1990, especially by stimulating deliveries conducted by nurse midwives (NM), regardless of the choice of delivery site<sup>(5)</sup>. The valorization of births conducted by NM aims to minimize the use of resources and encourage the use of soft technologies in public health<sup>(6)</sup>.

The participation of NM in childbirth enables the humanization of care and the preservation of women's autonomy at the time of delivery, can contribute to the reduction of maternal morbidity and mortality, besides ensuring a safe birth through the technical skills of these professionals and the inclusion of practices based on scientific evidence, recommended by the World Health Organization (WHO)<sup>(7)</sup>.

In Brazil, the resumption of the practice of home births has occurred by choice of women in search of obstetric care focused on their needs. From the moment the health team offers the woman information, she becomes autonomous and a key actor in the birthing process, seeing childbirth not only as a natural and physiological process, but also conscious, and chooses to give birth in the most natural way possible<sup>(4)</sup>.

The dissemination of information based on scientific evidence, which aims to humanize labor and raise awareness about natural childbirth, contributes to the choice of PHB<sup>(3)</sup>. Nevertheless, in Brazil, there is an idea shared by some health professionals that home birth, even if planned, is associated with a higher risk of negative outcomes when compared to hospital birth<sup>(2)</sup>.

PHB is an internationally recognized delivery model<sup>(8)</sup>. However, it is not a service offered by the Brazilian public health system. Women who want this type of birth need to look for private teams that offer it<sup>(9)</sup>. In Sweden, approximately one in every thousand women have a planned home birth, and about ten times more women would choose home birth if it were an option in the health system<sup>(10)</sup>. In this sense, it is asked: What are the motivations that lead women to hire this private service in Brazil? What are the meanings and how was the experience of women who have dealt with a PHB assisted by NM?

The article aimed to understand the meanings and experiences of women who have dealt with

a PHB assisted by NM and the motivation (of these women) for this choice.

## METHODOLOGY

This is a descriptive and exploratory study, with a qualitative approach, developed with 16 women who dealt with a PHB, assisted by NM, selected by convenience. Inclusion criteria were women who had experienced labor and delivery at home, assisted by NM from the *Manjedoura team*, in the period from August 2014 to August 2016, aged 18 years or older and living in the city of Cascavel, PR. Of the 20 women indicated by the team, according to inclusion criteria, four were excluded. Of these, two were not living in the city during the study period and two declined to participate in the study.

The interviews lasted an average of 30 minutes each and were guided by a semi-structured questionnaire, initiated with the following guiding questions: comment on your motivation for choosing a PHB assisted by NM; talk about your experience when dealing with PHB assisted by NM; what are the meanings you attribute to the experience of undergoing a PHB assisted by NM? During the interviews, new questions were made to deepen the data, as well as field notes. A digital voice recording was carried out, with manual transcription in its entirety, whose content was forwarded by e-mail to the participants for reading and approval. All of them read and approved. Data collection took place at the participants' homes, without the presence of other people, in the period from June to August 2016. The phenomenon of theoretical saturation allowed us to close the data collection.

The data were analyzed using Minayo's thematic content analysis<sup>(11)</sup>. In the pre-analysis, a floating and comprehensive reading of the interviews was performed, followed by a strenuous reading to organize the thematic units. In the material exploration, the contents of the thematic units were aggregated to compose the thematic categories that would command the analysis. In the step related to the treatment and interpretation of results, the obtained information was brought into sharp relief to check the agreement of the thematic categories.

The research was developed by an

undergraduate nursing student, under faculty guidance, supported by members of the Research Group on Maternal and Child Nursing, in accordance with the guidelines and regulatory standards involving human beings, with a favorable opinion from the Research Ethics Committee of the Western Paraná State University, under nº 1.530.010, and complied with the recommendations of the *Consolidated Criteria for Reporting Qualitative Research (COREQ)*. The Free and Informed Consent Form was read and signed by the participants. In order to ensure anonymity, they were identified with the letter P, followed by an ordinal number in the order of the interview.

## RESULTS

Of the study participants, 50% (8) were between 25 and 29 years old, 31% (5) between 30 and 34 years old, 13% (2) between 20 and 24 years old, and 6% (1) aged 35 years or older. All of them considered themselves white. Regarding marital status, 88% (14) were married, 6% (1) were in a stable union and 6% (1) were single. As for education, 81% (13) have completed higher education and 19% (3) have not completed higher education. With respect to income, 56% (9) had family income higher than five minimum wages, 25% (4) had income between 1 and 3, and 19% (3) between 3 and 5. The description of the thematic categories can be seen below.

### Motivations for planned home birth

The participation in a support group for pregnant women and active birth, called *Gesta Cascavel*, and the access to information on the internet, such as consultation of scientific articles, birth reports, movies and videos of childbirth, motivated woman to choose a PHB.

I began to take part in the Gesta Cascavel. There, we sought support, we met the doula who accompanied us, the nurses [...] (P16).

I began to research, see indices [...] the rates, mortality rate [...] it is practically lower than inside the hospital [...] I began to see it on websites, articles (P1).

I read about the difference among a cesarean in the hospital, a normal birth in the hospital and a

home birth. Then, I found the best option for me (P10).

The previous experience of obstetric violence, the dissatisfaction with the current model of childbirth care and the non-valuation of the woman's desire for a normal birth by some obstetricians, who lead the woman to a cesarean section, were also conditions that motivated PHB.

I wanted to escape the system. [...] This excess of interference during delivery (P5).

In the hospital, maybe I had to undergo interventions I didn't want (P11).

I already had the first normal hospital birth [...] the way it was assisted, it did not respect my individuality [...] several interventions were made there (P15).

The obstetrician said I would not be able to have a normal delivery, at 39 weeks, he said I wouldn't have dilation, and he wanted to schedule a cesarean (P4).

The home environment was considered by the participants as safe, comfortable and tranquil. The women's desire was for the delivery to be by means of vaginal route, natural, determined by human physiology, in a humanized way, for a better evolution of the birth.

I felt much safer at home (P5).

At home, it would be more comfortable for me. I think it'd evolve better (P16).

At home, you have tranquility to wait for the moment without being in a hurry (P15).

I wanted to give birth as naturally as possible (P12).

Because he was born and came straight to my lap, because he was able to suckle at the first moment, because his father could wait for the umbilical cord to stop pulsating and cut it (P7).

### Family participation in the choice of home birth and in the birthing process

When sharing the choice of PHB, some family members supported and/or respected the choice, but others considered it an irresponsible choice. In order to avoid others' comments and opinions, some couples chose not to share their resolution, keeping their choice of PHB a secret.

I told my mother and his mother (husband). As I had already had a quiet normal birth [...], they respected our decision (P15).

My mother, father and siblings [...] commented that they think it's crazy (P13).

My husband and I decided that we weren't going to tell anyone, that it was our decision, that it was our responsibility (P4).

The home environment allowed the woman to be accompanied by more than one family member, including other children. The presence of people of the woman's choice allowed for a pleasant, tranquil and relaxed environment.

Being at home, being in our environment, being with my mother and my husband. We laughed, played, talked, joked, relaxed a lot [...] I was with the people close to you at that moment, it was very important for me (P3).

Everyone was quiet, my husband with me, my daughters with me, everything was silent, little lighting, no one asking me to do anything. When she was born, she came to my lap [...] it was a celebration for us (P15).

From the women's point of view, their partners had active participation and were involved in the birthing process. They supported them, gave massages, participated in the birth, had contact with the newborn and were able to cut the umbilical cord. In addition to participating in the birthing process, they offered security and emotional support.

He [husband] helped count the contractions [...] supporting, helping, giving massage [...] I can't imagine what birth would be like without him (P1).

During labor, he had a very active participation [...] he who received the baby at birth, he wanted to take it, took it, and cut the cord (P6).

The husband's participation in childbirth is important, because he is in the background in a hospital. But not at home, even with the nurses, all around, he can play a leading role (P4).

### Experiences and meanings of planned home birth

The women were oriented about the signs and symptoms of the beginning of labor, as well as about the phases of this process. Accordingly,

they were able to deal with labor and delivery with tranquility, autonomy and respect for their individuality.

I had breakfast and listened [...] go to the shower, go to the birthing ball, rest. [...] I had a snack, sang, we laughed, joked, played a little (P3).

There comes a time when you have to be naked, when you don't care about anything else. [...] you don't even know if you've been there for half an hour or two (P13).

Women were able to choose their preferred positions during labor and/or received suggestions from NM or *doula* to change them when necessary. The choice of birthing position and delivery site was made by the woman, with the most frequent births being: squatting, on four supports, in the water, lying on the bed and on the birthing stool.

I squatted down, and that's where she started being born (P2).

My birth was in the water. He was born in the water (P7).

It was on the bed, on all fours, supported by a Pilates ball (P14).

The experience of pain sensation was unique for each woman, being perceived as intense by all, but with different degrees of pain perception. They considered the pain experienced in normal childbirth as expected and natural.

I felt pain with reason, I had a reason. It was my daughter being born [...] it was important for her to go through that, it was important for me to go through that (P8).

As for the pain of childbirth, I really see that it is a pain, yes, but it is a pain that is bringing my child, and then I face it in a different way (P9).

Comparisons were made between home and hospital. In the hospital, the woman could not exercise autonomy and freedom as at home, because institutional norms, routines and protocols are prevalent:

Maybe, within the hospital, I didn't have that tranquility, that autonomy. Staying at home gave me autonomy for things to happen as planned (P11).

In my home [...] I don't need to obey the rules of an institution. I'm no longer one who complies with a hospital protocol [...]. Thus, no one

intervenes in a process that is so mine, so particular, so individual (P15).

For the surveyed women, childbirth had a meaning of victory and liberation, whose experience was described as unforgettable, fantastic and intense, as they had hoped and/or dreamed of. The testimonials highlighted the leading role of the woman and the strength of will, which made it possible to experience a natural birth and free of interventions.

It was an unforgettable experience. [...] it was very intense and it was just like I dreamed [...] my experience was amazing (P3).

Me being the main actor in childbirth, not the professional who assists me [...] it was a liberation from the medicalized view of delivery [...]. It was the possibility of giving birth in the most natural way I expected [...] (P15).

### Obstetric care in the birthing process

NM offered necessary information; ensured they had materials, equipment and experience for adequate care; presented the possibilities for transfer to a reference hospital, in an abnormal condition; ensured they would be by the woman's side full time, among other factors. These requirements provided confidence, security and tranquility to the women before and during their PHB.

The nursing professional is fundamental, both for the safety issue and for the information issue (P9).

They had the material, they had the training, they had the experience. [...] I managed to turn off my head and think: "if something different happens they'll know, I don't need to worry about that". [...] It left me quiet and safe (P15).

Obstetric care was focused on the woman's needs, on valuing her individuality, respecting her wishes and choices. The words of confidence and the positioning of the nurse as a caregiver promoted the empowerment of women in the process of labor and delivery:

She (nurse) empowered me. She said that if I really wanted that birth, I could have it at home. Because she would be there by my side (P8).

She (nurse) took part, of course. But the birth was mine. She respected my body, my desires (P9).

The *doula's* role has been shown to be primarily focused on emotional support and labor pain relief, empowering the woman to believe in her body's physiology and her ability to give birth.

You need to be empowered, you gotta get someone who believes in you [...]. She made me believe that I could. [...] the doula is there by your side: "You can do it, you can do it, I'm here with you" (P4).

She [doula] put me on the birthing ball to do the exercises to relieve the contraction pains, she gave me massages (P4).

### DISCUSSION

The socioeconomic characteristics of women endorse that the choice of PHB is related to the access to quality information, for a safe and informed resolution, commonly related to the level of education, besides the economic condition to pay professional fees, since the health care is private<sup>(12)</sup>.

It is confirmed that prenatal care is the most appropriate period to inform women about the physiological process of childbirth and that prior knowledge of the stages to be experienced favors the female leading role and empowerment during childbirth<sup>(13)</sup>. However, the choice of birth route involves, in addition to information, previous experiences, family reports and sharing of knowledge in groups for pregnant women, where women can be guided about the types of birth, including PHB<sup>(3)</sup>.

The knowledge of the interventionist obstetric model, centered on the physician, in addition to reports of obstetric violence in hospital institutions, such as the accomplishment of unnecessary procedures, led women to seek new alternatives for childbirth, such as PHB<sup>(12,14)</sup>. It should be underlined that the excessive use of obstetric interventions can entail unfavorable physiological outcomes and hinder the female leading role<sup>(15)</sup>.

In this regard, episiotomy, in the hospital environment, can be performed in about 60% of pregnant women at usual risk, but in the home environment, in only 0.47% to 6.1% of them. These data reflect the woman's choice of the delivery setting, considering that the rates of

interventions in the hospital environment are higher than those in the home environment<sup>(12)</sup>. Moreover, in some experiences, episiotomy is performed without prior warning and consent of the woman<sup>(16)</sup>.

In Brazil, the rates of cesarean births in hospitals are around 52%, reaching 88% in the private network. In the home environment, this rate ranges between 5.7% and 9%<sup>(12)</sup>. As recommended by the WHO, cesarean sections should occur in 10% to 15% of all births<sup>(7)</sup>.

In countries like Netherlands, Canada and Australia, home birth represents an event not only recognized, but also encouraged by the public health system<sup>(17)</sup>. Nonetheless, in Brazil, it is still seen with prejudice by society, especially with the dissemination of misconceptions about the topic. This may explain the occurrence of less than 1% of home births in the country<sup>(4)</sup>. It is worth underlining that home birth rates reach 62.7% in the Netherlands, 11.3% in New Zealand and 2.8% in England<sup>(18)</sup>.

Women who choose to give birth at home value the sense of mastery over their bodies and the birthing process<sup>(9)</sup>. Accordingly, the home is perceived as a place of care, where the woman is empowered with her own birth, has more possibility to make her choices, to experience her desires and to respect her customs and those of her family members<sup>(8)</sup>.

The choice of PHB is shared with the spouse and both agree it is a safe methods<sup>(3)</sup>. Nevertheless, when sharing the choice of PHB with others, they face opposing opinions. Pregnant women who choose home birth are viewed with suspicion, as someone out of the ordinary, as if they were putting the baby's life and themselves at risk. Because of this, many of them keep their choice of PHB a secret so that they are not repressed by family members and the health system<sup>(12)</sup>.

In PHB, the partner can actively exercise his role as a father and be included in the planning of the labor and birth of the baby<sup>(8)</sup>. He transmits security and supports the woman during the birthing process, and can contribute to the reduction of pain during this moment. Many institutions do not respect the Companion's Law (Law nº 11.108/2005), restricting the presence of the same under the argument of lack of physical structure in the institution or for hindering the

labor process. Thus, it is confirmed that the participation of the family during birth, especially the companion, can contribute to making the birth more humanized<sup>(3)</sup>.

It is confirmed that, during the birthing process, the studied women had autonomy and freedom to walk, feed themselves and choose the birthing position. The professionals involved encouraged the women to try the position that was most comfortable for them, supporting their choices and avoiding long periods in dorsal decubitus, which is in line with what the WHO recommends<sup>(7)</sup>.

The experience of natural childbirth was accompanied by labor pain. Nonetheless, women faced this pain as necessary for birth. Non-pharmacological techniques were employed for pain relief. The most used were the use of massage, Swiss ball, shower bath and water immersion, considered safe methods that facilitate the relaxation of the pelvic muscles, favoring the evolution of labor<sup>(14-15)</sup>. Women preferred squatting positions and four supports at the expulsive moment of delivery<sup>(19)</sup>.

The home environment was considered safe, comfortable and tranquil, including diversified scenarios, such as water birth. The aquatic environment collaborates with the decrease in systemic adrenaline levels, providing a decrease in anxiety, relaxation and pain reduction. Consequently, it favors the stimulation of oxytocin production, which can contribute to the intensification of pelvic dilation, allowing labor to occur more quickly<sup>(15)</sup>.

Women compare the experiences of childbirth in the home environment and in the hospital. As for home births, it is confirmed that they are natural, physiological, without interventions and complications for the mother and the newborn<sup>(20)</sup>. In turn, hospital births can be performed with traumatic and unnecessary interventions. These are the reasons why women choose a natural home birth<sup>(8)</sup>.

The woman, when being in a familiar environment, such as her home, with people of her affective bond, presents less anxiety during labor, which may also favor the experience of a faster delivery, with less pain and more meaning<sup>(21)</sup>. However, it is appropriate to state that, even in hospitals, childbirth care through NM can also reduce unnecessary interventions

and birth complications, decrease the use of painkillers and shorten the labor duration<sup>(19)</sup>.

In addition, home birth favors the creation of a bond between the mother-child binomial through skin-to-skin contact at the time of birth and breastfeeding in the first hours of life<sup>(10)</sup>. Above all, the moment of birth should not be discontinued, because it is in this period that the natural reflexes take place, such as the emergence of the baby's sucking reflex with the search for the mother's breast<sup>(21)</sup>. This bond was strongly experienced not only by the studied women, but also by their partners, who actively experienced the labor and birthing process and were able to accompany the beginning of breastfeeding.

The security about the choice of the place to give birth was shown to be mainly linked to the training of the people who perform the childbirth care<sup>(8)</sup> and the transfer plan to a reference hospital, in case of eventual complications. In this context, based on positive maternal and neonatal outcomes, it is confirmed the safety of PHB for women at usual risk and assisted by well-trained professionals. This highlights that the care held by well-trained NM does not add risk to labor and birth, in addition to presenting complication rates similar to those recorded in the hospital environment<sup>(12)</sup>.

Obstetric nursing has expanded its area of activity, adding scientific knowledge through specialization and updating courses in obstetric practices, thus favoring an active posture, especially with the creation of humanized delivery services, such as normal birth houses and centers, as well as the accomplishment of home births<sup>(22)</sup>.

Regarding this topic, NM aims to use practices based on scientific evidence and humanization of childbirth, such as freedom of position and movement, the use of non-pharmacological pain relief methods and the employment of words of encouragement for the woman<sup>(3)</sup>. Women perceive the care provided by NM as favoring the autonomy and encouragement of pregnant women's ability to give birth at home in a natural way, which contributes to a physiological and positive evolution of birth, less perception of pain and respect for the bond between mother and child at birth.

The *doula's* participation includes physical and emotional support. In the physical support, it takes place with breathing techniques, positioning, walking and body movements. In the emotional support, it takes place with active listening, welcoming encouragement and information, with guidance on obstetric interventions and information for family members<sup>(14)</sup>. *Doula* helps in pain relief with the use of comfort massages, body movements with a ball, music therapy, hydrotherapy and meditation, actions performed with technical knowledge and love.

In this sense, it is confirmed the need for professionals who provide obstetric care to respect the physiological and biological factors, considering the psycho-emotional aspects involved in the birthing process, with the least possible interventions<sup>(15)</sup>. These are attitudes of humane care that consider the individuality and uniqueness of each woman in her birth-related experience.

## FINAL CONSIDERATIONS

The study made it possible to understand the meanings and experiences of women who dealt with planned home birth assisted by a midwife nurse and the motivation [of these women] for this choice.

The women's experiences converge towards the exercise of autonomy and respect for individuality. The leading role of women who experienced a natural birth and free of interventions, should be highlighted. The obstetric care was focused on the parturient woman's needs, provided confidence, security, tranquility and respect for her choices and the physiology of birth. The dissatisfaction with the current model of care, the participation in a group for pregnant women, the access to information and the experience of previous obstetric violence were motivations for the choice of PHB, which had a meaning of victory and liberation.

The study contributes to the visibility of the performance of obstetric/midwifery nursing also in the home environment. It is indicated the need for pregnant women to have access to information about childbirth during prenatal care and to expand the childbirth care by NM to

women who desire PHB. Public policies aimed to assist natural childbirth can make this possible.

Data collection restricted the interviews to women who experienced PHB, which may be a

limitation of the study. It is suggested to investigate the phenomenon also from the point of view of family members or people of the woman's choice, who were present in the birthing process.

## PARTO DOMICILIAR PLANEJADO ASSISTIDO POR ENFERMEIRA OBSTÉTRICA: SIGNIFICADOS, EXPERIÊNCIAS E MOTIVAÇÃO PARA ESSA ESCOLHA

### RESUMO

**Objetivo:** compreender os significados e experiências de mulheres que vivenciaram o parto domiciliar planejado assistido por enfermeira obstétrica e a motivação (das mulheres) para essa escolha. **Metodologia:** estudo qualitativo, exploratório e descritivo, com 16 mulheres, realizado por meio de entrevista semiestruturada e analisado pelos pressupostos da análise temática de conteúdo. **Resultados:** as mulheres vivenciaram o parto com tranquilidade, autonomia e respeito, escolheram as posições e as pessoas de sua preferência. O parto teve significado de vitória e de libertação, cuja experiência foi descrita como inesquecível, fantástica, intensa e protagonizada pela mulher. O descontentamento com o modelo de assistência vigente, a participação em grupo de gestantes, o acesso a informações e a vivência de violência obstétrica anterior motivaram as mulheres a optarem pelo parto domiciliar. **Considerações finais:** as experiências das mulheres convergem para o exercício da autonomia e respeito à individualidade. Evidencia-se o protagonismo das mulheres que vivenciaram um parto natural e livre de intervenções. A assistência obstétrica foi centrada nas necessidades da parturiente, proporcionou confiança, segurança, tranquilidade e respeito às suas escolhas. Aponta-se a necessidade de ampliar a assistência ao parto por enfermeiras obstétricas às mulheres que desejam o parto domiciliar planejado. Políticas públicas de assistência ao parto podem viabilizar isso.

**Palavras-chave:** Enfermeiras Obstétricas. Enfermagem Obstétrica. Parto Domiciliar. Parto Normal. Parto Humanizado.

## PARTO DOMICILIARIO PLANIFICADO ASISTIDO POR ENFERMERA OBSTÉTRICA: SIGNIFICADOS, EXPERIENCIAS Y MOTIVACIÓN PARA ESTA ELECCIÓN

### RESUMEN

**Objetivo:** comprender los significados y las experiencias de las mujeres que vivieron el parto domiciliario planificado asistido por enfermera obstétrica y la motivación (de las mujeres) para esta elección. **Metodología:** estudio cualitativo, exploratorio y descriptivo, con 16 mujeres, realizado a través de entrevista semiestructurada y analizado por los supuestos del análisis de contenido temático. **Resultados:** las mujeres experimentaron el parto con tranquilidad, autonomía y respeto, eligieron las posiciones y las personas de su preferencia. El parto tuvo un significado de victoria y liberación, cuya experiencia se describió como inolvidable, fantástica, intensa y protagonizada por la mujer. La insatisfacción con el modelo de atención actual, la participación en grupo de mujeres embarazadas, el acceso a informaciones y la experiencia de violencia obstétrica anterior motivaron a las mujeres a optar por el parto domiciliario. **Consideraciones finales:** las experiencias de las mujeres convergen para el ejercicio de la autonomía y respeto a la individualidad. Se evidencia el protagonismo de las mujeres que experimentaron un parto natural y libre de intervenciones. La atención obstétrica se centró en las necesidades de la parturienta, proporcionó confianza, seguridad, tranquilidad y respeto con sus elecciones. Se señala la necesidad de ampliar la atención al parto por enfermeras obstétricas a las mujeres que desean el parto domiciliario planificado. Las políticas públicas de atención al parto pueden hacer esto posible.

**Palabras clave:** Enfermeras Obstétricas. Enfermería Obstétrica. Parto Domiciliario. Parto Normal. Parto Humanizado.

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