ISSN-e [2675-5602]

Global Academic Nursing Journal

ORIGINAL ARTICLE

The role of obstetric nursing in hospital care during labor and delivery

El papel de la enfermería obstétrica en la atención hospitalaria durante el trabajo de parto y el parto

A atuação da enfermagem obstétrica na assistência hospitalar ao trabalho de parto e parto

Caroline Gomes Chibante[1]
ORCID: 0000-0002-2878-7197
Carlos Eduardo Pessanha Boller[1*]
ORCID: 0000-0002-5180-3159
Eric Rosa Pereira[2]
ORCID: 0000-0003-0202-6653
Paulo Alexandre de Souza São Bento[1]
ORCID: 0000-0002-1598-3340

[1]Instituto Nacional de Saúde da Mulher, da Criança e do Adolescente Fernandes Figueira/Fiocruz. Rio de Janeiro, Brazil.
[2]Faculdade Souza Marques. Rio de Janeiro, Brazil.

How to cite this article:
Chibante CG, Boller CEP, Pereira ER, São Bento PAS. The role of obstetric nursing in hospital care during labor and delivery. Glob Acad Nurs. 2026;7(1):e533. https://dx.doi.org/10.5935/2675-5602.20200533

***Corresponding author:**
kadu.boller@gmail.com

Submission: 12-22-2025
Approval: 01-24-2026

Abstract

The aim was to understand the role of obstetric nurses in assisting women during labor and delivery, particularly those with low-risk pregnancies, in hospital units. This qualitative study was conducted in two medium-sized specialized public maternity hospitals in the city of Rio de Janeiro with 23 obstetric nurses experienced in the field. Data was collected through semi-structured interviews. Content analysis was performed using Bardin's methodology. The research was approved by two Ethics and Research Committees (opinions 4.333.114/4.387.593). Two categories emerged: 'as expected: the role of obstetric nursing' and 'under and about resistance: the autonomy of obstetric nurses'. The study observed observations made by the professionals regarding their performance and autonomy in assisting women during labor and delivery, as well as the setbacks faced in the daily routine of this assistance within the hospital setting. It is concluded that the participants recognize the importance of humanized care and address a set of measures based, for example, on welcoming, listening, guidance, and non-pharmacological technologies. They also understand that their actions are supported by Law No. 7,498/86 and the Professional Code of Ethics, guaranteeing autonomy and freedom of action.

Descriptors: Birthing Centers; Obstetric Nursing; Humanizing Delivery; Natural Childbirth; Delivery Rooms.

Resumén

El objetivo fue comprender el papel de las enfermeras obstétricas en la asistencia a las mujeres durante el trabajo de parto y el parto, particularmente aquellas con embarazos de bajo riesgo, en unidades hospitalarias. Este estudio cualitativo se realizó en dos maternidades públicas especializadas de tamaño medio en la ciudad de Río de Janeiro con 23 enfermeras obstétricas con experiencia en el campo. Los datos se recopilaron mediante entrevistas semiestructuradas. El análisis de contenido se realizó utilizando la metodología de Bardin. La investigación fue aprobada por dos Comités de Ética e Investigación (opiniones 4.333.114/4.387.593). Surgieron dos categorías: "como se esperaba: el papel de la enfermería obstétrica" y "bajo y sobre la resistencia: la autonomía de las enfermeras obstétricas". El estudio observó observaciones realizadas por los profesionales sobre su desempeño y autonomía en la asistencia a las mujeres durante el trabajo de parto y el parto, así como los reveses enfrentados en la rutina diaria de esta asistencia dentro del entorno hospitalario. Se concluye que los participantes reconocen la importancia de la atención humanizada y abordan un conjunto de medidas basadas, por ejemplo, en la acogida, la escucha, la orientación y el uso de tecnologías no farmacológicas. También comprenden que sus acciones se sustentan en la Ley n.º 7.498/86 y el Código de Ética Profesional, lo que garantiza la autonomía y la libertad de acción.

Descriptores: Centros de Asistencia al Embarazo y al Parto; Enfermería Obstétrica; Parto Humanizado; Parto Normal; Salas de Parto.

Resumo

Objetivou-se compreender a atuação das enfermeiras obstétricas na assistência ao trabalho de parto e parto, de risco habitual, em unidades hospitalares. Estudo qualitativo realizado em duas maternidades públicas especializadas de médio porte do município do Rio de Janeiro com 23 enfermeiras obstétricas com experiência na área. A coleta se deu por meio de entrevista semiestruturada. Realizada a Análise de Conteúdo por Bardin. A pesquisa foi aprovada por dois Comitês de Ética e Pesquisa (pareceres 4.333.114/4.387.593). Emergiram duas categorias: 'como manda o figurino: a atuação da enfermagem obstétrica' e 'sobre e sob resistência: a autonomia dos enfermeiros obstétricos'. Observaram-se apontamentos realizados pelos profissionais sobre sua atuação e autonomia na assistência à mulher no trabalho de parto e parto e os reveses enfrentados no cotidiano desta assistência em âmbito hospitalar. Conclui-se que as participantes reconhecem a importância do cuidado humanizado e abordam um conjunto de medidas pautadas, por exemplo, no acolhimento, escuta, orientações e tecnologias não farmacológicas. Também entendem a atuação respaldada pela Lei n.º 7.498/86 e pelo Código de Ética do Profissional, garantindo autonomia e liberdade de atuação.

Descritores: Centros de Assistência à Gravidez e ao Parto; Enfermagem Obstétrica; Parto Humanizado; Parto Normal; Salas de Parto.

Introduction

Pregnancy is a time in life marked by intense physical, hormonal, emotional, and psychological transformations, directly or indirectly impacting the self-image and self-esteem of the pregnant woman, as well as her social relationships and her relationship with herself[1,2].

Therefore, childbirth is a unique experience marked by emotional, social, and cultural issues experienced from subjective perspectives. More than a biological event, it is a complex process involving dimensions that can evoke feelings and memories, whether positive or negative[1,3].

In the context of women's healthcare in Brazil, according to the document HumanizaSUS: Humanization of childbirth and birth[4], obstetric nursing plays an essential role in promoting a humanized model of care for childbirth and birth. By incorporating practices based on scientific evidence that respect the physiology of birth, as well as autonomy, it contributes to the reduction of interventions considered unnecessary in this healthcare setting.

Nursing care during childbirth and delivery is supported by Law No. 7,498/1986, regulated by Decree No. 94,406/1987. According to Article 11, item I, subparagraphs g, h, and i, it is the responsibility of the Nurse, as a member of the health team, to provide: "nursing care to pregnant women, women in labor, and postpartum women; monitoring the progress and labor; and performing deliveries without dystocia." The Law adds a single paragraph to the article, subparagraphs a and b, legitimizing that it is the responsibility of Obstetric Nurses (ONs) to provide: "care to the woman in labor and normal delivery; and identification of obstetric dystocias and taking measures until the arrival of the physician."5 In addition, there is COFEN Resolution No. 516/2016[6] (and its subsequent amendments by Resolutions No. 524/2016 and 672/2021), which regulates the actions of Nurses, Obstetric Nurses, and Midwives with pregnant women, women in labor, postpartum women, and newborns, defining responsibilities.

It is worth noting that, despite the legal frameworks, Ferreira and colleagues[7] state that obstetric nursing teams still routinely face several structural and cultural obstacles that compromise the full exercise of their professional practice. Among the challenges are restricted areas of practice, little professional autonomy, medical hegemony, and the biomedical model of care, which is still dominant in health services.

Given this context, reflections arise regarding the role of the ONs, as members of the healthcare team, and their responsibilities in assisting the parturient woman. It is also worth reflecting on how these professionals understand their role, considering the exercise of their autonomy, since they have legal backing to conduct care in low-risk childbirths.

That being said, the objective of this research is to understand the role of obstetric nurses in assisting with labor and delivery of low-risk pregnancies in hospital units. This research aims to foster dialogue on the topic and contribute to the construction of a theoretical framework capable of highlighting the challenges faced by professionals working on the front lines of childbirth care.

Methodology

This is a qualitative, descriptive study that used the content analysis method proposed by Laurence Bardin[8].

The research was conducted in two maternity hospitals located in programmatic areas 2.1 and 3.2 of the municipality of Rio de Janeiro. Both units, according to the National Registry of Health Establishments[9], have neonatal ICU beds, attending to high-risk fetal pregnancies without maternal risk. The interest in conducting the research in these institutions stemmed from the main author of this article, as she was a resident in obstetric nursing working in these practice settings.

Twenty-three healthcare professionals (ONs) with employment contracts, holding a specialist title in the field, and with at least two years of hospital professional experience after obtaining the title, were included as participants in the study. Professionals who did not agree to participate in the research and those who, due to scheduling conflicts, could not schedule the interview were excluded.

Data collection was carried out through a semi-structured interview, containing seven open-ended and nine closed-ended questions. The face-to-face meetings for the interviews took place at a convenient time for both the researcher and the participant, with prior scheduling of a private location free from interference. The interviews were recorded using a mobile phone application, totaling 7 hours of recording. The interviews were transcribed and read by the authors in the following stages: pre-analysis, exploration of the material, treatment of the results obtained, and interpretation. Sample saturation was obtained from the frequency distribution of statements[10]. The data obtained through the interviews were subjected to the Content Analysis proposed by Bardin[8].

The research was conducted in accordance with ethical and legal precepts, approved by two Research Ethics Committees (RECs) related to the institutions that were the study settings, under opinions No. 4,333,114 and No. 4,387,593, respectively, the Fernandes Figueira National Institute of Women's, Children's and Adolescents' Health (REC of IFF/Fiocruz) and the Carmela Dutra Maternity Hospital (REC of the Municipal Health Secretariat of Rio de Janeiro). In accordance with Resolution No. 466/1211, the ONs that agreed to participate voluntarily and anonymously in the research signed an Informed Consent Form (ICF), and their identities were characterized by an alphanumeric sequence represented by the acronym ONs.

Results

A total of 23 ONs from both maternity hospitals were interviewed. The group of participants is mostly female, at 87.0% (20). This finding corroborates the observation made by Silveira, Ribeiro and Mininel[12], which affirms the predominance of women among nursing professionals. This also justifies the authors' choice to use feminine pronouns in this article.

Regarding age range, the interviewees are between 29 and 53 years old, with an average of 35 (SD 5) years. In relation to race/ethnicity, 65.2% (15) of the ONs declared themselves white, 30.4% (7) mixed-race, and 4.4% (1) black. Regarding marital status, 56.5% (13) of the professionals are married, 13.0% (3) divorced, and 30.5% (7) are single. In Brazil, the sociodemographic profile of the nursing category is predominantly composed of nursing technicians and assistants, approximately 77% of the total category, of which 53% are black and mixed-race. Of the nurses, 57% declare themselves white and 37.9% declare themselves black and mixed-race.

Regarding the length of training in obstetrics, the profile shows an average of 9 (SD 4) years, with 8 nurses stating that they have had a specialization in obstetric nursing for more than 10 years. The most experienced has 23 years of training, and the one with the least experience has 3 years. Also, regarding training, 73.9% (17) of the professionals state that their specialization was through a residency program, while 26.1% (6) completed a specialization course. Regarding postgraduate studies, 43.48% (10) hold a master's degree, and 4.4% (1) hold a doctorate.

The participants state that they make decisions based on the principle of autonomy when faced with situations that arise in the daily practice of care, including legal regulations.

> *"I understand it in two aspects related to autonomy. The first is the legal aspect, right? The practice of the profession is regulated by 7.498 and, ultimately, by ministerial decrees that regulate and emphasize the role of the obstetric nurse in assisting with low-risk childbirth [...]"* (ON.01).

> *"Autonomy means being able to assess a patient and determine the appropriate course of action [...]"* (ON.07).

> *"[...] that you don't have another professional invading your space, that you have the respect of the woman, the companion, your work colleagues, the technicians, assistants, doctors, and other spheres as well [...]"* (ON.14).

> *"[...] to have their decision-making power [...] to exercise their profession fully and freely, without needing consent [...]"* (ON.18).

> *"[...] we also have a code of ethics that we can base ourselves on [...]"* (ON.23).

The professionals also point to factors that hinder their assistance, with medical hegemony being the biggest obstacle.

> *"[...] there have already been board meetings, and one doctor even asked how she's going to supervise a nurse during childbirth [...]"* (ON.05).

> *"[...] they think we are a threat to women, and our actions without their oversight and guidance create a chance for these women to be at risk [...]"* (ON.07).

> *"[...] the difficulty I have is dealing with more extensive lacerations, third or fourth-degree lacerations; most of the time they start by asking why we didn't do an 'episio' or why we were in a different position than usual [...]"* (ON.08).

> *"[...] there are many forms of institutional violence that we, as nurses, suffer to achieve some change"* (ON.14).

> *"We often encounter instances where, in our view, the prescription of oxytocin or directed induction is inappropriate [...]"* (ON.16).

> *"[...] So they see us as somewhat submissive, and sometimes our acting is a loss of power in their eyes"* (ON.19).

> *"[...] sometimes, at 8 cm dilation, they're already "getting ready to be born" [...] directing pushing, telling people to push, shortening the cervix, interfering unnecessarily [...]"* (ON.22).

Multiprofessional communication is challenging in the daily lives of those who provide direct assistance during childbirth. This is exacerbated when the interviewees are unable to establish interprofessional relationships and require the mediation of managers to communicate effectively.

> *"[...] communication exists, it's not always effective, but it exists, we try, and if we can't, we read the entire medical record [...]"* (ON.02).

> *"[...] the communication is terrible here [...] between the professionals, the nurses, the technician, the doctor, between the departments [...]"* (ON.14).

> *"Communication happens through management, because communication between the professionals themselves is a bit complicated [...]"* (ON.15).

The physical structure of healthcare facilities can directly impact the quality of care provided. The speeches highlighted that hospital facilities are old and limited. The lack of infrastructure makes it impossible for nurses to offer warm baths individually and privately as a form of care.

> *"[...] having only one bathroom is also limiting, right? Because it exposes the patient quite a bit [...]"* (ON.02).

> *"[...] here we don't have a CPN (Central Peripheral Clinic), we have a PPP (Pre-partum, Post-partum) room inside the surgical center [...]. We have this issue of the bathroom being a single bathroom [...]"* (ON.14).

The lack of human resources, especially of ONs, directly reflects in lower-quality care for women. Due to work overload, professionals are unable to adequately assist with childbirth and offer non-pharmacological methods of pain relief. Often, being alone on duty, they must attend to other demands, compromising the comprehensiveness of care during labor and delivery.

> *"Not every shift has a midwife [...] a lone nurse having to fight against a medical team that is heavily represented by residents is an unfair fight, I would say so [...]"* (ON.04).

> *"[...] I think the fact that we don't have a nurse specifically assigned to the obstetrics center 24 hours a day is a major hindrance [...]"* (ON.17).

> *"[...] during the night shift on my shift, I'm the only obstetric nurse [...] it's a bit complicated for me to be able to participate in all the deliveries and especially to be present during labor, right?"* (ON.17).

> *"[...] more than 70% of the time I'm alone, so we end up attending to the demands of the ward much more than acting as obstetric nurses [...]"* (ON.22).

Discussion

Autonomy can be characterized as the human being's ability to govern themselves, to make independent and responsible decisions. The term 'freedom' was evoked by the participants to define the concept of autonomy. Although they are distinct terms, they share similar concepts, since they both address and support the idea that freedom is the human being's ability to act autonomously[13,14].

When applied to a professional context, autonomy refers to the freedom to make decisions based on technical, scientific, legal, and ethical knowledge inherent to the scope of the profession. This enables the professionals to perform their duties competently and offer humanized, comprehensive care based on scientific evidence and in accordance with bioethical principles, the Nursing Professional Code of Ethics (CEPE), and Law No. 7.498/86[7].

The analyzed discourses point to an understanding of nurse autonomy as that which allows them to chart courses of action in the face of situations, using the knowledge acquired during their training as a specialist. This notion is directly linked to freedom in decision-making in pursuit of client satisfaction.

Certainly, autonomy is necessary for professional practice. It is through autonomy that the ON is able to develop their work within healthcare institutions, as part of a multidisciplinary team[15]. However, some adversities emerge from the discourse regarding the inclusion of obstetric nursing in the care of women in labor.

Thus, some participants highlighted that they work exclusively in the midwifery process. When specifically observing their role during the expulsive phase of labor, the interviewees criticized the restriction of the obstetric nurse's practice by medical residents and obstetric staff. Conversely, other professionals stated that obstetric nursing work is collaborative, but they resist the disputes that characterize the field and fragment the care provided to women. From this perspective, it is observed that, to some extent, resistance remains on the part of the medical team towards the obstetric nurse's role in childbirth care, also reflecting a lack of recognition of their autonomy.

It is worth noting that conflicts exist between the professional categories that provide direct assistance to women in labor. One study indicates that one of the factors contributing to these conflicts in the relationship between obstetric nursing and medicine may be the lack of knowledge on the part of the medical team regarding the current laws that guarantee the role of ON in this care setting[16].

Concerning legislation, the current CEPE[17] ensures the nursing profession the right to practice according to the principles of ethics and bioethics. It also asserts, in Chapter I - On Rights, in its 1st Article, that it is the professional's right to "Practice Nursing with freedom, technical, scientific and environmental safety, autonomy and to be treated without discrimination of any kind," a right that, according to the interviewees, is not always respected. In its Article 4, it establishes that it is the nurse's right to "Participate in multiprofessional, interdisciplinary and transdisciplinary practice with responsibility, autonomy and freedom, observing the ethical and legal precepts of the profession". 17:27

Another regulatory milestone for the practice of Obstetric Nursing is COFEN Resolution No. 524/2016. This regulation addresses the role and defines the responsibilities of this professional category. The competencies of the Nurse, Obstetric Nurse, and Midwife are ensured in Article 3, which includes: welcoming and assessing the parturient's health conditions, promoting care centered on the woman's needs, providing assistance during normal childbirth with physiological progression, and assisting the newborn. The interviewees demonstrated knowledge of the legal frameworks for nursing[18].

Another aspect that deserves attention is the logic of technocratic care, which, in the context of obstetric assistance, stems from a historical process marked by the hierarchization and centralization of knowledge based on the biomedical model. A paradigm that reduces the woman's body to a defective physiology, in need of corrections, to be corrected by interventions[16,19]. Despite the determinations, the discourse points to a hospital care system based on a technocratic model that runs counter to the care that is sought to be provided. Even under the influence of the current model, the practice of obstetric nursing seeks to guide care based on the principles of humanization and evidence-based practice. These paradigmatic tensions trigger potential conflicts.

The interviewees mention that, for some doctors, the work of the obstetric nurse during childbirth lacks oversight from the medical team. In one article, which presents the medical perspective, there are accounts stating that the work of obstetric nurses should be supervised by them. This understanding contradicts Law No. 7.498/86 and the CEPE (Code of Ethics for Nursing Professionals). This mistaken and illegal conception reveals the veiled discrimination and asymmetrical hierarchy that obstetric nurses may face in their daily work[19].

A vestige of the regulatory conception of medicine can be understood by the promulgation, in 1945, of Decree-Law No. 8,445, which sanctioned that 'practical nurses' and 'practical midwives' would be qualified and registered with the National Medical Inspection Service. Almost 30 years later, Federal Law No. 5,905/1973 was enacted, creating the Federal Nursing Council and the Regional Nursing Councils. This law separated the oversight of nursing practice from the National Medical Inspection Service[20].

Considering the above, it is observed that the relationship between the two categories that provide direct assistance during childbirth still reflects a historically consolidated hierarchy in the biomedical model based on subordination, to the detriment of the collaboration necessary for comprehensive care of pregnant women in the hospital environment. Given this, the hierarchical culture ends up generating inequality among professionals, causing

negative impacts and feelings of devaluation among staff, by minimizing the professional identity of obstetric nursing[7].

The hierarchical structure and authoritarianism defined by the technocratic model can "harm nursing care because important information regarding the health-disease process ceases to be shared among the professionals on the team"[21:471]. The ONs mention ineffective communication between health professionals working within institutions, a problem that deteriorates the relationship between professional categories.

Ineffective communication can affect the quality of service provided, leading to incidents related to patient safety. Communication failures have been one of the main reasons for the occurrence of adverse events, considering that the quality of service and patient safety are based on its effectiveness. In this sense, the exchange of knowledge between teams contributes to the promotion of more efficient care, improving quality and favoring humanization[22,23].

The participants also reported problems related to the physical structure of the maternity wards, classifying it as inadequate. Among the problems mentioned is the issue of having only one bathroom for all the pre-labor, labor, and postpartum (PPP) rooms, which must be shared by all pregnant women.

The lack of a suitable physical structure for administering a warm shower negatively impacts prenatal care. A warm shower, one of the non-pharmacological techniques for pain relief, promotes muscle relaxation and helps alleviate anxiety. However, it becomes impractical when individual bathroom use is not possible[24,25].

In this sense, the physical environment of maternity wards should promote the well-being and safety of the pregnant woman and her companion. Inadequate physical space and infrastructure generate dissatisfaction among professionals, as they hinder the humanization of care. This aspect has a double effect, since dissatisfaction with the care provided will also affect the parturient woman[24].

The structure, criticized by the participants, does not comply with Ordinance No. 3 of September 28, 2017, which defines that the physical environment of PPP (Pre-partum, Partum, Post-partum) rooms must contain a private bathroom for the pregnant woman, attached to the PPP room. The bathroom space must have a minimum area of 4.8 m², with a minimum dimension of 1.70 m². The shower stall must have safety bars for the pregnant woman and have a minimum dimension (0.90 x 1.0 m²)[26].

The professionals address the shortage of human resources in both shifts, day and night, every day of the week. Amaral and colleagues[16] state that the number of trained professionals is insufficient. In Brazil, according to the study, there are only 5,000 ONs, when approximately 200,000 professionals are needed to provide assistance to women. Therefore, the lack of human resources is not a problem exclusive to and inherent to the scenarios of this research.

One strategy used to promote the qualification and hiring of EO (Early Childhood Education) professionals in the SUS (Brazilian Public Health System) network was implemented with the advent of the Stork Network (Rede Cegonha), starting in 2011. Beyond simply increasing the number of professionals in the market, this initiative aimed to ensure quality care for women from reproductive planning to childbirth, as well as healthy growth and development for newborns[16,27].

In September 2024, replacing the Stork Network, the Ministry of Health published Ordinance No. 5,350 to establish the Alyne Network. Article 4 ratifies that the Network "must be organized in a way that allows for the continuous provision of maternal and child health care actions for the population of a given territory." This program reinforces the promotion of equity, observes ethnic-racial inequities; protects and promotes the bond between family and baby; adopts evidence-based practices; maintains guarantees of a companion of the woman's free choice; and seeks to reduce maternal and infant morbidity and mortality, with emphasis on the neonatal component, especially among the Black and Indigenous populations. The current Ordinance addresses the composition of health teams and, within it, provides for the presence of obstetric nursing in health establishments[28].

The discourses point to the existence of challenges related to the practice of obstetric nursing in the care of low-risk childbirth, such as lack of autonomy and professional recognition, inadequate infrastructure, a shortage of human resources, as well as issues concerning the relationship between different professional categories. Through content analysis, a dichotomy can be identified between the lived reality and what is theorized about professional autonomy, despite legal guarantees.

The role of obstetric nursing in assisting with labor and delivery of low-risk pregnancies does not exclude the role of physicians. When performed collaboratively, both optimize care, especially for physicians in situations requiring their specialized assistance[29].

Final Considerations

This research sought to understand the role of obstetric nursing in assisting with labor and delivery of low-risk pregnancies in a hospital setting. It was observed that the ONs understand that welcoming, active, and sensitive listening, as well as providing guidance based on the complaints of the parturient and her companion, are essential components of what is understood as the humanization of childbirth.

The use of non-pharmacological pain relief technologies was highlighted as part of the ONs approach, promoting comfort, safety, and anxiety reduction, while respecting the uniqueness, individuality, and right to choose of each woman in labor. It is clear that the care offered by the professionals recognizes the women's leading role and contributes to reclaiming childbirth as a physiological event.

The dichotomies between what is described by legislation and other normative instruments and professional practice remain. Regarding professional autonomy, setbacks range from medical hegemony to structural problems. The ONs highlighted the resistance of the medical profession to its autonomy, present in

authoritarian discourses and a hierarchical structure of care based on asymmetrical power relations.

It is important to highlight, as a limitation of the study, that this research was conducted with ONs from two maternity hospitals in Rio de Janeiro, from distinct programmatic areas, and reflects the healthcare reality of these two settings. Further studies with this investigative interest are needed to understand the phenomenon from the perspective of other professionals working in other settings.

References

1. Lima MM, Gouvêa NA, Lavelle CDA, Lopes ALF, Pinto ELG, Coutinho APA, et al. Atividades educativas no período pré-natal como estratégia de empoderamento da parturiente. Glob Acad Nurs. 2023;4(Sup.3):e374. https://doi.org/10.5935/2675-5602.20200374
2. Pickler L, et al. Adaptation strategies for preparing for childbirth in the context of the COVID-19 pandemic (Roy's theory—adaptation to childbirth). Rev Bras Enferm [Internet]. 2024 [acesso em 10 out 2025]. Disponível em: https://www.scielo.br/j/reben/a/dyz3Qt7mgsZwhLzKDKbwgXP/
3. Ferreira TSB, et al. Fatores associados ao bem-estar materno em situação de parto de puérperas em Minas Gerais. Rev Bras Enferm. 2024;77(6):e20230304. https://doi.org/10.1590/0034-7167-2023-0304p
4. Brasil. Ministério da Saúde. Humanização do parto e do nascimento. Brasília: Ministério da Saúde; 2014.
5. Brasil. Lei nº 7.498, de 25 de junho de 1986. Dispõe sobre a regulamentação do exercício da enfermagem e dá outras providências. Diário Oficial da União [Internet]. 26 jun 1986 [citado em 18 nov 2025]. Disponível em: https://www.cofen.gov.br/lei-n-749886-de-25-de-junho-de-1986/
6. Conselho Federal de Enfermagem (COFEN). Resolução nº 516, de 24 de junho de 2016. Dispõe sobre a atuação e a responsabilidade do enfermeiro [Internet]. 2016 [citado em 18 nov 2025]. Disponível em: https://www.cofen.gov.br/resolucao-cofen-no-05162016/
7. Ferreira RN, Vargas MAO, Velho MB, et al. Professional identity and limitation of autonomy of the obstetric nurse in a teaching hospital: a qualitative study. Esc Anna Nery. 2024;28:e20240064. https://doi.org/10.1590/2177-9465-EAN-2024-0064
8. Bardin L. Análise de conteúdo. 3ª reimp. da 1ª ed. São Paulo: Edições 70; 2016.
9. Conselho Nacional de Saúde (CNS) [Internet]. Brasília (DF): CNS; s.d. [acesso em 11 out 2025]. Disponível em: https://conselho.saude.gov.br/
10. Fontanella BJB, Ricas J, Turato ER. Amostragem por saturação em pesquisas qualitativas em saúde: contribuições teóricas. Cad Saude Publica. 2008;24(1):17-27. https://doi.org/10.1590/S0102-311X2008000100003
11. Brasil. Conselho Nacional de Saúde. Resolução nº 466, de 12 de dezembro de 2012. Aprova diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Diário Oficial da União, Brasília, 12 dez 2012.
12. Silveira RCP, Ribeiro IKS, Mininel VA. Qualidade de vida e sua relação com o perfil sociodemográfico e laboral de trabalhadores de enfermagem hospitalar. Rev Enfermería Actual de Costa Rica [Internet]. [citado em 18 nov 2025]. Disponível em: https://archivo.revistas.ucr.ac.cr//index.php/enfermeria/article/view/44769/47107
13. Przenyczka RA, Lenardt MH, Mazza VA, et al. O paradoxo da liberdade e da autonomia nas ações do enfermeiro. Texto Contexto Enferm. 2012;21(2):427-35. https://doi.org/10.1590/S0104-07072012000200022
14. Campos A, Oliveira DR. A relação entre o princípio da autonomia e o princípio da beneficência (e não maleficência) na bioética médica. Rev Bras Estud Polit. 2017;(115):13-45. Disponível em: http://www.bioetica.org.br/library/modulos/varias_bioeticas/arquivos/Autonomia_e_Beneficencia.pdf
15. Melo CMM, Florentino TC, Mascarenhas NB, et al. Autonomia profissional da enfermeira: algumas reflexões. Esc Anna Nery. 2016;20(4):e20160085. https://doi.org/10.5935/1414-8145.20160085
16. Amaral RCS, Alves VH, Pereira AV, et al. A inserção da enfermeira obstétrica no parto e nascimento: obstáculos em um hospital de ensino no Rio de Janeiro. Esc Anna Nery. 2019;23(1):e20180218. https://doi.org/10.1590/2177-9465-ean-2018-0218
17. Brasil. Conselho Federal de Enfermagem. Resolução nº 564, de 6 de novembro de 2017. Aprova o novo Código de Ética dos Profissionais de Enfermagem. Brasília (DF): COFEN; 2017.
18. Brasil. Conselho Federal de Enfermagem. Resolução nº 524, de 4 de outubro de 2016. Brasília (DF): COFEN; 2016.
19. Fabrizzio GC, Schmalfuss JM, Silveira L, et al. Práticas obstétricas de uma parteira: contribuições para a gestão do cuidado de enfermagem à parturiente. Rev Enferm Cent Oeste Min. 2019;9:e2892. http://dx.doi.org/10.19175/recom.v9i0.2892
20. Dantas RAS, Aguillar OM. O ensino médio e o exercício profissional no contexto da enfermagem brasileira. Rev Latino-Am Enfermagem. 1999;7(2):25-32. https://doi.org/10.1590/S0104-11691999000200005
21. Broca PV, Ferreira MA. Processo de comunicação na equipe de enfermagem fundamentado no diálogo entre Berlo e King. Esc Anna Nery. 2015;19(3):467-74. https://doi.org/10.5935/1414-8145.20150062
22. Olino L, Goncalves AC, Strada JKR, et al. Comunicação efetiva para a segurança do paciente: nota de transferência e Modified Early Warning Score. Rev Gaucha Enferm. 2019;40(esp):e20180341. https://doi.org/10.1590/1983-1447.2019.20180341
23. Barboza BC, Sousa CALSC, Morais LAS. Percepção da equipe multidisciplinar acerca da assistência humanizada no centro cirúrgico. Rev SOBECC. 2020;25(4):212-8. https://doi.org/10.5327/Z1414-4425202000040007
24. Dodou HD, Sousa AAS, Barbosa EMG, et al. Sala de parto: condições de trabalho e humanização da assistência. Cad Saude Colet. 2017;25(3):332-8. https://doi.org/10.1590/1414-462x201700030233
25. Silva CA, Lara SRG. Uso do banho de aspersão associado à bola suíça como método de alívio da dor na fase ativa do trabalho de parto. BrJP. 2018;1(2):167-72. https://doi.org/10.5935/2595-0118.20180031
26. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Orientações para elaboração de projetos arquitetônicos Rede Cegonha: ambientes de atenção ao parto e nascimento [Internet]. Brasília (DF): Ministério da Saúde; 2018.

27. Brasil. Ministério da Saúde. Portaria nº 1.459, de 24 de junho de 2011. Institui, no âmbito do Sistema Único de Saúde (SUS), a Rede Cegonha. Diário Oficial da União, Brasília, 24 jun 2011.
28. Brasil. Ministério da Saúde. Portaria nº 5.350, de 12 de setembro de 2024. Altera a Portaria de Consolidação GM/MS nº 3, de 28 de setembro de 2017, para dispor sobre a Rede Alyne. Diário Oficial da União, Brasília, 12 set 2024.
29. Fundação Oswaldo Cruz (Fiocruz). Principais questões sobre atuação da enfermagem obstétrica na equipe multidisciplinar [Internet]. 2020 [citado em 14 fev 2021]. Disponível em: https://portaldeboaspraticas.iff.fiocruz.br/atencao-mulher/principais-questoes-sobre-atuacao-da-enfermagem-obstetrica-na-equipe-multidisciplinar/