Journal Pre-proof

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PII: S0266-6138(26)00117-8
DOI: https://doi.org/10.1016/j.midw.2026.104813
Reference: YMIDW 104813

To appear in: *idwifery*

Received date: 30 June 2025
Revised date: 7 April 2026
Accepted date: 8 April 2026

Please cite this article as: Thayná C. Queiroz , Jamile C.C. Bussadori , Pollyana G. Silva , Fernanda B. Girão , Ana Clara G. Cerqueira , Nathalie Leister , Christine McCourt , Model of Planned Home Birth Care in Brazil: A Scoping Review, *idwifery* (2026), doi: https://doi.org/10.1016/j.midw.2026.104813

Model of Planned Home Birth Care in Brazil: A Scoping Review

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ABSTRACT

Problem: Unlike England, Canada, and the Netherlands, where home birth is regulated and integrated into public health care, Brazil still lacks formal regulation, clinical standards, and national guidelines for planned home birth. **Background:** In Brazil, 99.3% of births occur in hospitals. Planned home birth with nurse-midwives and midwives has grown as an alternative, promoting professional autonomy and respecting physiological processes. International evidence supports its safety, but it remains outside the formal health system. **Aim:** To map the scientific literature on planned home birth care provided by nurse-midwives and midwives in Brazil. **Method:** A scoping review was conducted in accordance with the JBI Reviewer's Manual. Searches were carried out between January and February 2024 and updated in December 2024. Databases and repositories included BVS, PubMed, CINAHL, Cochrane Library, Scopus, Web of Science, EMBASE and national thesis repositories. The inclusion criteria were population, nurse-midwives and midwives; concept, childbirth care model; context, planned home births in Brazil. **Findings:** Thirteen studies published between 2012 and 2023 were included, involving 124 nurse-midwives and one midwife. Findings were grouped into categories: care process, team composition, materials, protocols, good practice indicators, evaluation indicators, and professional experience. **Discussion:** While planned home birth is expanding in Brazil, barriers remain, including absence of national protocols, difficulty accessing supplies, and poor integration with hospital services. **Conclusion:** The autonomy, integration and expertise of nurse-midwives and midwives are central to safe planned home

births. National policies and standardised guidelines are needed in Brazil to strengthen this model of care and ensure safety, legitimacy, and sustainability.

Descriptors: Nurse Midwives; Healthcare Models; Midwifery; Home Childbirth; Brazil

STATEMENT OF SIGNIFICANCE	
Problem	In Brazil, planned home birth attended by nurse-midwives and midwives remains outside the public health system and lacks formal integration with referral and transfer services.
What is already known	Planned home birth in Brazil has expanded through private midwife-led teams, but evidence on how care is organised, practiced and monitored remains fragmented across small studies.
What this article adds	This scoping review shows that planned home birth in Brazil is delivered through a midwife-led, continuity-based model that uses eligibility criteria and evidence-based physiological birth practices, but operates without standardised national protocols, formal quality indicators, or integrated referral pathways with hospital services.

INTRODUCTION

Childbirth care has undergone progressive medicalisation throughout the 20th century, shifting from a social model (home based, midwife led) to a technocratic, hospital centred paradigm. This transition removed women's control over childbirth, transforming a physiological process into a medical event marked by unnecessary interventions (Sanfelice et al., 2015).

In Brazil, this change led to 99% of births occurring in hospitals, accompanied by high rates of unnecessary interventions and one of the world's highest caesarean rates (Webler et al., 2023; Miller et al., 2016; Lancet, 2014; Leal et al., 2014). Although hospitalisation initially helped reduce maternal and perinatal morbidity and mortality, its indiscriminate use has had

negative consequences, such as the loss of autonomy, disregard for birth physiology and increased obstetric violence (Katz et al., 2020; Livinhale, 2018).

In response, the World Health Organization (WHO) and national policies promoting positive birth experiences have proposed strategies to restore women's autonomy and ensure respectful, evidence-based care (WHO, 2024; Brazil, 2017). One such alternative is planned midwife-attended home birth (PHB), which promotes woman centred, physiological care. This model is recognised and supported in countries like England, the Netherlands, and Canada, where it is available through public health systems (NICE, 2017; Public Health Agency of Canada, 2017). In Brazil, however, PHB still faces institutional and cultural barriers to expansion (Cursino et al., 2020).

Currently, PHB accounts for less than 1% of births in Brazil and is not part of the public health system (SUS) (Brazil, 2023), being offered only through private teams. Despite strong international evidence of its safety for low-risk pregnancies (Reitsma et al., 2019; Scarf et al., 2018; Birthplace, 2011), the Brazilian medical community often frames PHB as regressive and unsafe (Brazil, 2021; CRM-PR, 2020; CRM-SC, 2019; FEBRASGO, 2018; SBP, 2018; CRM-SP, 2011; WHO, 1997).

International studies continue to support the safety of this model. Comparative data show that when PHB is integrated into a health system and supported by trained midwives, it is associated with lower maternal morbidity, similar neonatal mortality, fewer interventions, and higher maternal satisfaction than hospital births (Reitsma et al., 2019; Scarf et al., 2018; Birthplace, 2011). A sub-analysis by Reitsma et al. (2020) confirmed PHB's safety in countries with trained midwives and system integration.

Although Brazilian literature remains limited, it reflects similar findings (Cursino et al., 2020; Koettker et al., 2013; Koettker et al., 2012). A recent advancement was COFEN (Federal Nursing Council) Resolution number 786, which formally regulates the role of nurse-midwives and midwives in PHB, supporting comprehensive care grounded in autonomy and safety. However, the absence of national clinical protocols remains a barrier to broader adoption.

Unlike England and the Netherlands, where midwives attend home births within publicly funded care pathways, PHB in Brazil is provided by nurse-midwives and midwives working almost exclusively in private teams, without formal referral or transfer agreements. This fragmented, privately financed model is only partly aligned with international midwife-led standards and remains disconnected from the public health system (Cursino et al, 2020). Understanding how these teams organise care requires describing their clinical practices and recognising the socio-institutional conditions sustaining this model. Analysing the Brazilian

experience contributes to international debates on place of birth by showing that PHB can develop outside public systems, with implications for access, regulation, and equity.

Building on this, it was considered relevant to systematise the scientific literature to map how planned home birth care provided by nurse-midwives and midwives is organised and practiced in Brazil, as well as the outcomes reported for this model of care. This study was guided by the following research question: "How is planned home birth care provided by nurse-midwives and midwives in Brazil organised and practiced, and what outcomes are reported in the literature?"

This review aims to provide evidence to inform reflections on PHB care and support future health policies to improve its quality.

OBJECTIVE

To map the scientific literature on how planned home birth care provided by nurse-midwives and midwives is organised and practiced in Brazil, including the outcomes reported for this model of care.

METHODS

This scoping review aimed to synthesise available scientific evidence on a complex and underexplored topic. The study followed Joanna Briggs Institute (JBI) guidelines (Aromataris, 2020) and adhered to the PRISMA-ScR checklist for reporting (Peters, 2015; Peters et al., 2020). The following steps were conducted: (1) identifying the research question; (2) identifying relevant studies; (3) selecting and including studies; (4) organising data; and (5) compiling, synthesising and reporting data (Peters et al., 2020).

Protocol and Registration

The protocol was registered on the Open Science Framework (OSF). The DOI and full access link will be provided upon acceptance to preserve author anonymity during peer review. No similar studies or registered protocols were found on OSF, the Virtual Health Library (BVS), or PubMed.

Eligibility Criteria

The research question and eligibility criteria followed the PCC mnemonic (Population, Concept, Context), as recommended by JBI. The "Population" included nurse-midwives and midwives; the "Concept" was the childbirth care model; the "Context" referred to planned home births in Brazil (see Supplementary Table 1).

The concept of the model of care draws on Paim's (2008) definition: the organisation of technologies aimed at addressing health needs. This model integrates managerial, organisational, and relational dimensions. The managerial dimension refers to health service restructuring; the organisational dimension relates to interactions across care levels; and the technical care dimension involves professional user interaction, mediated by knowledge and technologies at all care levels.

Studies were included if they were full text, used any methodology, were indexed in relevant databases, addressed the research question, and involved nurse-midwives or midwives. They needed to discuss care practices, human and material resources, clinical protocols, or good practice indicators in PHB in Brazil. Theses, dissertations, and guidelines were also considered, with no restriction on year or language.

Studies were excluded if they did not address the research question, focused on unplanned home births or those attended by traditional midwives or physicians, had restricted access, or were classified as opinion pieces, retractions, websites, or media advertisements.

In this review nurse-midwife was used to refer to registered nurses with postgraduate midwifery training; midwife to refer to professionals trained in direct-entry midwifery programmes; and traditional midwife to refer to community-based, non-formally trained birth attendants with empirical knowledge.

Search Strategy

With librarian support, the following sources were consulted: a) Portals: BVS, PubMed, and PubMed PMC; b) Databases: CINAHL–EBSCO, Cochrane Library, Scopus, Web of Science Core Collection, EMBASE, SciELO and the brazilian Digital Library of Theses and Dissertations (BTDT); c) Repositories: Capes Theses & Dissertations and Cybertesis.

Controlled vocabulary terms included DeCS, MeSH, CINAHL headings, and EMTREE. Based on preliminary keyword searches, the final strategy was: "Nurse Midwives" AND ("Healthcare Models" OR Midwifery) AND "Home Childbirth" AND BRAZIL.

For example, in PubMed: ((((Nurse Midwives[MeSH Terms]) OR ("Nurse Midwives"[Title/Abstract] OR "Nurse-Midwives"[Title/Abstract] OR "Nurse-

Midwife"[Title/Abstract] OR "Nurse Midwife"[Title/Abstract])) AND (("Healthcare Models"[Title/Abstract]) OR ((Midwifery[MeSH Terms]) OR (Midwifery[Title/Abstract] OR Midwives[Title/Abstract] OR Midwife[Title/Abstract])))) AND (((Home Childbirth[MeSH Terms]) OR ("Home Childbirth"[Title/Abstract] OR "Childbirth at Home"[Title/Abstract] OR "Home Birth"[Title/Abstract] OR "Home Births"[Title/Abstract] OR "Childbirths at Home"[Title/Abstract])) OR ("home delivery"[Title/Abstract]))) AND (BRAZIL OR BRASIL OR BRAZILIAN OR BRAZILIANS).

This strategy was adapted for each platform using Boolean operators (see Supplementary Table 2).

Data Extraction and Synthesis

Retrieved references were imported into EndNote Web® for duplicate removal, then 28 studies were uploaded to Rayyan® for screening.

The process was conducted by researchers trained in review methods and software use. Selection was done independently to ensure rigour, with consensus reached through peer review and resolution of disagreements by a third reviewer. All reviewers are listed as authors.

In phase one, titles and abstracts were screened. Studies meeting inclusion criteria moved to full text review (n=19). A manual search of reference lists yielded no new studies. Thirteen studies were selected for final inclusion.

Screening and selection occurred from January to March 2024. An updated search in December 2024 found no additional studies.

A structured data extraction tool captured the following: title, author, year, study design, results, and key findings (see Supplementary Table 3). Extracted data were systematically organised and synthesised, presented in Tables 1 and 2. A narrative summary provides a comprehensive overview of PHB care in Brazil.

Ethical Considerations

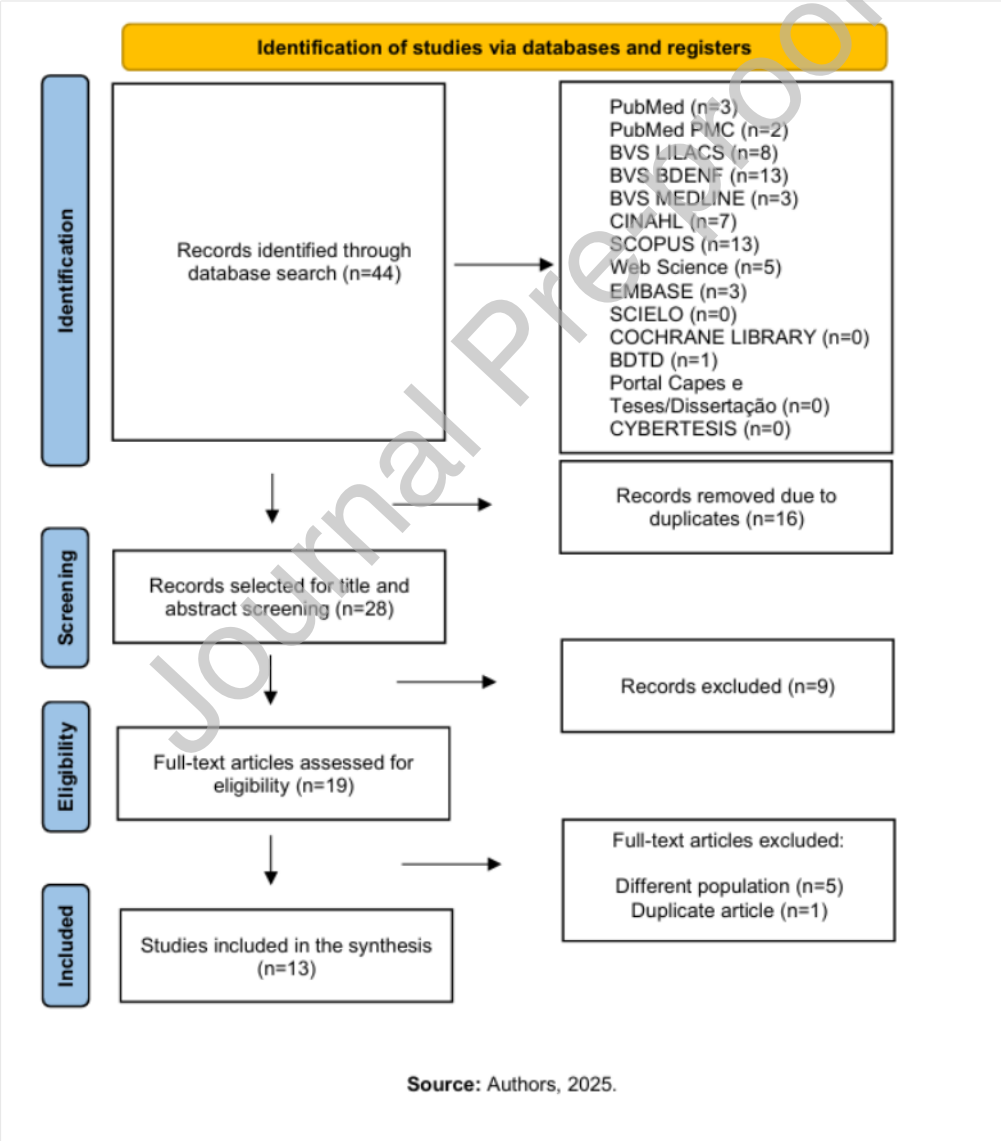
As this was a scoping review, submission to a research ethics committee was not required.

RESULTS

The selection process identified 28 studies, of which 13 met the established eligibility criteria and were included in this review (Figure 1, Table 1). Among these, 11 were peer-

reviewed articles, one was a master's dissertation, and one a doctoral thesis. Ten studies adopted qualitative approaches and three were quantitative. The publications span from 2012 to 2023 and collectively include interviews with 124 nurse-midwives and one midwife. Some publications appeared to derive from the same empirical context while addressing different analytical questions. Koettker et al. (2012) and Koettker et al. (2013) seem to report different analyses from the same planned home birth service in Florianópolis, while Mattos et al. (2016) and Mattos et al. (2018) also appear to draw on related field settings and professional teams. These studies were retained because each contributed distinct information relevant to the review question.

Figure 1 – Study Selection Flow Diagram



Source: Authors, 2025.

Table 1 – General Characteristics of Documents Included in the Scoping Review

Author/s, Year	Title	Objective	Methodology/Information	Sample
Webler et al. (2023)	Professional autonomy in dealing with complications: discourse of obstetric nurses working in planned home births	Understand the exercise of professional autonomy by nurse-midwives in managing complications during planned home birth.	Scientific article / Qualitative; Descriptive within the theory of collective subject discourse	7 nurse-midwives
Santos et al. (2021)	Trajectories of obstetric nurses in the care of planned home childbirth: oral history	Describe the trajectory of nurse-midwives' involvement in planned home birth care in Rio Grande do Sul.	Scientific article / Qualitative; Descriptive with thematic oral history application	13 nurse-midwives
Dos Santos Pascoto et al. (2020)	Difficulties in home birth care from the perspective of obstetric nurses	Investigate the challenges faced by nurse-midwives working in home birth care.	Scientific article / Qualitative; Descriptive	9 nurse-midwives
Peripolli (2019)	The experience of women, companions, and obstetric nurses in planned home birth	Explore the experiences of women, birth companions, and nurse-midwives involved in planned home birth.	Dissertation / Quantitative; Exploratory	8 nurse-midwives
Da Silva et al. (2019)	Experience of professional autonomy in the assistance to home birth by obstetric nurses	Identify the experience of autonomy in home birth care among nurse-midwives.	Qualitative approach; Descriptive study	10 nurse-midwives

Bochnia et al. (2019)	The role of obstetric nurses in planned home birth	Understand the perception that nurse-midwives attending planned home birth have of their professional role.	Scientific article / Qualitative; Exploratory	7 nurse-midwives
Santos et al. (2018)	Outcomes of planned home births assisted by obstetric nurses	Describe the maternal and neonatal outcomes of planned home births assisted by nurse-midwives.	Scientific article / Quantitative; Descriptive, exploratory, retrospective document analysis	6 nurse-midwives
Mattos et al. (2018)	Relationships with the parturient in home birth assistance: traditional and modern perspectives	Analyse the relationships in the construction of care in home birth by traditional midwives and trained midwives.	Thesis / Qualitative; Exploratory, descriptive	5 nurse-midwives 1 midwife
Mattos et al. (2016)	Obstetric nurses in planned home birth	Describe the challenges and obstacles faced by nurse-midwives in planned home birth care.	Scientific article / Qualitative; Exploratory, descriptive	22 nurse-midwives
Sanfelice et al. (2014)	From institutionalized birth to home birth	Describe the experience of a group of nurse-midwives in Campinas, São Paulo, Brazil, regarding the transition process from institutionalized birth care to home birth, occurring between 2011 and 2013.	Scientific article / Qualitative; Descriptive, experience report	5 nurse-midwives

De Mattos et al. (2014)	Motivation of obstetric nurses for planned home birth	Analyse the motivations of nurse-midwives for practicing planned home birth.	Scientific article / Qualitative; Exploratory and interpretative	22 nurse-midwives
Koettker et al. (2013)	Planned home births assisted by nurse-midwives: maternal and neonatal transfers	Describe the rate and causes of intrapartum hospital transfers of women assisted at home by nurse-midwives, as well as the outcomes of these births.	Scientific article / Quantitative; Exploratory, descriptive, cross-sectional	7 nurse-midwives
Koettker et al. (2012)	Outcomes of home births assisted by nurses from 2005 to 2009 in Florianópolis, SC	Examine the obstetric and neonatal outcomes of planned home births assisted by nurse-midwives in Florianópolis, Santa Catarina.	Scientific article / Quantitative; Retrospective cross-sectional	3 nurse-midwives

Source: Authors, 2025.

The studies were categorised into the following thematic areas: care processes and practices, team, material resources, care protocols, good practices, evaluation indicators and outcomes, professional experience, challenges and professional benefits (Table 2A and Table 2B).

Table 2A – Results (Part 1)

Author/s, Year	Processes and Practices	Team	Material Resources	Care Protocols
Webler et al. (2023)	Rapport established during antenatal care; continuity from antenatal through postnatal; informed consent guided.	Interdisciplinary team incl. nurse- midwives and physicians; two midwives attend PHBs.	Resuscitation kit, surgical instruments and essential materials available.	Guided by current scientific evidence and regular professional updates.

Santos et al. (2021)	Eligibility criteria and continuity of care explicitly addressed.	Involvement of nurse-midwives.	Not specified.	Guided by Ministry of Health guidelines and international references.
Dos Santos Pascoto et al. (2020)	Sensitive antenatal care; infrastructural limitations acknowledged.	Not specified.	Not specified.	Not specified.
Peripolli (2019)	Thorough antenatal assessment; eligibility criteria; continuity through perinatal period; informed consent; attention to technical/logistical preparation.	Teams working collaboratively; often group-based care; one nurse- midwife reported working alone.	Emergency equipment and techniques available.	Based on COREN-PR Technical Opinion 001/2016 and WHO recommendations.
Da Silva et al. (2019)	Antenatal care from 30th week through to the 10th postpartum day; eligibility criteria; respectful, physiology-oriented care; informed consent.	Nurse-midwives work in various configurations; one team has two nurse-midwives; another has nine nurse- midwives and one neonatal nurse; physician available on backup for transfers.	Fetal Doppler, measuring tape, neonatal resuscitation equipment, non-pharmacological pain-relief methods.	Based on Professional Practice Act, Coren-PR Resolution, Ministry of Health guidelines.
Bochnia et al. (2019)	High-quality antenatal care provided.	Two nurse-midwives involved in each birth.	Not specified.	Based on COFEN Res. 516/2016 and Brazil's National Guidelines for Normal Birth (2017).
Santos et al. (2018)	High-quality antenatal care; eligibility criteria; transfer protocols planned.	Two nurse-midwives present at each birth. Physicians on call for transfers.	Not specified.	Based on scientific evidence; aligned with Ministry of Health care timeline.
Mattos et al. (2018)	Birth planning begins during antenatal care; home visits ~36 weeks; emphasis on natural processes, autonomy, individualized support; follow-up to day 10 (up to 30 in some cases); transfer planning included.	Multidisciplinary team incl. nurse-midwives and midwife; two nurse-midwives at PHBs; rotating teams; physicians on call for transfers.	Not specified.	Protocols follow Brazilian MoH guidelines.

Mattos et al. (2016)	Antenatal consultations and home visits incl. transfer preparation.	Informal contact with physicians; care organized via shift rotations.	Medications used include Ringer's solution, oxytocin, methylergometrine (Methergin), among others.	Not specified.
Sanfelice et al. (2014)	Transition from hospital- to home-based care with biopsychosocial focus.	Small teams with multiprofessional collaboration.	Not specified.	Evidence-based practice without rigid protocols.
De Mattos et al. (2014)	Support for women's autonomy during antenatal care; emphasis on self-care.	Not specified.	Not specified.	Evidence-based and tradition-informed; guided by COFEN Res. 223/1999.
Koettker et al. (2013)	Antenatal care up to 37 weeks; home-based follow-up until the 10th postpartum day; eligibility criteria; guidance on newborn care; transfer planning included.	Seven nurse- midwives and two physicians involved in antenatal care.	Basic life support equipment available to ensure safety of mother and baby until hospital arrival.	Documented clinical care protocol.
Koettker et al. (2012)	Weekly antenatal visits from 37 weeks through the 10th postpartum day; eligibility criteria.	Three nurse- midwives, four generalist nurses, with support from two obstetricians.	All necessary equipment carried; basic life support tools.	Selection protocol for low-risk pregnancies.

Source: Authors, 2025.

Table 2B – Results (Part 2)

Author/s, Year	Good Practices	Evaluation Indicators / Outcomes	Professional Experiences	Challenges	Professional Benefits
Webler et al. (2023)	Shared decision-making fosters autonomy and strong caregiver–client relationships.	No formal indicators.	Avg ~5 years' experience; previous institutional background; exclusive PHB practice; ongoing training essential.	Absence of official clinical protocols; transfers may be experienced as professional violence; lack of institutional recognition.	Not specified.

Santos et al. (2021)	Not specified.	No formal indicators.	Experience 1–6 years; ongoing education essential.	Lack of PHB-specific training in postgraduate programs.	Professional autonomy.
Dos Santos Pascoto et al. (2020)	Emphasis on physiological birth and evidence-based practices.	No formal indicators.	All had prior obstetric experience; 1–5 years in PHB.	Prejudice, infrastructural gaps, political invisibility; absence of clinical protocols; supply purchase and diagnostic access difficulties; attempted PHBs omitted from hospital records.	Not specified.
Peripolli (2019)	Bonding with woman/family; promotion of women's protagonism.	No formal indicators; Evidence of safety cited from systematic reviews.	Mixed background incl. hospital experience; 6 months–4 years in PHB; continuing education emphasized.	Hostile reception during transfers; social stigma; fear of discontinuity and judgement.	Not specified.
Da Silva et al. (2019)	Welcoming environment, active listening, emotional support; respect for physiology; non-pharmacological pain relief; presence of a birth companion; vertical positions.	No formal indicators.	Midwives trained through residency programmes; 1-4 years in PHB.	Lack of standardised protocols; difficulty acquiring supplies. Feelings of frustration during transfers; fear of judgement from hospital staff.	Professional autonomy.
Bochnia et al. (2019)	Evidence-based care and non-pharmacological pain relief.	No formal indicators.	Training grounded in hospital practice; PHB experience 6 months–6 years.	Difficulties, professional insecurities, interprofessional conflicts.	Professional autonomy.
Santos et al. (2018)	Evidence-based practices; strong midwife–woman bond; non-pharmacological methods; focused care in first hour.	Low transfer rate used as a quality indicator. Outcomes: Transfer: 21.1% women / 1.2% neonates; all favourable outcomes; Apgar	Ongoing professional development essential.	Not specified.	Not specified.

		≥7 at 5 min: 98.7%.			
Mattos et al. (2018)	Massage, aromatherapy, herbal medicine; individualized respectful care.	No formal indicators.	Diverse backgrounds; 2–18 years' experience; preparedness for complications emphasized.	Lack of standardised protocols; uneven training backgrounds; need stronger linkage with hospitals services.	Not specified.
Mattos et al. (2016)	Touch, massage, birthing ball, aromatherapy, comfort techniques.	No formal indicators.	Not specified.	Need for public policies; difficulties accessing live birth certificates; transfer challenges.	Not specified.
Sanfelice et al. (2014)	Woman-centred care; respect for physiological processes.	No formal indicators.	Prior hospital experience considered essential; ~2 years of PHB practice; continuous training.	Social stigma; absence of public policies; transfers may be hostile; practice demands courage/ resilience.	Not specified.
De Mattos et al. (2014)	Techniques that promote physiological birth.	No formal indicators.	Hospital experience valued; technical preparedness essential.	Lack of regulatory support to purchase supplies; institutional resistance; transfers seldom discussed.	Not specified.
Koettker et al. (2013)	Integration of traditional knowledge is valued.	Structured data collection with descriptive statistical analysis. Outcomes: Service transfer rate: 11% (all in 1st stage); Apgar ≥7 at 5 min: 81.8%; no neonatal ICU admissions.	Team operated 2005-2009.	Lack of national data; outcomes assessed based on a small sample.	Not specified.

Koettker et al. (2012)	Focus on safety; evidence-based practice; encouragement of mobility, oral intake, and presence of a birth companion.	Standardised forms and descriptive statistical analysis. Outcomes: Transfer rate: 11%; 9/11 caesareans; Apgar ≥7 at 5 min: 98.9%; episiotomy 1%; 49.4% intact perineum.	Team operated 2005–2009; previous experience considered beneficial.	Not specified.	Not specified.

Source: Authors, 2025.

Organisation, care practices and reported outcomes in planned home birth

Care process and practices

The antenatal care model within PHB is widely discussed across the literature, with ten studies highlighting the value of continuous support by the care team throughout pregnancy. While there is consensus on the importance of this bond, studies vary in terms of when care should begin and how many consultations are necessary (Webler et al., 2023; Dos Santos et al., 2020; Peripolli, 2019; Da Silva et al., 2019; Bochnia et al., 2019; Santos et al., 2018; Mattos, 2018; Mattos et al., 2016; Koettker et al., 2013; Koettker et al., 2012).

One study described team practices such as providing a checklist of materials for birth and conducting at least one home visit to plan the route and prepare the environment (Mattos, 2018). Four studies emphasised the importance of discussing transfer planning during antenatal care to anticipate risks and define shared actions if transfer becomes necessary (Santos et al., 2018; Mattos, 2018; Mattos et al., 2016; Koettker et al., 2013). Most studies also stressed individualised, woman centred care and the importance of clear guidance for managing risks, urgencies, and emergencies.

Six studies reported using eligibility criteria as a safety measure for PHB. The most common criteria included low-risk pregnancy, singleton gestation, cephalic presentation, gestational age between 37 and 42 weeks, minimum home hygiene conditions and proximity to a hospital (Santos et al., 2021; Peripolli, 2019; Da Silva et al., 2019; Santos et al., 2018; Koettker et al., 2013; Koettker et al., 2012).

Regarding care during labour and birth, one study described the midwife arriving during the active phase of labour (Matos et al., 2018) and conducting regular assessments, including intermittent fetal heart rate auscultation (Santos et al., 2018; Mattos, 2018). Another study noted assessments every 30 minutes, increasing to every 10 minutes during the second stage. The use of a partograph as a monitoring tool was also reported (Da Silva et al., 2019).

In the immediate postpartum period, only one study detailed practices such as assessing maternal bleeding, evaluating the newborn's condition, and the team's length of stay post placental delivery, which ranged from 3 to 12 hours (Mattos, 2018).

On the topic of hospital transfer, some studies described strategies to support continuity of care. One suggested including obstetricians in PHB teams to improve integration across levels of care (Koettker et al., 2013). In this study, transfers occurred via the attending midwife's personal vehicle. Mattos et al. (2016) noted that in some regions, informal collaboration with physicians facilitated transfers. In the absence of such ties, hospital reception was often described as resistant, affecting continuity of care (Webler et al., 2023; Dos Santos Pascoto et al., 2020; Peripolli et al., 2019; Da Silva et al., 2019; Mattos et al., 2016; Sanfelice et al., 2014; Koettker et al., 2012).

Several studies highlighted that nurse-midwives and midwives frequently experience fear and insecurity during transfers, particularly in contexts where PHB is not formally recognised or faces resistance from other professionals (Webler et al., 2023; Dos Santos Pascoto et al., 2020; Peripolli et al., 2019; Da Silva et al., 2019; Mattos et al., 2016; Sanfelice et al., 2014; Koettker et al., 2012). According to Mattos et al. (2016), strengthening collaboration between physicians and midwives could improve continuity of care and reduce emergency related risks.

Postpartum follow up was addressed in five studies, which highlighted its importance for monitoring maternal and neonatal recovery (Webler et al., 2023; Da Silva et al., 2019; Mattos, 2018; Koettker et al., 2013; Koettker et al., 2012). While the timing and number of visits varied, some records included visits on days 3, 4, 10, 15, and 30, especially when the newborn had not yet achieved adequate weight (Mattos, 2018).

Only one study detailed guidance provided to families during postnatal consultations, such as information on newborn screening tests and recommended vaccinations, with instructions to access them through local primary health units (Koettker et al., 2013).

Home birth team professional attendance

Eleven studies, either briefly or in detail, mentioned the professionals involved in PHB care. These included nurse-midwives, midwives, traditional midwives, obstetricians and family physicians. Several studies noted that PHB care was generally provided by teams composed of at least two professionals (Webler et al., 2023; Peripolli, 2019; Da Silva et al., 2019; Bochnia et al., 2019; Santos et al., 2018; Mattos, 2018; Mattos et al., 2016; Sanfelice et al., 2014; De Mattos et al., 2014; Koettker et al., 2013; Koettker et al., 2012). Only one study described care being provided individually by a single nurse-midwife (Peripolli, 2019).

Team composition varied across the included studies. Some teams were made up exclusively of midwives and nurse-midwives, while others included combinations involving neonatal or generalist nurses. Two teams reported the involvement of physicians during antenatal care, reflecting a multiprofessional approach from the early stages of care (Koettker et al., 2013; Koettker et al., 2012). Three other studies mentioned the presence of physicians specifically during hospital transfers, acting as support in cases requiring referral to health services (Da Silva et al., 2019; Santos et al., 2018; Mattos, 2018).

However, a gap persists in the literature regarding the working dynamics of these teams during labour, particularly in terms of the order in which professionals arrive at the home and their availability throughout the process. Only one study reported that, in urban settings, the lead midwife typically arrived once labour had reached the active phase. In teams with more than one midwife, care was often organised in shifts, with professionals rotating during the intrapartum period (Mattos, 2018).

Material Resources

Six studies addressed the material resources used in PHB care (Webler et al., 2023; Peripolli, 2019; Da Silva et al., 2019; Mattos et al., 2016; Koettker et al., 2013; Koettker et al., 2012). Two of them provided detailed descriptions of essential equipment necessary to ensure safe care, including intravenous cannulation supplies, emergency medications, a bag valve mask (ambu), and Doppler devices (Webler et al., 2023; Da Silva et al., 2019). One study emphasised that the availability of such items is crucial for comprehensive and safe care, especially in case of complications (Da Silva et al., 2019).

One article described how a team organised its materials based on adapted clinical records and protocols developed from documents shared by other groups. This team also prioritised familiarity with each item, including where to purchase it and how to guarantee proper sterilisation (Dos Santos Pascoto et al., 2020).

An emerging issue noted in three studies was the difficulty nurse-midwives and midwives face in accessing essential medications for PHB (Dos Santos Pascoto et al., 2020; Santos et al., 2019; Mattos et al., 2014). Although Brazilian legislation allows these professionals to administer emergency medications, access is often restricted by pharmaceutical suppliers who typically sell only to physicians with a national registration number. As a result, these professionals frequently rely on physician partnerships to obtain the necessary drugs (Dos Santos Pascoto et al., 2020). Only one study specified the medications used: lactated Ringer's solution, saline, injectable oxytocin, ergotrate (methylergometrine maleate), and adrenaline (Mattos et al., 2016).

In addition to challenges involving equipment and medications, the studies also identified other practical barriers in the daily provision of PHB care. These include the inability of nursing teams to order diagnostic tests and the difficulties in issuing official Live Birth Certificates (Dos Santos Pascoto et al., 2020; Peripolli, 2019; Mattos et al., 2016; Sanfelice et al., 2014). These issues reflect broader structural limitations and reinforce the need for public policies that guarantee quality, safety, and institutional legitimacy for this model of care.

Care Protocols

Eight studies addressed issues related to care protocols in PHB. Three of them highlighted the use of the Brazilian Ministry of Health's *National Guidelines for Normal Birth Care* (Ministério da Saúde, 2017) as a key reference, and one cited the recommendations of the WHO (1996) (Santos et al., 2021; Peripolli, 2019; Da Silva et al., 2019; Bochnia et al., 2019). Four studies referred to resolutions issued by COREN (Regional Nursing Council) and COFEN, the bodies that regulate nursing in Brazil, alongside professional legislation and technical guidelines defining competencies and offering support for safe practice. One study also reported using protocols from national health systems in countries where PHB is integrated into public healthcare, such as those in Europe and North America (Santos et al., 2021; Peripolli, 2019; Da Silva et al., 2019; Bochnia et al., 2019; Sanfelice et al., 2014; De Mattos et al., 2014).

One study emphasised the commitment and professionalism of PHB providers. Although their protocols often resemble those used in institutional settings, such as antenatal schedules, their approach differs significantly in the postpartum period, with greater attention to the woman and her family (Koettker et al., 2013). This reflects a model centred on individual needs and family contexts.

The development of this care model was described as intentional and informed. One study noted that theoretical engagement with PHB, along with participation in research groups and professional congresses, was essential to consolidating practice grounded in scientific evidence and collective experience (Sanfelice et al., 2014).

Despite these efforts, significant challenges remain. Four studies reported the absence of standardised clinical protocols for the home birth setting, which contributes to inconsistencies in care delivery (Webler et al., 2023; Dos Santos Pascoto et al., 2020; Da Silva et al., 2019; Mattos, 2018).

Good Practice

The reviewed studies show that PHB teams are strongly committed to evidence based best practices, with an emphasis on respecting birth physiology and promoting women's autonomy and agency. These practices encompass physical, emotional, social, spiritual, and biological dimensions, and include the recognition of sexual and reproductive rights (Da Silva et al., 2019; Bochnia et al., 2019; Santos et al., 2018; Mattos, 2018; Koettiker et al., 2013).

During labour, studies reported frequent use of upright birthing positions, free movement, food intake based on the woman's preferences, massages, warm baths, birthing balls, essential oils, and the presence of birth companions and doulas (Da Silva et al., 2019; Bochnia et al., 2019; Santos et al., 2018; Mattos, 2017; De Mattos et al., 2014; Koettiker et al., 2012). Neonatal care included delayed cord clamping, skin to skin contact, and breastfeeding within the first hour of life, which were routine in some care models (Santos et al., 2018).

Planned Home Birth care also reinforces the professional autonomy of nurse-midwives by combining sensitivity in care, the use of low-tech interventions, such as active listening, emotional support, and therapeutic touch and respect for each woman's individuality (Webler et al., 2023; Da Silva et al., 2019; Mattos, 2018; Sanfelice et al., 2014).

Shared decision making, bonds built during antenatal care and continuity into the postpartum period contribute to co-responsibility, safety, and quality of care. Additionally, some professionals reported valuing the incorporation of empirical knowledge from traditional midwives as a complement to formal academic training (Mattos, 2018; De Mattos et al., 2014).

Evaluation Indicators and Outcomes

Across the included studies, no unified system of formal indicators to evaluate quality of care in Planned Home Birth (PHB) in Brazil was identified. However, safety and quality outcomes appeared indirectly in the reported data.

Some teams collected outcome data to monitor their practice. Two studies from Florianópolis (Koettker et al., 2012; Koettker et al., 2013) used structured forms and descriptive statistics. They reported an intrapartum transfer rate of 11%, a caesarean rate of 9% (among transfers), Apgar ≥7 at five minutes in 98.9% of newborns, only 1% episiotomy, 49.4% intact or unsutured perineum, and no neonatal ICU admissions.

Another study, in the Distrito Federal (Santos et al., 2018), evaluated 99 medical records and identified a maternal transfer rate of 21.2%, with 17.2% caesareans among transfers. The neonatal transfer rate was 1.2%, and 98.7% of newborns presented Apgar ≥7 at five minutes. There were no neonatal intensive care admissions.

Professional Experience

Professional training and experience were identified as fundamental for ensuring safe and high quality care in PHB. Continued professional development and access to appropriate equipment and materials were considered essential to maintaining high standards (Webler et al., 2023; Santos et al., 2021; Peripolli, 2019; Santos et al., 2018; Mattos, 2018; Sanfelice et al., 2014; De Mattos et al., 2014; Koettker et al., 2012).

Eight studies reported professional experience ranging from six months to eighteen years. Many professionals began their careers in maternity hospitals or midwifery led birth centres (Webler et al., 2023; Santos et al., 2021; Dos Santos Pascoto et al., 2020; Peripolli, 2019; Da Silva et al., 2019; Bochnia et al., 2019; Mattos, 2018; Sanfelice et al., 2014).

The academic background of nurse-midwives was diverse. Two studies distinguished between those who completed lato sensu postgraduate courses and those who undertook midwifery residency programmes, with the latter offering more hands-on experience in emergency care (Webler et al., 2023; Da Silva et al., 2019). Hospital experience was consistently viewed as crucial for developing clinical judgement, autonomy and emotional readiness to manage complications (Peripolli, 2019; De Mattos et al., 2014). Most professionals interviewed were either currently employed in or had previous ties to institutional care settings, including maternity hospitals and birth centres (Webler et al., 2023; Dos Santos Pascoto et al., 2020).

In one study, nurses trained through residency programmes stated that hospital-based emergency training provided a solid foundation for working in PHB, where they felt greater freedom to apply evidence-based practices (Da Silva et al., 2019). Another study reported that although ethical and philosophical values influenced the decision to work with PHB, continuous education and prior clinical experience were essential for a safe and confident transition (Sanfelice et al., 2014).

Despite these qualifications, gaps in training persist. According to Santos et al. (2021), PHB is still insufficiently addressed in obstetric nursing postgraduate programmes, which limits technical and conceptual preparation. In light of this, Mattos et al. (2016) highlighted the need for public policies to support and institutionalise PHB as a legitimate and safe care model.

Nonetheless, studies also emphasised positive aspects of PHB practice. Three studies pointed to the promotion of professional autonomy and one highlighted the potential for more humanised and less interventionist environments. Supporting physiological and respectful childbirth, along with forming strong bonds with women, contributed to high levels of job satisfaction and personal fulfilment. These experiences contrast with the more rigid routines, standardised protocols and limited autonomy often found in hospital-based care (Santos et al., 2021; Da Silva et al., 2019; Bochnia et al., 2019; Sanfelice et al., 2014).

DISCUSSION

National vital statistics in Brazil do not distinguish between planned and unplanned home births. The reported 0.7% therefore includes unattended deliveries and culturally specific practices and does not represent the true prevalence of PHB (Brazil, 2023). Within this context, the review suggests that PHB in Brazil has developed as a midwife-led model of care that is clinically structured at team level but weakly supported at organisational and policy level. Rather than identifying multiple clearly distinct care models, the included studies point to a broadly shared pattern of practice organised around continuity of care, antenatal risk selection, support for physiological birth, and close relationships between professionals and women (Webler et al., 2023; Da Silva et al., 2019; Santos et al., 2018; Mattos et al., 2018; Koettker et al., 2013; Koettker et al., 2012).

Across the studies, PHB was consistently described as being provided by independent nurse-midwives and midwives working outside the public health system and without formal integration with referral networks. This configuration gives professionals considerable autonomy in care provision, but it also restricts access, since care depends largely on private

payment, and limits equity in the availability of safety resources and institutional support (Bochnia et al., 2019; Mattos et al., 2016; Santos et al., 2021; Cursino et al., 2020). In this sense, the main distinction identified in the review is not between substantially different clinical models, but between a common philosophy and logic of care, on the one hand, and a fragile institutional environment in which that care is provided, on the other (Dos Santos Pascoto et al., 2020; Webler et al., 2023; Mattos et al., 2016).

The findings also indicate that Brazilian home birth teams tend to adopt practices broadly aligned with international midwife-led models. Continuity from antenatal to postnatal care, eligibility criteria for low-risk pregnancies, informed decision-making, non-pharmacological pain relief, respect for physiological birth, and support for women's autonomy were recurring features across the studies (Webler et al., 2023; Peripolli, 2019; Da Silva et al., 2019; Bochnia et al., 2019; Santos et al., 2018; Mattos et al., 2018; Koettker et al., 2013; Koettker et al., 2012). These characteristics are consistent with international evidence on midwife-led continuity models and with guidance that supports physiological labour and birth (Birthplace in England Collaborative Group, 2011; NICE, 2017; WHO, 2018; WHO, 2024). However, in contrast to countries where home birth is formally integrated into health systems, the Brazilian literature revealed limited standardisation in intrapartum detail, postpartum follow-up routines, and neonatal care reporting (Mattos et al., 2018; Koettker et al., 2013; Koettker et al., 2012).

Another important synthesis concerns the relationship between clinical organisation and structural vulnerability. Although several studies described the use of emergency equipment, transfer planning, and evidence-based criteria for care, they also reported repeated difficulties in obtaining medications and supplies, limited authority to request diagnostic tests, barriers to issuing live birth certificates, and fragile coordination with hospital services (Dos Santos Pascoto et al., 2020; Peripolli, 2019; Mattos et al., 2016; Sanfelice et al., 2014; Webler et al., 2023). The recent COFEN Resolution no. 786/2025 represents an important regulatory advance by formally defining minimum requirements for planned home birth practice. Even so, the review suggests that regulation alone does not resolve the lack of integrated referral pathways, standardised clinical protocols, or unified monitoring systems (Webler et al., 2023; Dos Santos Pascoto et al., 2020; Da Silva et al., 2019; Mattos et al., 2018).

The quantitative evidence included in the review was limited and derived from only a small number of studies, some of which appear to represent secondary analyses from the same empirical settings. For example, Koettker et al. (2012) and Koettker et al. (2013) seem to report different analyses from the same service in Florianópolis, and Mattos et al. (2016) and Mattos

et al. (2018) also appear to draw on related professional contexts. Although these publications contributed distinct findings, this overlap limits the extent to which the literature can be interpreted as representing independent models of care across Brazil. It also reinforces the concentration of available evidence in a small number of teams and local contexts.

These findings suggest that the main weakness of PHB in Brazil is not the absence of a recognisable care model, but the absence of structural conditions to sustain and monitor that model consistently across settings. In other words, the literature points less to clinical incoherence within teams than to institutional fragmentation around them. This distinction is important because it shifts the focus of analysis from individual professional practice alone to the broader health system arrangements required for safe and equitable planned home birth care.

Hospital transfer emerged as the most critical challenge. International literature indicates that intrapartum transfer is an expected component of PHB models and, when supported by integrated systems, is not inherently associated with poor outcomes (Nethery et al., 2021). A systematic review reported transfer rates and reasons that align with safe escalation pathways when eligibility and referral protocols are in place (Blix et al., 2014). In Brazil, however, qualitative and observational reports describe fragile coordination, non-welcoming environments and even private-vehicle transfers, underscoring the system-level gap (Mattos et al., 2016; Sanfelice et al., 2014; Dos Santos Pascoto et al., 2020). Even though Brazil has an emergency response system (SAMU), its coverage is inconsistent and lacks formal articulation with PHB teams. Beyond clinical outcomes, recent qualitative work shows that the experience of transfer can range from supportive to distressing depending on inter-service relationships, clarity of roles and receiving-unit culture (Neerland et al., 2025). This is consistent with Brazilian reports of strained handovers and perceived institutional stigma, which may contribute to hesitation in initiating transfers even when clinically indicated (Webler et al., 2023; Peripolli, 2019; Da Silva et al., 2019).

The review also found that quality and safety monitoring in Brazilian PHB remains underdeveloped. Only a small subset of studies reported quantitative outcomes, and even then, outcome reporting was not based on a common framework. The available studies described transfer rates, caesarean sections among transferred women, Apgar scores, episiotomy, perineal outcomes and neonatal intensive care admissions, but these measures were reported inconsistently and without standardised definitions across studies (Koettker et al., 2012; Koettker et al., 2013; Santos et al., 2018). This limits comparability between teams and hinders broader assessment of safety, quality, and performance. The absence of formal indicators

therefore appears not merely as a methodological issue in the literature, but as a relevant weakness in the governance of the model itself.

Recent comparative analyses also support that, for low-risk populations and within structured systems, outcomes for planned home births can be comparable to those in midwifery-led birth centres (Bovbjerg et al., 2024). This international pattern reinforces our interpretation that Brazilian teams tend to mirror midwife-led practices. However this interpretation must be treated cautiously, given the scarcity of Brazilian studies, their uneven regional distribution, and the limited independence of part of the evidence base. Without system integration, standardised indicators and formal referral pathways, the capacity to achieve comparable results at population level remains limited (Bovbjerg et al., 2024; Reitsma et al., 2020; Scarf et al., 2018).

In summary, the review indicates that PHB in Brazil has evolved as a midwife-led model that is technically and ethically aligned with key features of international midwife-led care, particularly continuity, physiological birth support, and respect for women's autonomy. However, its development has occurred in a context of structural non-integration with the health system. As a result, the main barriers to its consolidation as an accessible, equitable, and monitorable model of care are not only clinical, but institutional: the absence of national technical standards, formal referral arrangements, unified indicators, and supportive public policies.

CONCLUSIONS

Planned home birth in Brazil has evolved as a midwife-led model operating outside the public health system and primarily sustained by independent, self-employed midwives and nurse-midwives. Care provision is grounded in international recommendations and professional regulation rather than national standards. As a result, even where clinical practices align with midwife-led physiological care, the model remains structurally fragmented, with restricted access and limited system-level integration.

Compared with countries where PHB is integrated into public health systems, this configuration raises concerns for equity, data comparability, and safety oversight. Moving forward will require national clinical protocols with core indicators, formal referral pathways linked to hospital services, and regulated access to essential supplies and continuing professional development. Strengthening these structural elements would bring Brazil closer to international standards while preserving the core midwife-led principles that underpin PHB.

Study Limitations

This review is limited by the scarcity of national research on the PHB care in Brazil, the concentration of evidence in a small number of local teams and services, and the heterogeneity of reporting across studies, particularly regarding outcomes and indicators. In addition, some included publications appear to derive from the same empirical contexts while addressing different research questions, which limits the independence of part of the evidence base. New research may add evidence that refines or expands the findings presented here.

Contributions to the Field

By identifying recurrent features of how planned home birth care is organised and practiced in Brazil, this review provides a clearer analytical basis for future regulatory frameworks, standardised clinical protocols, monitoring indicators, and policy debate. The findings also show that strengthening planned home birth in Brazil depends not only on professional regulation, but on improving integration with referral services, data systems, and broader health system governance.

Use of Artificial Intelligence

Artificial intelligence (AI) tools, specifically ChatGPT (OpenAI, 2024), were used to assist in improving the language clarity and coherence of this manuscript. The authors reviewed, edited, and approved all AI generated content and take full responsibility for the integrity and accuracy of the final version.

Word count (excluding references, tables and figure): 5,531

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CRediT Authorship Contribution Statement

Thayná Queiroz: Writing, review & editing, Writing – original draft, Visualization, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Jamile Bussadori:** Writing, Review & editing, Visualization, Conceptualization, Methodology, Formal analysis. **Pollyana Silva:** Writing – review & editing, Writing – original draft,

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Acknowledgements

We appreciate the funding opportunity from CNPQ and CAPES and the collaboration of Librarian Ana.

Funding Statement

This work was supported by the Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPq) [grant number(s) 141409/2023-1] and Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (CAPES) [grant number(s) 88881.980792/2024 01]

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at https://osf.io/axh52.

Declaration of Interest Statement

[ ]The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

[x] The author is an Editorial Board Member/Editor-in-Chief/Associate Editor/Guest Editor for this journal and was not involved in the editorial review or the decision to publish this article.

[x]The authors declare the following financial interests/personal relationships which may be considered as potential competing interests:

Autors approved the version submitted.

This work is part of the doctoral research of author Thayná Caixeiro Queiroz. It was funded by the National Council for Scientific and Technological Development (CNPq) through a doctoral scholarship in Brazil, and by the Coordination for the Improvement of Higher Education Personnel (CAPES) through a scholarship for international doctoral exchange.

Author Christine McCourt is an Editorial Board Member for this journal and was not involved in the editorial review or the decision to publish this article.

Author Nathalie Leister is a Guest Editor for this journal and was not involved in the editorial review or the decision to publish this article.