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EXPERIENCE OF PROFESSIONAL AUTONOMY IN THE ASSISTANCE TO HOME BIRTH BY OBSTETRIC NURSES

EXPERIÊNCIA DA AUTONOMIA PROFISSIONAL NA ASSISTÊNCIA AO PARTO DOMICILIAR POR ENFERMEIRAS OBSTÉTRICAS

EXPERIENCIA DE AUTONOMÍA PROFESIONAL EN LA ASISTENCIA AL PARTO EN CASA POR LAS ENFERMERAS OBSTÉTRICAS

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Objective: to identify the experience of autonomy in the assistance to home birth by Obstetric Nurses. Method: descriptive study of qualitative approach. Data were collected through a semi-structured interview applied to professionals who worked in teams of home birth. Data analysis used the content analysis of Bardin. Results: the experience of the exercise of autonomy is broad in the home environment, mainly by the presence of the biomedical model still rooted in the hospital environment and that limits the performance of the Obstetric Nurse. Conclusion: the legal support, scientific knowledge and materials/technologies support Obstetric Nurses to exercise their autonomy in the home birth.

Descriptors: Nursing. Professional Autonomy. Nurse Midwives. Home Childbirth.

Objetivo: identificar a experiência da autonomia na assistência ao parto domiciliar por Enfermeiras Obstétricas. Método: estudo descritivo de abordagem qualitativa. Os dados foram coletados por meio de entrevista semiestruturada aplicada às profissionais que atuavam em equipes de parto domiciliar. Para análise de dados utilizou-se a análise de conteúdo de Bardin. Resultados: a experiência do exercício da autonomia é ampla no ambiente domiciliar, principalmente pela presença do modelo biomédico ainda enraizado no ambiente hospitalar e que limita a atuação da Enfermeira Obstétrica. Conclusão: o respaldo legal, o conhecimento científico e os materiais/tecnologias dão suporte às Enfermeiras Obstétricas para exercer sua autonomia no parto domiciliar.

Descritores: Enfermagem. Autonomia Profissional. Enfermeira Obstétrica. Parto Domiciliar.

Objetivo: identificar las experiencias de autonomía en la asistencia al parto en casa por las Enfermeras Obstétricas. Método: estudio descriptivo de enfoque cualitativo. Los datos fueron recolectados a través de una entrevista semi-estructurada aplicada a los profesionales que trabajan en equipos de parto en casa. Para el análisis de los datos, se utilizó el análisis de contenido de Bardin. Resultados: la experiencia del ejercicio de la autonomía es amplia en

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el ambiente domiciliario, principalmente por la presencia del modelo biomédico que sigue arraigado en el medio hospitalario y que limita el desempeño de la Enfermera Obstétrica. Conclusión: el apoyo legal, el conocimiento científico y materiales/tecnologías apoyan a las Enfermeras Obstétricas ejerzan su autonomía en el hogar del nacimiento.

Descriptores: Enfermería. Autonomía Profesional. Enfermeras Obstétricas. Parto Domiciliario.

Introduction

Over time, the obstetric care in Brazil has been undergoing a series of transformations. There has been the rescue of a more natural way to give birth, in which the household is resumed as a favorable location to childbirth, thus increasing the performance spaces of Obstetric Nurses. In this context, it is important to understand how these professionals exercise their autonomy in the assistance to the planned home birth.

The nurse's autonomy is deeply connected with practices and knowledge developed over the centuries, which enable professionals to perform their specific activities for the care. These activities should be based on the theoretical-practical knowledge, recognized as a resource of greater value in their professional performance[1].

The Obstetric Nurse should perform their activities in accordance with the legislation in force for the development of a safe practice for women and newborns. No legislation prohibits the planned home birth, thus it is not a crime. In addition, the Ethics Code of Nursing Professionals stipulates, in Article 1 of Chapter 1, which addresses the professional relations, the right to "Exercise the nursing with freedom, autonomy and be treated according to the assumptions and legal, ethical principles and human rights"[2:2]. In this way, there is no impediment to the performance of this professional in the planned home birth.

Thus, the Obstetric Nurse has autonomy to fully meet the labor and childbirth without dystocia, within the hospital and the house of pregnant women stratified in the usual risk.

There are few studies published on the subject in the Brazilian scientific production. Therefore, this research will contribute to understanding the care promoted by these professionals in the home environment, recognizing them as professionals qualified and trained to perform assistance to home birth, in addition to inspiring new professionals to follow this path.

The objective of this study is to identify the experience of exercising autonomy in the assistance to home birth by Obstetric Nurses.

Method

This is a descriptive study with a qualitative approach, which encompasses the meanings and the intentionality as inherent to the actions, relations and social structures for significant human compositions[3].

As the research involves human beings, the project was submitted to the Research Ethics Committee through the *Plataforma Brasil* to be appreciated according to the formal requirements contained in Resolution n. 466 of 12 December 2012, of the National Health Council (NHC), obtaining approval through Opinion n. 2.744.474.

The study was conducted with two groups of home birth that provide service in Maceió, capital of the state of Alagoas: Supporting Empowered Women Group (AME) and Godmothers' Garden Group. These groups are formed only by female professionals. Initially, a survey on the number of Obstetric Nurses active in groups. After, they were contacted individually by telephone or social networks, for the invitation to participate in the survey and schedule the meeting for the interview. This occurred in a place suggested by them, according to their availability.

The participants were ten Obstetric Nurses. The inclusion criterion was working in Home Birth teams of Maceió, Alagoas. The exclusion criterion was being absent from the Home Birth teams in the period of collection. The data were collected between July and October 2018.

The technique used for data collection was a semi-structured interview. Initially, each participant of the survey received an Informed Consent Form (ICF) containing information on the research procedures and conditions for their participation. The interview form was divided into two blocks: the first contained questions related to the professional characterization and their services; and the second block comprised six guiding questions, which promoted the discussion about the autonomy of childbirth care in the home environment. All the interviews were recorded and then fully transcribed. To ensure the confidentiality of the nurses' identity, the speeches were identified through the letter N followed by a cardinal number indicating the order of the interview.

The methodological strategy used for data analysis was the Content Analysis of Bardin, once it enabled the organization of the statements into categories, helping the researcher to understand them based on inferences.

In this way, after transcribing the interviews, they were gathered and a floating reading was performed to recognize the indicators that would emerge from the analysis categories. The themes that repeated with greater frequency were cut out of the texts for thematic analysis, being held a first categorization. Then, the data received treatment for the retention of the content from the statements and comparative analysis of categories, to reveal the aspects considered similar or designed as different, enabling the establishment of categories. This treatment of the collected data allowed for the inference and interpretation to achieve the results.

Results and Discussion

The results presented next are arranged in two moments: the first refers to the characterization of the teams and nurses who worked in the assistance to home birth in Maceió (AL); the second, to the themes relevant to the job.

Characterization of the Teams and the Nurses who provided Assistance to the Planned Home Birth in Maceió (AL)

The Godmothers' Garden was the pioneer group for home birth in the state of Alagoas. It has been operating since 2013 and, up to 2018, met 80 assistances to families. During the data collection period, the team was composed of two Obstetric Nurses. The Supporting Empowered Women Group (AME) has worked with the assistance to home birth in Alagoas since 2014, with a total of 98 assistances until 2018. During the data collection period, the team was composed of nine Obstetric Nurses and one Neonatal Nurse.

The procedures of the two groups, in general, coincided regarding the use of the Contract for Service Provision and the Informed Consent Form (ICF). This legally supports the team concerning the clarifications to the woman/couple/family of all possible benefits, risks and procedures of choosing the assistance to home birth.

Furthermore, the teams established the following inclusion criteria for care to pregnant women: women classified in healthy pregnancy, single pregnancy, gestational age greater than or equal to 37 weeks and less than 42 weeks. The consultations started from the 30tth week of gestation and followed until the 10th day after birth.

None of the teams had a physician, but there were medical professionals available to help when necessary, the so-called backup, in case the patient needed transfer to the hospital.

The data compiled in Chart 1 show that 100% of the participants were female. This follows the trend of the profession, which is mostly women[4]. In the Obstetric field, it is no different, because the performance in aiding in childbirth is traditionally assigned to women.

Chart 1 – Characterization of Obstetric Nurses active in home birth teams

Subject	Sex	Age	Institution of graduation	Year of graduation	Complementary education	Time acting in Home Birth
N1	F	26	UFAL	2015	Specialization/ Master's (in progress)	1 year and 5 months
N2	F	36	UFAL	2006	Specialization/ Master's (in progress)	4 years
N3	F	28	UFAL	2014	Residency	2 years
N4	F	36	CESMAC	2007	Specialization	5 years
N5	F	26	UFAL	2015	Residency	1 year
N6	F	39	CESMAC	2003	Specialization/ Master's degree and Residency	4 years and 4 months
N7	F	56	UFAL	1986	Specialization	3 years and 8 months
N8	F	28	CESMAC	2012	Specialization	2 years
N9	F	28	UFAL	2012	Residency/Master's degree	4 years
N10	F	34	UFAL	2008	Residency/Master's degree	4 years

Source: Created by the authors.

Regarding the participants' age, the data showed a mean age of 34 years. And as the initial formation, 70% graduated from public institutions and 30%, private institutions.

In relation to degrees of complementary education, 50% graduates in the Residency modality. This type of degree develops the theory-practice integration. It constitutes in subjects that provide the appropriation of scientific knowledge combined with the practice that allows, through an approximation with the professional scenarios, for acquiring skills and knowledge resulting from experienced situations[5].

The time of practical learning that Residency enables not only the development but also the enhancement of professional abilities and skills, providing more safety for the Obstetric Nurse regarding her performance in the planned home birth. The experience in assisted birth in a hospital environment allows the resident act in obstetric emergencies and other complications that arise.

Regarding the time working with planned home birth, the greatest time working with it was only five years. This shows that this type of modality of assistance to childbirth is still recent in Alagoas and proves that the obstetric care in this state follows the Brazilian trend, which is predominantly hospitalized and medicalized.

Next are the categories and units of meaning that emerged from the speeches of the group studied about their experience in exercising professional autonomy in the assistance to home birth.

Category 1: The environment as a factor for (not) exercising autonomy

The current scenario of labor and birth has suffered modifications and the domicile returned as an alternative for families who crave the rescue of women as protagonists of their body and the full experience of this event[6-7]. In addition, it is a "new" field for professionals from the Obstetric Nursing.

Since the hospital environment is a scenario with assisted births, especially by obstetric physicians, the work of the Obstetric Nurse, many times, is seen as a dispute of power[8]. This causes conflicts in the work of these specialties, which can hinder the exercise of autonomy of the Obstetric Nurse.

The work of the Obstetric Nurse in the hospital environment has many interferences. These are

related to the current model of childbirth care, the non-acceptance, by other professionals, of the practice in their specialty, by the lack of interdisciplinarity in the assistance and reactions of hierarchy in this environment[9].

This non-acceptance is corroborated in the statements of the interviewed Obstetric Nurses, when demonstrating restlessness and loss of autonomy in the hospital work:

> [...] *in the hospital, we end up losing the autonomy to carry out the labor. Why? Because it is another context, where there are doctors, nursing technicians, anesthetist, pediatrician, several other professionals*[...] *so, I'm the boss, right? That's what doctors say. I'm the one responsible for the duty, so I'm the one who makes decisions.* (N2).

> *How about decision-making in the hospital? The nurse often ends up not making any decision, because, many times, in the hospital, the decisions are doctor-centered, right? Especially in high-risk hospitals* [...] (N3).

> *We lose this autonomy and often have practical experience, knowledge about scientific evidence, but we get a little limited by the medical professional.* (N4).

The statements show that, despite being a professional with technical and scientific knowledge and legally empowered to meet the labor and birth, as ratified by the Law of Nursing Professional Exercise n. 7.498/86 and other official documents, the autonomy of the Obstetric Nurse is often curtailed in hospital institutions[10].

Therefore, one asks: What would be the reason for Obstetric Nurses, even with laws and recommendations supporting their assistance to normal birth, to still have obstacles in exercising their autonomy within the hospital environment? The medical hegemony, reinforced by the biomedical model still rooted in these institutions, would be one of the main barriers. This is because, in this type of model, the physician is socially recognized as the professional with the knowledge, occupying the central position in healthcare decisions, placing other professional categories as subaltern, as researchers corroborate[11].

In this sense, the domicile constitutes a neutral place for the biomedical model, which makes it an environment where the Obstetric Nurse can fully work, as can be seen in the statements of the interviewees:

> *The house has ensured the exercise of autonomy of the obstetric nursing regarding the focus of care practices, once we fully take over the assistance situation* [...] *the autonomy exercised in the home environment allows us consider the whole social context, individual values, unsolved personal processes of the woman, spirituality, everything that may influence that woman's experience in the birth.* (N1).

> *Although the Obstetric Nurse already has autonomy, in the home environment, we feel freer to perform our evidence-based practices, within the scope of Obstetric Nursing.* (N4).

> *Since we're outside the hospital environment, our autonomy is full, once we don't depend on other professionals to decide or act. We work based on our knowledge and with the potential we have to provide this assistance with safety and ability.* (N7).

The home birth rescues the autonomy of the Obstetric Nurse and of the woman. For the first, it enables a humanized work, encouraging the rescue of the natural and physiological process of childbirth and eliminating invasive practices. For the latter, it preserves the rights and choices, with a qualified assistance. The nurse's practice, when within the hospital environment, usually bases on a traditional technical-assistance and impersonal model of obstetric care[12]. Furthermore, the professional hired by a hospital must follow the protocols adopted by the institution, even if they lack more recent scientific evidence.

Moreover, even when there is a medical professional in the configuration of the teams that meet home birth, or even when they are only a backup for the assistance, labor relations are based on trust, respect, assertive communication and shared responsibility, indicating that there is no hierarchy between the professions.

Another special feature of the household environment is to encourage non-traditional practices, such as the verticalized positions during the birth process, in which the parturient has a more active participation, becoming the protagonist of the process[12].

In the extra-hospital environment, the assistance of the Obstetric Nurse is not configured as a technical assistance only or based on care procedures. Her practice places the woman in the center of the care, in which there are dialog, qualified listening, recognition of previous experiences and strengthening of her ability to conduct childbirth. Since the domicile is a

domain environment for the woman, she is free and encouraged by the Obstetric Nurse to make decisions about how and what should happen in the delivery, together with the professional, and both will be based on current scientific evidence[13].

In this sense, a characteristic of the home birth is the promotion of comfort, respect for labor physiology, nutrition, rest, provision of non-pharmacological care to relieve pain, such as massages, hot baths and the valuable presence of companions chosen by the woman[13].

These characteristics are intrinsically related to the ability to exercise their autonomy provided by the home environment, as described in the previous speeches of the interviewees. These features affect the satisfaction of women who experience the planned home birth.

Studies show positive experiences of women who have had home birth, such as the research that interviewed eight women who had planned home births between the years 2009 and 2010. This study concluded that the experience of women during the home care provided by nurses was perceived as respectful and allowed their autonomy, as well as of their relatives, in the process of birth, generating multiple benefits[12]. Moreover, even with the small amount of Brazilian quantitative researches on planned home birth, and with small samples, the researches demonstrate good obstetric and neonatal outcomes[12].

Therefore, the assistance performed by the Obstetric Nurse in the home environment, in addition to fostering and strengthening the exercise of their professional autonomy, also relates to good maternal and neonatal outcomes. In this way, this model of childbirth care, contrary to that established by institutions, does not focus on the professional, but on the care toward the woman and her family, following the precepts of the model of humanization of labor and birth.

Category 2: Legal support and scientific knowledge as a foundation for the exercise of the autonomy

The Law of Nursing Professional Exercise n. 7.498/86 regulates the practice of nursing and defines the basic professional requirements and skills of the nurse. Among the powers, Article 11 states that the "nursing care to pregnant women, parturient and puerpera; monitoring of developments and labor, delivery and accomplishment of delivery without dystocia" are exclusive responsibilities of the nurse, as part of the health teams[10].

The single paragraph of art. 11 ensures to the Obstetric Nurse the "assistance to the parturient and the normal delivery; identification of obstetric dystocia and action until the arrival of the physician; accomplishment of episiotomy and perineal suture and application of local anesthesia, when necessary"[10].

The Decree n. 94.406/87 establishes that Obstetric Nurses are professionals specialized in the care of usual-risk birth, having autonomy for developing this activity[14]. The Resolution n. 516/2016, of the Federal Council of Nursing, regulates the activity and the responsibility of the Obstetric Nurse in the gravid-puerperal cycle, as well as the care to newborns in specialized services for the care with normal delivery[15].

These and other legal instruments demonstrate that the obstetric nurses have an abundant legislation that sustain their professional activity, and this gives the interviewees greater safety to exercise their professional autonomy in the assisted home birth, as can be observed in the following speeches:

> [...] *another thing that describes the autonomy to work with home birth is knowing we have the legal support, right? Through our council, as obstetric professional, which helps a lot.* (N2).

> *So, we can work within the scope of the Nursing law. So we develop this autonomy in the home environment.* (N4).

Even in the extra-hospital environment, the Obstetric Nurses are legally supported and, therefore, must play their assistance activities in accordance with the legislation in force, thereby exercising their autonomy, ensuring a safe assistance to women and newborns. It is important to have the knowledge of information on the legal aspects of the profession, in this case, the Obstetric Nurse, because it allows for considering ethical-legal questions that relate to professional action and provide information

to equip themselves with strategies for operationalization of the profession[11].

Interview with Obstetric Nurses in a study on the responsibility in the assistance to childbirth revealed that the professionals used the records on medical charts and on the partogram as a way to protect themselves legally regarding decision-making and implemented procedures. In the same survey, there was the recommendation to fill in the chart always in detail, since it has great value when there is need to assess the work performed[11].

The following fragment emphasizes the importance of nursing records for the safety of the team working with homecare:

> *The HB* [Home Birth] *is totally documented for the safety of the woman, the baby and the team working with them. Even in the legal point of view. Because it's not random, meaningless.* (N6).

Therefore, in addition to normative acts that ensure legality and autonomy to Obstetric Nursing professionals' work in the assisted home birth, its proper documentation is of great importance to back their professional action, in addition to being an allowance for decision-making. However, all legal support for the free and independent exercise of Obstetric Nursing must base on scientific knowledge, as reported by the Obstetric Nurses interviewed in this research:

> *Our autonomy, it begins from the moment we show knowledge. Because, when we have the knowledge, in certain situations, in the case of obstetrics, everything works easier in the sense you can direct your work better.* (N2).

> *When you are at the home environment, and you have the scientific knowledge that supports you properly, you have greater autonomy in your service. So you feel freer to develop your function within the scope of your scientific knowledge.* (N8).

The scientific knowledge is a propeller of the exercise of autonomy, because, besides being the basis for the care, in the planned home birth, it provides the professionals with the freedom to seek change and overcome the traditional health care practices rooted and disseminated as right for years.

The "National Guideline for Assistance to Normal Delivery" highlights the Obstetric Nurses as one of the key professionals in the care with the delivery outside the hospital. Nevertheless, it reaffirms the importance of the allocation of resources for training these professionals, in addition to the need to establish a minimum curriculum, which addresses the competencies and skills necessary for the safe care with quality for the binomial[16].

The performance of obstetric nurses must be based on the recommendations of the World Health Organization (WHO) and the Ministry of Health (MOH). Even outside the hospital environment, the Obstetric Nurse must follow biosafety, quality and safety requirements in the assistance and use the best scientific evidence to act[17].

The guidelines for planned home birth care by Obstetric Nurses and Midwives in the state of Santa Catarina recommend that the professionals must have qualification to work with the birth and the newborn in the home environment, and they must have updated training every two years in maternal and neonatal resuscitation and obstetric emergency[17].

The obstetric nurses interviewed mentioned the importance of constant updating:

> *Well, I think that every obstetric nursing professional must indeed attend courses, especially those directed to the best scientific evidence. And the most, let's say, important, with the greatest references of the WHO* [World Health Organization], *among other references. Top-rated references.* (N2).

> *We need to study, to be updated. So, to attend courses of emergency support, to have autonomy and safety, right? During the work. Every neonatal resuscitation courses, as well as adult resuscitation, obstetric urgency and emergency for situations of bleedings, we have to be able to act.* (N10).

The exercise of autonomy is potentiated by the appropriation of the theoretical knowledge to provide a problem-solving work in complex situations and in the ability of decision-making. Therefore, in the assistance to planned home birth, the obstetric nursing is mostly the single category present in teams, thus, these professionals must be always updated and trained in current scientific evidence.

The professional qualification must always be integrated with a qualified assistance, whatever

the environment. Nonetheless, in the home environment, this must be strengthened, so that the delivery is near the reality experienced by the family, because the ability to be sensitive in the assisted birth is essential to understand that this event often does not follow the standards established by the books. Moreover, the dynamics of each household and each family needs to be considered and respected[18].

Category 3: Materials/Technologies that provide safety to exercise autonomy

Revisiting the history of childbirth, traditionally, it was a family event, conducted by women. These women, midwives/godmothers, were trusted by the pregnant woman or had experience recognized by the community[19]. In this way, only the midwives performed this practice.

Traditional midwives fulfilled an important role during many years in society. Even today, they are still the only alternative for assistance in more distant communities, whose access to health care is limited. In these places, their work often is also based on empirical knowledge and carried out very far from the desired (safety and hygiene) conditions.

Based on this context of precarious assistance and with few material resources and technology, coupled with people's imagination, in which the ideal birth is represented by the hospital childbirth, surrounded by technologies, many people have demonstrated prejudice against and unawareness of how the assistance to home birth occurs in the current model.

> *Many people think, oh, home birth is like old times. From the time of traditional midwives, which was like a bowl, a cloth, hot water, thereby carrying out the birth, right? So, there is still much of this taboo, in which people think that Home Birth occurs this way, but it doesn't.* (N2).

> *Well, home birth is still permeated by unawareness from the population in general, which thinks that we take a piece of cloth, a bowl full of hot water, right? But it's not like that.* (N6).

The home birth is perceived as a throwback to old molds of childbirth care conducted by traditional midwives. There is a view that the benefits of scientific and technological advances currently offered by the health area are being denied to women and newborns. This view is related to the social construction that the hospital is the only place possible for childbirth, which resulted in a "naturalization" of hospital childbirth, and that home birth became an abnormal event and readily associated with lack of health care[20]. However, the current model of assistance to home birth evolving in the country occurs in a planned manner and with trained professionals. In these molds, the Obstetric Nurse is responsible for ensuring equipment and inputs required for the process of care to women and the neonate[17] .

In this sense, Obstetric Nurses participating in this research considered the presence of materials/technologies as a contribution to the safety of their autonomy, since, in case of indications or complications, they could perform their assistance more thoroughly and safely. The fragments below illustrate it:

> *All materials we use, in the prenatal care, delivery and puerperium, to develop our care process, are available for us to exercise our work with autonomy. Everything we use inside a doctor's office, such as sonar, tape, right? All the neonatal resuscitation devices we have are also present in the HB* [Home Birth] *group, chart, other printouts. Non-pharmacological methodologies for pain relief, everything* [...] *we have several possibilities, right? Because the practice requires the materials.* (N5).

> *And we have the supporting material, such as the Ambu bag, serum, some medications used in emergency* [...] *So, we're able to offer a basic support in case of any complication, which also gives me safety for my assistance. First of all, I think everything will be alright, once delivery is a physiological event. We don't need this, but, if we do, because, even in a usual-risk pregnancy, we can face some complications, these materials will be there, available for us. But we rarely use them.* (N6).

In this way, the assistance to planned home birth does not dispense with the use of materials/technologies. On the contrary, these make professionals feel safe to exercise their autonomy outside the hospital environment, because they can be used by Obstetric Nurses in case of need for intervention or some type of complication.

Even with all the material support present, the home birth is used only when necessary, although conducted by an Obstetric Nurse or Midwife and associated with lower rates

of interventions, lower risk of episiotomy and instrumental delivery, as showed by a systematic review performed by the Cochrane Library about care models for usual-risk[21]. Other international studies have also showed that the risks of Planned Home Birth and hospital birth are equivalent, but the first presents a lower rate of intervention during the entire process, which results in a smaller number of complications[22-23].

These studies show that assistance to home birth diverges from the interventionist and medicalized model commonly employed in the hospital environment. The assistance offered in the household is mostly based on non-invasive care technologies, which employ, among other resources, emotional support, qualified listening, empathy, appropriate uterine examination, promotion of a welcoming environment, stimulus to conscious breathing and walking.

The study had limitations regarding the size of the sample, which was reduced in number, which does not allow for generalizations. Nevertheless, it is expected to clarify how the Obstetric Nurse's work occurs in the assistance to home birth, broadening and strengthening this "new" work field.

Conclusion

The study revealed that the legal backups, scientific knowledge and the materials/ technologies give Obstetric Nurses safety to work with autonomy in the assistance to home birth, because they are legally sustained by the Law of Nursing Professional Practice, regulated by decrees and resolutions of the Federal Nursing Council, in addition to the recognition of WHO and MOH as professionals qualified for assistance to labor and birth.

There were also differences in the performance of the Obstetric Nurse at home when compared to the hospital institution. In the home environment, they can exercise their professional autonomy more effectively, whereas, in the hospital environment, the biomedical model is still rooted, which centralizes the care on the medical professional and restricts the autonomy of other categories.

Therefore, the results show that these professionals seek to provide a problem-solving assistance, always assessing risks and benefits based on evidence and best practices for qualification of obstetric care and autonomy of the professional exercise. With this performance, they contribute to the strengthening of the category and women's role.

Collaborations:

1 – conception, design, analysis and interpretation of data: Elyssandra Oliveira da Silva and Maria Elisângela Torres de Lima Sanches;

2 – writing of the article and relevant critical review of the intellectual content: Elyssandra Oliveira da Silva, Maria Elisângela Torres de Lima Sanches, Amuzza Aylla Pereira dos Santos and Luciana de Amorim Barros;

3 – final approval of the version to be published: Elyssandra Oliveira da Silva and Amuzza Aylla Pereira dos Santos.

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