Cogitare Enfermagem

ORIGINAL ARTICLE

Autonomic obstetric nursing: experiences and responsibilities related to the construction of the prenatal

HIGHLIGHTS

1. Obstetric care should prioritize humanized care.
2. Recognizing the rights of women is a duty of the obstetric professional.
3. Multi-professional conduct should be valued in the follow-up to pregnancy.
4. It is necessary to understand the singularity of the life of each pregnant woman.

Carine Amabile Guimarães[1]
Vanessa de Souza Aquino[1]

ABSTRACT

Objective: Understand the construction of the prenatal by autonomous obstetric nurses, considering their experiences, challenges and professional learning. **Method:** Descriptive study with a qualitative approach, in which participated seven autonomous obstetric nurses from different regions of Brazil, with at least one year of practice. Data collection took place in September 2024, followed by transcription and analysis of the interviews in November 2024. The data, obtained through online interviews, were transcribed and interpreted through content analysis. **Results:** It was observed that the follow-up provided by obstetric nurses prioritizes the woman, values her individuality, transmits information effectively and positively impacts pregnancy, with evidence-based behaviors. **Conclusion:** This study contributes to the legitimate struggle for the valuation of the professionals in question, by recognizing experiences that show significant results in relation to the prenatal care performed effectively.

KEYWORDS: Women's Health, Pregnancy, Maternal-Fetal Relations, Nursing Care, Maternal-Child Nursing.

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[1]Universidade do Alto Uruguai e das Missões, Campus Santo Ângelo, RS, Brasil.

INTRODUCTION

There is a process linked to the conception of a child, uniquely represented by the signs of presumption, probability and certainty of a pregnancy, a stage marked by symptoms that often go unnoticed, until the confirmation of pregnancy is announced, revealing a new story to be told. From this, the choice of good professionals for gestational monitoring becomes fundamental for a good maternal experience, with emphasis on the operation of obstetric nursing, which, in order to contribute positively to the quality of care to the pregnant woman, represents a professional practice based on safe recommendations and enables the performance of techniques in a qualified manner[1].

In accordance with this, it is known that the protagonism of the woman must be expressly prioritized during the construction of the prenatal, becoming more obvious when recorded in the pregnant woman's delivery plan (DP), in which she strategically describes her decisions in the most detailed way possible, resulting in an important document at the time when the challenges make her emotionally and physically vulnerable. Thus, it is understood that expressing her most intimate desires and desires is only possible when the woman understands the entire gestational process and manages to realize her expectations within what can happen during childbirth[2].

Thus, profitable listening favors effective communication, in which the way the professional conducts the prenatal directly affects the understanding of the woman about the gestational process, whose firm bond can mean greater adherence to consultations due to the construction of a favorable interpersonal relationship[3].

It is also important to highlight the challenges faced by the category in question, as regards professional valuation, in most cases the construction of bond and dialogue between the professional and the patient is not respected in hospital environments, demonstrating failure in relation to the outcome of a pregnancy. Thus, a collective effort in favor of the mother-child binomial becomes necessary so that the potential built during prenatal is not lost[4].

The present study seeks to understand the construction of the prenatal by autonomous obstetric nurses, considering their experiences, challenges and professional learning. It is justified by the persistent struggle for visibility and valuation of these professionals, reiterating their essence in the progress and effectiveness in prenatal planning.

METHOD

Descriptive study with a qualitative approach, enabling multifaceted views of the subject addressed, since the professional recognition of obstetric nursing still presents cultural gaps in the Brazilian population. Thus, considering that the chosen method elaborates its theories, methods, principles and establishes its results[5], it is understood that the interview as data collection, provides greater flexibility and the feeling of proximity between the interviewer and the participant.

It is known that "the interview enables an opportune moment for the expression of experiences not revealed in other contexts and that, when reviewing your history, the perception about her and about yourself can change throughout the narration"[6:1], potentiating the idea that social context, professional objective and methods of care influence different convictions of the category addressed.

Considering distance as an indispensable factor for conducting face-to-face interviews, participants were contacted through their professional social networks, and subsequently the contact followed via e-mail. In this, the presentation of the project and the Terms of Free and Informed Consent (TFIC) took place, including the adjustments of the date, time of the interview and receipt of the signed and digitized term.

As inclusion criteria, graduate nursing professionals were chosen, with at least one year of experience as obstetric nurse; and, as exclusion criterion, not acting autonomously in the mentioned category. Thus, the guiding question of the research was: how are consultations in the construction of the prenatal by autonomous obstetric nurses carried out?

It should be noted that the interviews were conducted online and lasted an average of one hour each, via the platform *Google Meet*, being recorded with a camera and properly archived. It should be noted that the interviews took place individually between the participants and the interviewer without any interruption. The TFIC was read prior to each interview, prioritizing clarification of the participant's free choice to withdraw from the study at any time, preserving their anonymity and considering that any harm to the participant's physical or mental health would be the responsibility of the researchers.

This study included seven professionals who met the inclusion criteria. These professionals are trained and operate in various regions of the country, enriching the study through distinct social realities that enable multifaceted views of care. So, in order not to reveal the identities of the participants, they were named with the letter "P" (Participant), continuing to number according to the order (P1, P2, P3, P4... P7) during the data analysis.

The questions present in the interview were divided into two parts: the first to identify the participant (name, age, year of training in nursing, year of training in obstetrics and the municipality where she works). The second stage included six subjective questions, with the aim of understanding the form of care, questioning the organization of the prenatal process within the consultations, main guidelines, the professional vision within their social reality, experiences associated with the delivery plan considering the types of delivery and challenges faced.

Meanwhile, the data collection took place in September 2024, followed by the transcription and analysis of the interviews in November 2024, and the reproduction of the speeches made it possible to interpret the subjective data, obtained individually from each participant. It was not possible to categorize the answers due to the degree of individuality and diversity regarding the professional experiences of each participant. Despite this, the information obtained reveals large professional potential of the participants and explores ambiguous experiences in the construction of the prenatal.

Through the data obtained in the interviews, analysis of the content of the questions and answers transcribed faithfully to the recording was carried out, because it is believed that through the analysis of the content, the constructed inferences and the quality of the process that precedes the conclusion of the study become even more essential in terms of the credibility of the work[7].

The sites chosen as research sources were: Scientific Electronic Library Online (SciELO), BVS Regional Portal and Coordination for the Improvement of Higher Level Personnel (CAPES). Considering the faithful transcription of the speeches, it was possible to create a picture with the demographic data of the participants, which made it possible to compare the time of performance and training, as well as in the course

of the study the social reality in which each lives in the municipality of care. Thus, it becomes potentially relevant to seek various interpretations regarding a subject, since the content analysis comprises a fundamental process in order to deepen knowledge and make new questions arise through the deep reading[8].

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RESULTS

Chart 1 describes data obtained during the interview as identification of each participant.

Chart 1. Demographic characteristics of participants. Santo Ângelo, RS, Brazil, 2024

Participant	Age	Actuation in Nursing	Actuation in obstetric nursing	Municipality and state of operation
P1	28 years	6 years	1 year and 5 months	Campinas (SP)
P2	46 years	19 years	9 years	Rio de Janeiro (RJ)
P3	44 years	20 years	19 years	São Paulo (SP)
P4	40 years	18 years	9 years	Aracaju (SE)
P5	31 years	7 years	3 years	Campinas (SP)
P6	32 years	9 years	7 years	Nova Mutum (MT)
P7	47 years	25 years	24 years	São Paulo (SP)

Source: The authors (2024).

For initial understanding of the construction of the prenatal, participants were asked about how the provision of service happens in the context of customer care and in the relationship with other professionals, being predominant the establishment of multi-professional partnerships, either in a shared environment or through indications, the following facts expressed:

[...] I have partnerships, even because the performance when it is 24 hours needs to have backup professionals, if it is necessary to have someone to count on is very important (P1).

Attending autonomously, in the hospitals in São Paulo you accompany but always linked to the patient's obstetric doctor, it is he who interned the patient and supported the entrance of the obstetric nurse (P3).

Here we are three Nurses and three Doctors [...] today we have a shared model, starts with the doctor, and later with us, that we promote perinatal education, has the care together and also individual consultations mine, this shared model causes a very good alignment of conduct for the pregnant woman, makes the follow-up harmonic (P5).

I have a partnership with two obstetric nurses and have appointments from professionals such as physicians, nutritionists and psychologists (P6).

When questioned about the main topics discussed during the prenatal process, the physiology of vaginal delivery, the phases of labor and interventions were mostly highlighted as indispensable topics in determining the expectations of each patient, aspects that are usually linked to the pregnant woman's greatest fears. Reality exposed on sequence:

[...] one of the main guidelines is about childbirth, this makes the consultations extensive, they are at least two hours of attendance, I have a model that I pass to them about the childbirth plan and also about the stages of childbirth (P1).

I like that they try to understand about the necessary interventions because I realize that women who seek natural birth when they need intervention they get extremely disturbed (P2).

[...] I always think so and I pass it to them, if something happens to me tomorrow, they need to know what to do, to be independent, I educate pregnant women so that they are not dependent on me, but rather that they understand the process (P4).

[...] I follow all protocols of the Ministry of Health, normally I divide the guidelines by trimester [...] and in the last trimester focused on breastfeeding, care for the newborn and childbirth work, clear within these matters much earlier until to understand the expectations and then resume (P6).

Orientation on childbirth phases, analgesia, childbirth plan, adverse outcomes, risks, on cesarean, shoulder dystocia, fetal death and other interventions in childbirth, of course that depends on whether it is home or hospital delivery. Everything is adapted to the situation, it is always oriented regarding the childbirth done by a plant specialist, it is done a whole preparation, as we know well each hospital this helps prepare the pregnant woman (P7).

Faced with the facts expressed, it is possible to note a search for excellence and bond in the professional conduct of each participant, even if, culturally, gestational consultations are seen only as a checklist of examinations and basic information by the majority of the Brazilian population. This goes totally against the immediatism perpetuated in society and which negatively affects the professional and patient relationship.

In this context, investing in qualified listening and resolving behaviors is not only necessary, but it is also a duty of the health professional who carries out care during prenatal. In order to promote access to a positive experience in pregnancy, the professional can use tools that facilitate this process, such as the Birth Plan (DP), promoting the protagonism of the woman during the stages and facilitating the face of possible adversities. Fortunately, all participants have knowledge and apply DP during prenatal, as evidenced in the following words:

I find it magnificent, it gives more security to the pregnant woman, I do not see it as a way to "beat" in front of the labor team, I see it as a way to improve the communication of the pregnant woman with the hospital staff as well (P1).

Because they are patients who have special obstetrics and most of them I know the work, that is, I already know the profile of each one, I always talk to them to implement the plan, however it has already been communicated to their wishes for us that we do the prenatal, it is necessary to describe in the delivery plan, because in the hospital the team that will attend her does not know her, the plantonist primarily in case of such being; this even I accompanying the whole process. In this question of plantonists, I see that the interventions are not so imposed by plantonists, due to my profile of patients of middle and upper class, many professionals are afraid to suffer

processes, so the medical interventions are not a challenge, the will of the pregnant woman as well as the birth plan are respected (P3)

My view is that families do not give the importance they should to the delivery plan, my biggest concern is that the woman understands what is there, registered, and that indeed her choices are respected (P4).

[...] all my patients construct the delivery plan, sometimes some do not want to, but I always instruct them to have it printed and request that the plan be attached to the record or signed by the professionals who received it (P6).

[...] a delivery plan that comes ready makes no sense, because she will only be checking something ready without knowing what that actually means [...] I always ask that they have the guardian of the delivery plan, usually the companion or the doula, who will remind her of what she decided at the moment when she was thinking about a particular subject (P7).

It is concluded that DP is not always adhered to by the patient or hospital staff, a challenge that is part of the daily life of the professional prepared to put it into practice. A situation that once again reveals the need for social immediacy, because at least health professionals do not respect the construction that involves the plan.

When asked about professional experiences in relation to vaginal delivery, the interviewees portray similar views, but different challenges, established according to their social reality, whether by the capacity of health services and/or the financial power of the patient. Thus, the question sought to understand, in general, how autonomous professionals face certain situations in the face of labor, experiences described here:

[...] I take care of patients so much that they are accompanied by a particular doctor when through their, I see many flaws in this preparation, and I believe that the pregnant woman who is oriented is the pregnant woman who has power, because she knows everything that will or can happen on the day of delivery. Here where I attend there are two hospitals with humanized delivery structure, which is very good, with privacy, so are those that I indicate, but not always the patient can, for issues of health or financial plan, in this case if the hospital of choice is another I prepare them as to the structure; even if the unit only has gynecological table, I orient that the pregnant woman does not need to give birth there, there are other possibilities that are more indicated and that helps at the time of delivery (P1).

There is a paradigm of cesarean, the profile is of cesareans in their majority, although there is an increase in the demand for childbirth, I try to guide my patients a lot about pros and cons of cesarean and childbirth; especially when I see that there is a great opportunity in a vaginal delivery (P3).

I have lived very positive experiences [...] it is very satisfying to see the woman carrying out childbirth with the minimum of interventions and without violence, of course that in my case in the maternities in the SUS and some particular way is allowed the entry only from Doulas, so when it depends on the planners the challenges are greater, so the need to actually prepare the pregnant women and accompanying women (P5).

Some patients I get to start the attempt to give birth, I establish the information, risks, including pros and cons, if the patient does not want everything well, but I feel that I need to try because often they do not want to do because of fear and lack of information (P6).

[...] for me, childbirth is childbirth, cesarean is a birth pathway, a surgical fetal extraction, my experience has changed a lot from my training to here, I act autonomously for 15 years, and I have been withdrawing more and more intervention, I have been

more assertive in the labor process (P7).

Thus, it is possible to identify the greater insistence of professionals in the attempt of labor and natural delivery, with the least possible interventions and the need to adapt to these situations in favor of the binomial, so that labor and labor take place in the best possible way.

Moreover, considering that nursing is still an extremely undervalued profession, this study aimed to further explore the main challenges faced in the practice of obstetric nursing. Even though some adversities in the professional everyday life of the category have already been presented in much of the answers, it is still possible to explore the following new questions:

[...] I have seen a situation where the pregnant woman presented a fasting glucose of 96mg/dL in the tests [...] in this case the doctor considered a healthy pregnancy, the baby ended up reaching a percentile of 99%, being the pregnant woman with diabetes, so I had to do all the guidance to her about this, which left her quite scared and insecure, not counting the situations with planting doctors during childbirth, most are Caesareans, so any difficulty during the process, they create a way to offer Caesarean as the best option (P1).

I consider a big challenge the lack of appreciation of the class, of our conduct during labor, because as I still treat with a doctor, there is a lot that business, I am the doctor I decide, you are here to be the cherry of the cake of labor, some doctors like to say that there is a obstetric nurse, but do not discuss a conduct, we see that we are there for decoration (P3).

Today the plant scenario is my biggest challenge, when it depends on the planters, in relation to the divergences of conduct, know how to handle the frustration of the pregnant woman and mine too, including the situation of unnecessary cesarean (P5).

Here you can still see our work as if they were just following the labor, so many pregnant women come to me at the end of the pregnancy, it becomes well-running to supply the prenatal that is necessary (P6).

The speeches demonstrated knowledge and safety among the professionals who participated in the study, which contributed to a fluid and simple interpretative reading. Among them, great courage emerged when they launched into a job market, often unfair and devalued. And yet, by reporting the reality in healthcare environments that still work through culturally backward models, they demonstrate that there is a long way to go in terms of truly humanized care.

Thus, it was understood that each pregnant woman should receive care that respects her choices, values her individuality, conveys information effectively and possesses evidence-based behaviors.

DISCUSSION

Regarding the construction of the prenatal hospital by obstetric nurses, the wide search for professional valuation has become remarkable, even though there are challenges in everyday life, aiming at a care that goes the opposite way to the current, constantly inefficient and flawed care model.

Through advances in the various modalities of health care, especially by nursing, there is an express growth in the provision of services in consultation or at home, and these are regulated by the Federal Council of Nursing (COFEN) which considers "the legal support of nurses to act autonomously and/or liberally through services contracts aimed at carrying out work related to consultations and programs and projects in their area of action"[9:1].

Uniting professional growth with humanized practice contributes to reaffirming the essence of nursing, as their conduct is based on scientific evidence and ensured by legislation that regulates their rights and duties[10]. Considering, including, that the presence of obstetric nursing care is linked to a higher quality of care provided to the pregnant woman, reduced risks of maternal mortality and increased promotion of reproductive health[11].

In this context, considering the individuality of the woman as a way to promote quality in the gestational process, the strategy in health in the construction of a delivery plan (DP) throughout the prenatal, in which the priority is established the female protagonism and reveals real consideration to the desires of the woman[12], contributing to the formation of real expectations and broad notion of the gestational scenario in a fair manner.

It is understood that the final period of pregnancy and respective labor of childbirth cause in the woman in labor changes at the physical and emotional level, therefore, establishing in advance and thoroughly the wishes of the woman makes the process less tiring and more human. When the health team does not consider the information exposed in the delivery plan it is evident that she will not be able to respect and prioritize the autonomy of the woman[13], and consequently there will be failures in the process of care for the mother-son binomial.

Thus, when all the people around childbirth prioritize care for the woman, there will be little chance of making the moment traumatizing for her, as the will of the childbirth is respected and she understands that all actions are carried out considering her rights and her autonomy as a woman and mother[14].

The daily care of an obstetric nurse does not always mean that she is allowed, for example, to be next to the pregnant woman at the time of labor, a fact that depends on the institution of choice and the respective internal protocols. Therefore, the prenatal process should also prepare the pregnant woman and her companion for this moment, where what was discussed and decided in the prenatal consultations is respected and followed by the health team, therefore, there must be a record of everything that was discussed and decided by the pregnant woman during the consultations[15].

It is known that the majority of prenatal procedures currently performed do not count on humanized and efficient methods in the follow-up to the pregnant woman, and the goal of the delivery plan does not meet only methodologies, it also values the opinion of the pregnant woman, ironically not always respected, in this sense, it becomes essential that if the woman has a delivery plan, the conditions for its implementation, organization of the place of care, limitations related to the unity and the availability of certain methods and techniques should be taken into account[16].

At the same time, it becomes indisputable the importance of improvement in the prenatal process, whether public or private, with the aim of reducing the use of unnecessary interventions, thus enabling the ideal support in all areas that the gestational process should ensure the pregnant woman, concepts that end up going

against obstetric medical traditions, which foster a culture in which the individuality of the woman is not considered and assigns the surgical path as ideal for all women[17].

In accordance with the above, the English Pediatrist and Psychoanalyst Donald Woods Winnicott, recognized for his theory of "the mother sufficiently good proceeds from an absolute adaptation and, a little later, to a relative adaptation to the real needs of the baby"[18:525] that is, the absolute adaptation fits the prenatal and its planning to receive what is still unknown, later, the stage of puerperium is directed to the baby. Offering the woman a childbirth with a minimum of interventions means a less painful and/or disabled postpartum, contributing to an adaptation to the new phase of the newborn and not to forget about the woman's life.

In this sense, it is understood that the newborn is provided with individuality and specific needs, and it is necessary to recognize expectations during pregnancy and seek to adapt the wills of the pregnant woman in a fair way to her reality. Especially during prenatal, when it becomes essential to encourage empowerment through self-knowledge in relation to the body itself and to lap the expectations and desires regarding motherhood[19].

Therefore, it is understood that the obstetric nursing professional possesses the technical skills necessary to offer assistance in a humanized and qualified way to the pregnant woman in all the processes that involve her, as well as the care of the newborn until its first year of life, going beyond the standards currently imposed on the right of choice of the pregnant woman, childbirth and postpartum, valuing those who are the main goal of a qualified care: the binomial, woman and her child[20].

Thus, by expressing a deep desire to create ties with the pregnant woman, these professionals open ways for the change of millennial practices that result in pain, fear and exclusion. Since this quest does not mean less obstacles in the pregnancy period, but rather, the understanding of what the woman is experiencing and what she may face during pregnancy, labor or childbirth.

This study is limited by the number of participants, but the data collected reflect the grandness of the work carried out, the autonomy of these professionals and the importance of their action for the health of the pregnant woman. It is identified among the participants extreme dedication to the profession in a comprehensive way, going far beyond the care and establishing bonds of reliability between patient and professional.

Therefore, it becomes obvious that obstetric nursing enriches gestational follow-up, being marked by humanized care and based on scientific evidence. Thus, this and other studies should corroborate for the evaluation of the category. It also implies the need to implement specialized care by obstetric nurses in obstetric centers and maternity centers, whether in a public or private environment, in order to complement the assistance to the pregnant woman and the newborn, contributing to improvements in the health services of the country.

FINAL CONSIDERATIONS

In this context, it becomes extremely relevant to understand the pregnant woman not only as someone who carries a child, but as a woman with her life, her family, her expectations, her desires and her dreams. Only basic checklist queries and automatic questions result in failures in gestational monitoring. The obstetric professional should

offer qualified care, centered on the woman and her protagonism, prioritizing the recognition of her limitations, wills and the environment in which the pregnant woman is inserted.

At the same time, obstetric nursing has robust challenges with regard to the interventionist culture in health, in which medical immediacy seeks to offer quick solutions to issues related to labor, most often unnecessary and resulting in harm to maternal health. In contrast, there is a growing movement of women in search of a healthier pregnancy and, subsequently, the realization of natural delivery in a humanized way.

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Corresponding author:
Vanessa de Souza Aquino
Universidade Regional Integrada do Alto Uruguai e das Missões
Rua Universidade Missões 464, Santo Ângelo, RS.
E-mail: vanessaaquino@aluno.santoangelo.uri.br

Role of Authors:
Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - **Aquino VS.** Drafting the work or revising it critically for important intellectual content - **Aquino VS.** Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - **Guimarães CA.** All authors approved the final version of the text.

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