

Perceptions of midwives regarding their role in childbirth at hospitals from Porto Alegre

Percepções de enfermeiras obstetras quanto a sua atuação no parto em hospitais de Porto Alegre

Percepciones de enfermeros obstetras sobre su papel en el parto en hospitales de Porto Alegre



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ABSTRACT

Objectives: To understand the perceptions of obstetric nurses (midwives) about the work dynamics in the parturition process at hospitals from Porto Alegre/Rio Grande do Sul.

Method: Exploratory-descriptive study with a qualitative approach with 12 midwives Who worked at eight obstetric centers in the city, recruited using the *snowball* technique. Data collection was carried out by the application of a semi-structured instrument and electronically, from September to November of 2023. The data analysis technique was thematic.

Results: Midwives realize that their performance contributes to the rescue of physiological birth. The work of midwives in households was replaced by a non-collaborative and often interventionist model. Administrative demands, the staffing framework, and the relationships between professionals appear as factors that hinder the insertion of nurses in childbirth care.

Final considerations: The legislation does not guarantee autonomy to provide birth assistance. Implications for practice are the need for managers committed to implementing the collaborative birth care model and review in staffing for full autonomy of midwives in this scenario.

Descriptors: Delivery Rooms. History. Obstetric Nursing. Parturition. Professional Autonomy.

RESUMO

Objetivo: Conhecer as percepções de enfermeiras obstetras sobre a sua dinâmica de trabalho no processo de parturição em hospitais de Porto Alegre/Rio Grande do Sul.

Método: Estudo exploratório-descritivo, de abordagem qualitativa. Foi realizado com 12 enfermeiras obstetras atuantes em oito hospitais do município, recrutadas pela técnica *snowball*. A coleta dos dados decorreu da aplicação de questionário semiestruturado por via eletrônica, no período de setembro a novembro de 2023. Os dados foram analisados pela técnica de análise de conteúdo temática.

Resultados: As enfermeiras obstetras percebem que suas atuações corroboram para o resgate do parto fisiológico. A atuação das parteiras nos domicílios foi substituída pelo modelo não colaborativo e frequentemente intervencionista. As demandas administrativas, o quadro de dimensionamento de pessoal, assim como as relações entre os profissionais aparecem como fatores que dificultam a inserção da enfermeira na assistência ao parto.

Considerações finais: A legislação não garante a autonomia para execução da assistência ao parto. São implicações para prática, a necessidade de gestores comprometidos com a implementação do modelo colaborativo de assistência ao parto e a revisão do dimensionamento de pessoal para a plena autonomia das enfermeiras obstetras no cenário hospitalar.

Descritores: Autonomia Profissional. Enfermagem Obstétrica. História. Parto. Salas de Parto.

RESUMEN

Objetivos: Comprender las percepciones de las enfermeras obstetras sobre su dinámica de trabajo en El proceso del parto en hospitales de Porto Alegre/Rio Grande do Sul.

Método: Estudio exploratorio-descriptivo con abordaje cualitativo con 12 enfermeras obstetras que laboraron en ocho centros obstétricos de La ciudad, reclutadas mediante la técnica de *snowball*. La recolección de datos se realizó mediante un instrumento semiestructurado y de forma electrónica, de septiembre a noviembre de 2023. La técnica de análisis de datos fue temática.

Resultados: Las enfermeras obstétricas perciben que sus actuaciones contribuyen al rescate del parto fisiológico. El trabajo de las parteras en los hogares fue sustituido por un modelo no colaborativo y a menudo intervencionista. Las demandas administrativas, la estructura de personal, así como las relaciones entre profesionales aparecen como factores que dificultan la inserción del enfermero en la atención del parto.

Consideraciones finales: La legislación no garantiza la autonomía para brindar asistencia en el parto. Las implicaciones para la práctica son la necesidad de que los gerentes se comprometan a implementar el modelo colaborativo de atención del parto y revisar la dotación de personal para lograr la plena autonomía de las enfermeras obstétricas en este escenario.

Descriptorios: Autonomía Profesional. Enfermería Obstétrica. Historia. Parto. Salas de Parto.

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INTRODUCTION

Obstetric nurses, or professional midwives, “midwives” as they are known in international literature, are globally recognized as qualified, responsible, and respectful professionals who have a very close connection with women, newborns, and their families. This relationship of support, care, technical, and scientific assistance, based on the assumptions of humanization, begins with reproductive planning and continues until the first weeks of the newborn’s life⁽¹⁾.

According to the 2021 State of the World’s Midwifery (SoWMy) report, there is a shortage of around 900,000 professional midwives worldwide. In the Americas, it is estimated that there are 160,000 professionals (1.9 per 10,000 inhabitants) and that qualified interventions with assistance from Obstetric Nursing can save 4.3 million lives annually worldwide⁽²⁾.

Unnecessary obstetric interventions increase maternal and perinatal morbidity and mortality rates, which are reduced when birth is attended by obstetric nurses or professional midwives. These professionals are recognized for respecting the physiological birthing process, providing women with self-confidence and a leading role⁽³⁾.

In Brazil, there is no prevalence of assistance during natural birth by obstetric nurses. The country has high rates of interventions such as the routine use of episiotomy, the standardized use of oxytocin, elective cesarean sections, and/or without obstetric indications, among others. It also has the second-highest rate of cesarean sections in the world, with a forecast of 57.4% of births by 2030, a percentage above the 15% rate recommended by the World Health Organization (WHO)⁽⁴⁾.

The Ministry of Health (MS) recommends that managers provide conditions for the implementation of a care model that includes obstetric nurses (OBs) in low-risk birth care. This is the ‘collaborative model’. This model of hospital care for labor and birth integrates medical professionals, and obstetric nurses into the team, and may also include doulas and other professionals. The OBs are responsible for caring for high-risk pregnant women, relying on medical teams in case of complications. In the collaborative model, high-risk pregnant women can be monitored by both professionals, doctors and obstetric nurses^(3,5).

Records from the Federal and Regional Nursing Council (COFEN/COREN) Systems for 2022 indicate that Brazil has around 13,722 obstetric nurses. It may be that a large number of these specialists in the country are not properly registered, as only professionals with titles registered with the COFEN/CORENs System are qualified to practice their specialty. In Rio Grande do Sul, there are fewer than 500 professionals⁽⁶⁾. Childbirth assisted by nurses was only regulated in 1986, through the Nursing Professional Practice Law (Law No.7,498/86), according to which assistance during childbirth without dystocia is a responsibility of generalist nurses⁽⁷⁾.

The School of Nursing at the Federal University of Rio Grande do Sul (EEnf/UFRGS), located in Porto Alegre, is a pioneer in the training of obstetric nurses, who received this title upon completing their undergraduate course. From 1966 to 2019, EEnf/UFRGS trained 146 obstetric nurses in 11 training courses. In 2005, national guidelines modified this specialty so that it could be carried out after graduation from specialization and residency courses⁽⁸⁾.

The inclusion of obstetric nurses in pregnancy, childbirth and postpartum care is one of the WHO recommendations for reducing maternal and neonatal mortality worldwide. Furthermore, these professionals are qualified to transform care settings, making birth a positive experience for women and their families^(1,2). Due to the difficulties Brazil faces in meeting WHO recommendations to encourage natural birth and the inclusion of OBs in this context, it is necessary to delve deeper into the role of these professionals in hospital obstetric centers. Thus, the following research question was posed: what are the perceptions of obstetric nurses about the work dynamics in the parturition process in hospitals in Porto Alegre/Rio Grande do Sul?

METHOD

Exploratory-descriptive study with a qualitative approach with 12 obstetric nurses who worked at eight obstetric centers in the city of Porto Alegre, Rio Grande do Sul, Brazil.

Participants were recruited using the snowball non-probability sampling technique⁽⁹⁾, which consists of reference chains for selecting participants. The first participant was intentionally selected by the researchers

who were aware of her length of experience in the area, insertion in an obstetric model that promotes the work of obstetric nurses, and the possibility of the participant inviting another colleague in the area to participate in the study, recommending the implementation of the snowball.

After data collection with participant "one", this participant suggested another obstetric nurse to the researchers, and each time a participant joined the research, she would suggest another name to the researchers. These would then invite the person to participate in the study and provide the necessary information, continuing with the data collection. This procedure was interrupted as soon as the researchers identified repetitions of themes and responses among the participants' statements⁽¹⁰⁾.

The sample consisted of 12 OB nurses. Regarding the eligibility criteria, nurses with an obstetric nurse title and who had been working in this specific area for more than 6 months were included, a period in which they would have had time to master the care processes and routines, in addition to being included in the teams. The exclusion criterion was obstetric nurses who did not work in a hospital environment.

Contacts with participants were made electronically (via an online form) and all nurses indicated to participate in the study agreed to take part.

Data collection took place through a semi-structured questionnaire constructed via Google Forms and applied online. The questionnaire allowed participants to freely write their answers. It contained four main questions listed from 1 to 5, as follows: 1. What do you know about the history of childbirth and the insertion of obstetric nursing in the labor and birth scenario? 2. What are your professional duties within the practice setting in which you work?: 3. What are the main challenges you face as a nurse in labor and birth care at your place of professional practice?: 4. What strategies do you consider possible to increase nurses' autonomy in childbirth care in the current hospital setting? 5. Optional space to list what was not addressed in the previous questions and considered relevant regarding the autonomy of the obstetric nurse in a hospital obstetric center.

Data collection was carried out from September to November 2023. The data were organized in spreadsheet

development software. These spreadsheets were updated as the online questionnaire was answered by the participants. As soon as the responses were made available, the researchers read and analyzed them to identify similarities and possible repetitions between the statements.

The data analysis technique was content analysis and was carried out in three stages: pre-analysis, exploration of the material, treatment and interpretation of the results. Pre-analysis refers to the first reading made as the responses were fed into the spreadsheet. After the data saturation stage came the material exploration, processing and interpretation of the results phase. After in-depth reading and classification of the speeches, the units to be referenced by themes were cut out, which, grouped by convergence of ideas, gave rise to the categories⁽¹¹⁾.

The study was approved by the UFRGS Research Ethics Committee (CEP/UFRGS), under CAAE No 70135423.6.0000.5347. Resolutions No. 516 of 2016 and No. 466 of 2012 of the National Health Council (CNS) were observed, which refer to the ethical standards that regulate research involving human beings in Brazil⁽¹²⁾. The items of Resolution No. 510 of 2016, which provides for the use of data directly obtained from participants or identifiable information or that may entail greater risks than those existing in everyday life⁽¹²⁾ and Circular Letter No. 1/2021 of the National Research Ethics Commission (CONEP) were also covered in order to preserve the protection, security and rights of participants in research carried out in a virtual environment⁽¹³⁾. The professionals signed the Free and Informed Consent Form (FICF) electronically. Letters and numbers were used to designate the participants, called OB (obstetric nurses) from 1 to 12.

■ RESULTS AND DISCUSSION

The participants consisted of 12 OB nurses, ages 28 to 59, with an average age of 37. Among the 12 participants, 58.3% had been nurses for over 10 years. Of the total, 83.3% completed postgraduate specialization courses in Obstetric Nursing, while the remainder (16.7%) specialized through Residency programs in Obstetric Nursing.

The OB nurses provided their services in eight hospitals, which corresponded to the total number of hospitals with obstetric centers operating in the city at the time of data collection. Four OB nurses worked in 100% public hospitals, three in 100% private hospitals and five in mixed-management hospitals. One of the mixed-management hospitals is a public and university hospital, but offers a percentage of private and health insurance beds, and the obstetric center also has procedures scheduled through these hospitals; and the other is a philanthropic hospital, which serves SUS patients, patients with private health insurance and other types of health insurance. Detailed data on the training and locations of operation are presented in Chart 1.

Based on the analysis and interpretation of the content obtained from the nurses' perception of their professional performance, two categories were generated,

namely: cultural trajectory and historical changes in the childbirth care model and administrative and managerial demands of the obstetric nurse: exclusion of the obstetric nurse from the delivery scene.

Cultural trajectory and historical changes in the childbirth care model

Regarding the birth scenario and the historical-cultural changes in the birth care model, the participants referred to such transition in their statements below:

Childbirth was considered a matter for women in the community, since childhood, these women cared for women who were giving birth and gradually participated in more specific care, as they also rose in their social position (before menarche, after menarche, marriageable age...). (OB2)

Chart 1 – Data on the participants. Porto Alegre, Rio Grande do Sul, Brazil, 2024.

Obstetric Nurse	Time elapsed since graduation	Type of specialization	Place of activity
OB1	> 10 years	Specialization in Obstetric Nursing	Mixed-management hospital
OB2	> 10 years	Specialization in Obstetric Nursing	Public hospital
OB3	> 10 years	Specialization in Obstetric Nursing	Public hospital
OB4	< 5 years	Specialization in Obstetric Nursing	Mixed-management hospital
OB5	> 5 years < 10 years	Specialization in Obstetric Nursing	Public hospital
OB6	> 10 years	Specialization in Obstetric Nursing	Mixed-management hospital
OB7	> 5 years < 10 years	Residency in Obstetric Nursing	Mixed-management hospital
OB8	> 5 years < 10 years	Residency in Obstetric Nursing	Public hospital
OB9	< 5 years	Specialization in Obstetric Nursing	Mixed-management hospital
OB10	> 10 years	Specialization in Obstetric Nursing	Private hospital
OB11	> 10 years	Specialization in Obstetric Nursing	Private hospital
OB12	> 10 years	Specialization in Obstetric Nursing	Private hospital

Source: the authors, 2024.

Childbirth was traditionally a home and family event. (OB3)

Childbirth was initially assisted by midwives more naturally, in the home of the woman giving birth and in the presence of only women. (OB5)

For a long time, historically speaking, the process of gestation and birth was a female experience - both for the pregnant woman and for the midwife. Birth assistance was carried out by midwives, at home. (OB8)

Women were assisted in childbirth by people they knew and who were experienced, called midwives. (OB10)

We were known as midwives and worked at home, passing on our knowledge from mother to daughter. (OB11)

In the past, childbirth was seen as a physiological issue, being born vaginally was common, and women in labor were often cared for by midwives. (OB12)

From their speeches, the OB nurses reported that childbirth has undergone several changes throughout the history of humanity, and different people were present at the scenes of childbirth before it began to be performed mainly in hospital settings in the mid-20th century. According to seven participants, until its institutionalization, childbirth was considered a physiological, community, family, home and exclusively female event, assisted by midwives.

Women assisted other women during childbirth, based on their own empirical experiences⁽¹⁴⁾, that is, based on their previous experiences, they helped other women in the act of giving birth. In this context, childbirth was the exclusive domain of women because it was considered a feminine mystery, which only women had special knowledge and understanding to conduct. Thus, it is said that obstetrics began with female midwives, internationally called midwives, but in Brazil they are called traditional midwives⁽¹⁵⁾.

Regarding the teaching of midwifery, in addition to what is reported by OB2 about knowledge being passed on among women within the family and community, OB8 adds that midwives at the time had experience, but did not have specific professional training for this role.

Many of these midwives had experience but no degree. My great-grandmother was a famous midwife in the riverside region where my family lived, a fact that I discovered some time after I graduated as an obstetric nurse. (OB8)

Until the mid-19th century, childbirth was a community event attended by traditional midwives, who the Ministry of Health now recognizes as those who assist home births based on traditional practices, with recognition by the community in which they live. Traditional midwives did not have scientific training, their knowledge was taught by women to other women, using techniques based on minimal intervention in the pregnant body and greater emotional support for the pregnant woman⁽¹⁶⁾, forming a network of support, acceptance, and reciprocity among the female group, throughout the gestational, birth and postpartum process⁽¹⁷⁾.

Regarding the reality of the labor and birth scenario, the participants approached the change of scenery as follows:

With the medicalization of childbirth, midwives were gradually removed from care, and women lost their autonomy and right to choose. (OB2)

Being assisted by midwives was common, but over time childbirth became medicalized, becoming increasingly medical. (OB12)

The obstetric reality reflects a scenario far removed from the practices of traditional midwives, with a model centered on the health professional. There is a scenario of interventions not supported by scientific evidence and births conducted mostly by doctors, which makes it difficult to implement a collaborative model. The medicalization of childbirth, which gained momentum in the mid-1920s, was one of the main reasons for the decline in midwives' work and a change in the scenario⁽¹⁸⁾.

The feminine and feminist action of the traditional midwife has become a formal, professionalized, and masculine activity that, according to medical discourse, must be surrounded by qualifications and certifications to practice midwifery⁽¹⁷⁾. The concept of medicalization comprises a process that makes non-medical situations and behaviors - such as the physiology of the

process of gestation and childbirth - pathological so that their treatment becomes the object of specialized medical knowledge⁽¹⁹⁾.

Regarding childbirth care and the biomedical model, the participants expressed themselves as follows:

With medicalization and the development of technology, it migrated to the hospital area. (OB3)

There was a movement towards medicalization of childbirth with the change from the home environment to the hospital environment. (OB4)

With the medical appropriation of this event, the women were taken into the hospital. (OB5)

With the medicalization of the pregnancy and birth process, there was a change in this scenario, births became institutionalized and assisted by doctors. (OB8)

Medical appropriation and the consequent medicalization of labor and birth is mentioned by four (4) of the OB nurses interviewed (OB3, OB4, OB5, OB8) as the crucial factor in the cultural change that led to women migrating to give birth in institutionalized environments. From 1940 onwards, hospitalization of births became a trend, and surpassed the number of births at home from 1976 to the present day⁽¹⁸⁾.

Regarding the reports of five participants (OB5, OB3, OB1, OB8, OB12), it is clear that changes related to medicalization and institutionalization may not be beneficial. Interventions in physiological processes are reported for greater benefit of the assisting professionals rather than the pregnant women, such as: standardization of the lithotomy position, episiotomy, Kristeller maneuver, indiscriminate use of oxytocin, emergence and high rate of cesarean sections, in addition to the relationship of these and other interventions with high rates of maternal and child morbidity and mortality.

OB5 reports her perception of medicalization, mainly regarding the aspect of women's loss of their leading role, the power relationship, and the interventions that began to be normalized in vaginal births.

With the medical appropriation of this event, women were taken to the hospital, where there were modifications to the birthing process for the

convenience of those assisting them, such as lithotomy.[...]. The focus shifted from the woman to the medical professional. (OB5)

The medicalization of childbirth is exercised through a camouflaged power that imposes the delegitimization of women's leading role and gives the doctor the leading role in obstetric care, naturalized by the medical authority through which these professionals are known as the best actors in decisions about the population's health⁽¹⁹⁾. In line with this logic, it was observed that the more power one has over the body, the more "trained" it is and, consequently, the more vulnerable it becomes to interventions and "repairs"⁽¹⁸⁾, which allows interventions to be associated with one another, triggering a "cascade" effect.

Lithotomy became the most "common" position for giving birth after the medicalization of childbirth, as it provided greater access for professionals to the perineum. In this position, the vaginal canal presents an upward curvature, making fetal descent difficult, which culminates in prolonged labor and expulsive period, increases the risk of severe perineal trauma, painful sensation and changes in fetal heart rate due to compression of the cephalic pole⁽²⁰⁾.

Despite the complications related to the lithotomy position, 91.7% of women with low-risk pregnancies use this position during the expulsive period⁽²¹⁾, which, in addition to promoting such risks, can also be associated with the triggering of other interventions such as episiotomy and Kristeller maneuver, as a cascade effect.

Labor was medicalized and, as a result, several procedures were adopted to normalize and accelerate it, such as episiotomy and the Kristeller maneuver. (OB5)

The WHO classified both episiotomy and the Kristeller maneuver as practices not based on scientific evidence and should be eliminated from the obstetric routine due to significant complications that do not bring any benefits that justify their use in evidence-based studies⁽⁵⁾. EO1, in turn, reports her perception of the induction of labor with the indiscriminate use of exogenous oxytocin, and its direct relationship with the risk of complications, such as postpartum hemorrhage (PPH).

High rates of postpartum hemorrhage are also related to the indiscriminate use of oxytocin for induction of labor. (OB1)

Exogenous oxytocin began to be used in Brazil when hospitalization for births increased. Excessive medication and its indiscriminate use during labor can produce adverse effects in women, such as tachysystole, uterine hypertonia and hyperstimulation, water intoxication, hyponatremia, uterine rupture, trauma to the perineal region, and maternal hemorrhage⁽²²⁾, as reported by OB1.

The most well-known complication rates, whether caused by interventions during childbirth or not, also gave rise to surgical deliveries, such as cesarean sections, which began to be used to reduce maternal and neonatal mortality rates. The medicalization of labor and birth was highlighted in the participants' statements.

With the medicalization of the process [...], Brazil has become one of the countries that performs the most cesarean sections, which entails greater risk and higher maternal mortality. (OB8)

Over time, childbirth became more medicalized, becoming increasingly medical and consequently more surgical. (OB12)

OB8 and OB12 cite the normalization of medicalization as the key to triggering Brazil's cesarean section culture, and OB8 sees this change as a greater risk to the binomial, as does the author⁽⁴⁾ who studies the phenomenon. The frequency of cesarean sections has increased gradually and significantly over the last 30 years, and currently, Brazil is the second country with the highest surgical rate: 15% in 1970, 30% in the early 1980s, 40% in 1990, exceeding 50% in 2009 and reaching 55.7% in 2017, considered an epidemic in Brazil^(4, 23).

In contrast to the initial concept of "saving lives", the WHO defines that there is an association between the increase in maternal and neonatal morbidity and mortality and the high rate of cesarean sections: the risk of death in cesarean surgery is 3 times greater than in vaginal birth. It can cause several future complications for the binomial, especially when unnecessary⁽²⁴⁾.

The risk of puerperal infection, when comparing cesarean section with vaginal birth, is five times greater and there are also complications such as abnormal uterine bleeding, chronic pelvic pain, uterine rupture, placenta accreta, severe and potentially lethal maternal hemorrhagic conditions, damage to organs located near the uterus (such as the bladder), pulmonary embolism, among others⁽¹⁸⁾.

OB12 reports that cesarean section surgery is advantageous for health professionals because it can be performed quickly if the pregnant woman does not go into labor, reducing the time of care provided individually to each pregnant woman.

The medical scenario did not include long hours of birth assistance, performing a cesarean section was much faster and more effective. [...] Currently, as I work in a private institution, my scenario is 80% dedicated to cesarean sections. We have a schedule with a large number of elective cesarean sections. Doctors choose the night shift to perform their elective procedures as this way they do not need to cancel their daytime appointments in their private offices. (OB12)

Cesarean-section rates reveal that Brazil does not perform this surgery only in cases where there is a real obstetric indication, as it is estimated that the need for surgical fetal extraction occurs in only 10 to 15% of pregnancies. The interventionist culture that stigmatizes childbirth, associating it with pain, suffering, difficulty, delay, and the possibility of scheduling the date and time for cesarean sections are facts that lead to high rates of cesarean sections, making it a surgery that is culturally normalized by the population and health teams^(18, 25).

In 1998, the Ministry of Health provided an incentive to train obstetric nurses for their inclusion in childbirth care, aiming at the humanization of health services and the reduction of maternal and perinatal morbidity and mortality, their action being necessary to reduce high rates of cesarean sections⁽²⁶⁾.

The statements of the OBs interviewed highlight the need for training obstetric nurses to change the scenario of childbirth care.

The emergence of obstetric nursing is also necessary to reduce the number of cesarean sections, a procedure with high rates in Brazil. (OB5)

The Federal Government's investment in the training of obstetric nurses when surgical rates became high and there was a greater tendency towards interventionism, aimed to provide more respectful and physiological comprehensive care in general. (OB8)

The search for evidence-based practice "showed" that excessive interventions were not beneficial for the mother-baby binomial. In this context, in favor of less interventionist and more physiological births, more humane and scientific practices with obstetric nurses are being revived. (OB3)

Multidisciplinary care during childbirth by multidisciplinary teams contributes to reducing cesarean sections without obstetric indication⁽⁴⁾. Obstetric nurses provide information and guidance during prenatal care, welcoming pregnant women, systematizing care, ensuring greater adherence to non-pharmacological methods with qualified care, giving autonomy, and demystifying labor⁽²⁵⁾.

A qualitative Brazilian study with nine obstetric nurses from a Natural Birth Center (CPN) in the state of Pará, aimed to understanding the identity of obstetric nursing in the field of activity, revealed that these nurses perceive their scientific practices as having great autonomy for professional practice, in a shared manner, which guarantees care centered on women and their rights⁽²⁷⁾.

A cohort study conducted in Norway with 7,277 women, aiming to investigate the association between care provided by midwives and obstetric outcomes, revealed that women who received care from midwives (n=4,234) used significantly fewer pharmacological methods of pain relief, such as nitrous oxide and epidural analgesia (p=0.000), had a shorter duration of the active phase of labor (p=0.001) and a lower rate of cesarean sections (p=0.020). As for the women who did not receive midwifery care (n=2,869), greater use of oxytocin was observed during the active phase of labor (p=0.001) and amniotomy (p=0.001)⁽²⁸⁾.

The participants believe that the inclusion of obstetric nursing is a way of rescuing the physiology of childbirth and requiring fewer interventions in the process.

The inclusion of obstetric nursing restores the physiology of labor and birth. It means non-interference in the natural process, respecting the woman's decisions and reducing adverse events. (OB1)

The work of obstetric nurses seeks to restore this physiological birth, which is more natural and less medicalized. (OB12)

Obstetric nursing plays an important role in restoring the autonomy of pregnant women. (OB4)

A review study highlighted that midwives are recognized as experts in the physiological processes of labor, delivery, birth, and postpartum, with an emphasis on supporting the experience of women and their families, both physically and psychologically. Their role differs from that of obstetric medical professionals, as they treat complications and perform surgeries when necessary. The midwife's model of obstetric care is based on trust, effective communication, and individualized care to promote women's empowerment and autonomy⁽²⁹⁾.

Participants associate nursing practice with traditional knowledge of childbirth care.

I know that our profession is one of the oldest in the world. In the past, we were known as midwives and we worked at home, passing on our knowledge from mother to daughter. Today our profession is recognized, based on scientific evidence, and is always being updated so that our care is recognized as science. (OB11)

The practice of obstetric nursing combines the ancient knowledge of midwives with science and evidence-based best practices. (OB5)

Referring to the natural process and the leading role of the woman giving birth, OB11 and OB5 recognize the practice of obstetric nursing as an association of the ancient knowledge of midwives with the study of science and adherence to good practices based on evidence. In line with what the aforementioned OB states, one author⁽¹³⁾ affirms that midwives, throughout history, had their knowledge subordinated to medicine, and women who mastered the craft being "trained", contributing to the training of obstetric nurses through the technification of midwifery practices.

A study⁽²⁰⁾ that defines good practices in childbirth care considers that obstetric nurses have constructed a “de-medicalized” model of care, as a non-invasive technology centered on autonomy, the principles of physiology, and women’s rights. There is evidence that where there is greater obstetric nursing activity, there is a greater supply of good practices and less use of interventions in the physiological process of birth, whether in homes, birthing centers, or hospital obstetric centers.

The nurses also express in their statements the importance of the team recognizing and valuing their knowledge as a strategy for inclusion in direct childbirth care.

Recognition and appreciation of the knowledge of obstetric nurses by the medical team. Being part of the care team, providing shared care. (OB1)

Autonomy comes with knowledge, when we take responsibility for care we start to gain space in childbirth care and in the care of the mother and baby. (OB11)

Nurses with specific training in obstetrics play an essential role in care and have been regaining space in the birth scenario, whether institutionalized or at home, restoring the right to choose of the person giving birth. (OB2)

OB nurses are increasingly recognized in the obstetric setting as key figures in the care of women at the time of birth. We are playing a fundamental role in ensuring individual, humanized, respectful and, above all, safe care. (OB11)

The recognition and appreciation of OBs is already one of the WHO’s agendas, as it recognizes, based on analyses, that the work of obstetric nursing improves care practices and can reduce up to 83% of maternal and fetal deaths⁽²⁶⁾.

Considering the performance of obstetric nursing from the participants’ perception, the insertion in Brazilian and Rio Grande do Sul childbirth scenarios divides opinions about the challenges faced by the profession, and which may be influenced by the reality of their fields of activity.

In turn, OB7, OB9 and OB12 have a less favorable opinion regarding the performance of OB in the Porto Alegre/RS scenario.

In general, it is one of the most active professions in the birth scenario, but when we observe daily practice in the southern region of Brazil, more precisely in Porto Alegre, the role of obstetric nurses is increasingly unnecessary. (OB7)

Unfortunately, Rio Grande do Sul (RS) is still behind compared to other states [...]. Obstetric nursing has been gradually gaining ground. (OB9)

Regarding the scenario, RS is a very backward state in terms of the performance of obstetric nursing, a scenario seen by many as unqualified care. (OB12)

The clear delimitation of the role of each professional and the difficulties in multidisciplinary interaction are present in the perceptions of OB2 and OB12.

The physician-centered care model, the difficulty of interdisciplinary teamwork, the absence of doulas and pelvic physiotherapists, the shortage of obstetric nurses and nursing technicians are the biggest obstacles to achieving our goal. (OB2)

I believe that we still need a very relevant cultural change so that we can have real conditions for humanized care within a private institution, a change in the care model that includes a larger space for the work of multidisciplinary teams (physician, obstetric nurse, doula). (OB12)

A study found that the inclusion of obstetric nursing is still a challenge to be overcome in obstetric care institutions, where there are barriers to this process. The understanding of the multidisciplinary team is one of the challenges for implementing the role of OB in childbirth⁽³⁰⁾. Furthermore, the historical trajectory of the childbirth transition model, the lack of recognition, and the lack of autonomy of OBs to act in the childbirth scenario are crossed and reinforced by administrative and managerial demands.

Administrative and managerial demands of the obstetric nurse: removal from the birth scene

In addition to the difficulties related to the lack of appreciation of multidisciplinary teams within services, humanized birth care is hampered by the different demands that make it impossible to provide comprehensive care to women in labor, which was elucidated by the experiences of the 12 participants.

The participants' statements reveal that the performance of OBs in the birth scenario is influenced by the low adherence of the multidisciplinary team to care. Still, their challenges are not solely centered on this factor. The occupation's performance is shaped according to the care model established by the different sectors in each of the hospitals, with the standardization of nurses' activities - care or administrative - to the various demands assigned to them concerning the nursing team due to their management role and personnel sizing.

OB nurses are responsible for administering the unit, controlling materials and equipment, supervising technical teams and organizing their work schedules. (OB2)

To manage the nursing team, work schedules and organization of the sector as a whole. (OB3)

The main challenge is being able to provide individual care during labor and delivery while having to deal with all the bureaucracy of an obstetric center. Protocols and paperwork take up a lot of time that could be better used in bedside care. (OB11)

In addition to my care duties, I am also responsible for 8 nursing technicians, I organize work-off and vacation schedules, and I guide task division schedules. [...] I work at night, that is, without support from most other care areas. Therefore, I also end up acting as a nutritionist, psychologist, and I solve IT problems, among other things. (OB12)

Nurses frequently mentioned administrative and team and sector management activities in most of their statements; they highlighted how much these activities take them away from direct care to the mother-baby binomial, including carrying out activities that go beyond the demands of the professional core.

A study carried out in southern Brazil revealed that the work of obstetric nurses is often marked by a split between the care and management dimensions, generating conflicts in the nurse's work, whether with their own practice or in their relationship with the nursing and health team. This drives users away, compromising the quality of care and increasing the moral suffering of these professionals⁽³¹⁾.

Participants listed the routine duties of nurses as shown below.

Pre-delivery: assessment of women in labor (except assessment of dilation). Delivery: auscultation of fetal heartbeats and care for the newborn, whether in skin-to-skin contact or neonatal resuscitation devices, encouragement of breastfeeding in the first hour of life, and skin-to-skin contact. (OB1)

Assessments of fetal movement, uterine dynamics, fetal heartbeat, vaginal losses, nursing's documentation of patient's progress and anamnesis, medications restricted to nurse use, patient's fluid balance, control of high-alert medication and psychotropic drugs, handover, nursing prescription, application of non-pharmacological methods, assistance to the family as a whole, handover, care for puerperal women and newborns, safe surgery checklist, assessment of neonatal sepsis, nursing prescription and diagnosis, discharge of the patient and newborn from the recovery room. (OB6)

When asked about their professional duties in the setting in which they work, it is clear that nurses omit activities resulting from direct care in the expulsive period (2nd period) of labor. Although these OBs are qualified to perform, for example, cervical dilation assessment in the sector (1st period assessment), they do not do so. Corroborating this, nurses who work, respectively, in a public hospital and a mixed-management hospital, revealed that they do not provide assistance during childbirth, and often perceive that their work is limited to "medical assistance".

In the delivery and cesarean section room, we care for all newborns together with neonatologists; we do not provide direct assistance during childbirth. (OB2)

Conducting anamnesis and physical examination of both the pregnant woman and the postpartum woman, offering non-pharmacological and pharmacological analgesia. Medical assistance for childbirth and birth. (OB5)

I provide care during labor, assisting with non-pharmacological methods for pain relief and exercises. Unfortunately, we are unable to assist with the birth but, whenever possible, I do this during labor. (OB9)

Regarding the prioritization of activities, the following stands out: nursing records related to the patient's hospitalization (anamnesis); patient's progress in pre-labor, labor and postpartum; prescription of nursing diagnoses; application of non-pharmacological methods for pain relief and relaxation during labor; control of care flows in natural birth and cesarean delivery rooms; and the management of the nursing team and the actions carried out by them during assistance. The activities described by the obstetric nurses in this study resemble a standard care model found in the local context, which promotes the exclusion of obstetric nursing from the birth scene⁽³¹⁾.

Exceptions to the pattern found and the collaborative care model are related to good practices in childbirth, and are addressed by only two of the nurses interviewed - in only two hospitals among the eight surveyed - as follows:

Provide ongoing assistance to the woman in labor throughout the labor, delivery, and postpartum process; assist in low-risk births; provide the first care for the newborn in the delivery room with the pediatrician; perform IUD insertion after delivery in patients who so desire. (OB3)

During delivery, hold the baby, deliver the placenta, check the birth canal, and suture lacerations if any. (OB11)

Only one nurse out of the 12 respondents mentioned comprehensive assistance during natural birth and the insertion of an IUD in the 4th stage of labor. Another OB nurse mentions her duties in the 4th stage of labor, with direct involvement in placental expulsion and suturing in case of laceration. The hospital where she works is the only one of the 8 hospitals that provide

childbirth care in Porto Alegre that has an institutional protocol in which natural birth care is carried out in a collaborative model, that is, all pregnant women with no risk factors are distributed for care by the obstetric team according to the 1:1 ratio (medicine: obstetric nursing)⁽³⁾.

Regarding the predominance of the surgical route of birth in the Porto Alegre scenario, with exclusive and essential activities performed by nurses in operating rooms and their high rates, the cesarean care model may also be associated with this decrease in comprehensive care provided by nurses to women in labor.

Supervision and organization of the preparation of surgical rooms (whether for cesarean sections, curettage, EMCC), postoperative monitoring in the recovery room, management of the Nursing team, application of the NCS. (OB8)

I work the night shift (7pm to 7am), I am just a nurse, I carry out all these steps, all these activities are carried out in the same physical area, in the same sector and floor. Patients admitted for clinical treatment, who require some intensive care, stay inside the OC in pre-delivery wards, I also gather information (history) and prescribe drugs for these patients. (OB12)

Because we have a lot of cesarean sections, there is not enough time to closely monitor labor. There is a high demand for elective cesarean sections. (OB12)

The professional duties described above by the OB nurses can be jeopardized and contribute to greater absence from assistance when there is an inadequate number of professionals. When only one nurse is working in the OC, it is not feasible for her to provide direct care to the woman in labor, due to the various responsibilities and demands. Below are the speeches highlighting the need to review the personnel staffing chart, which impacts the possibility of providing comprehensive assistance during labor and childbirth.

For a long time I have been specializing in techniques such as Spinning Babies, aromatherapy, and refresher courses in childbirth physiology... the applicability of these techniques demands exclusivity in assisting a woman in labor and the nurse's countless tasks make the process unfeasible. The resizing of obstetric nurses is necessary. (OB1)

First, we need to increase the number of professionals so that we can provide high-quality care in all sectors. Today, while one nurse is providing care in the observation rooms and another in the delivery or surgical rooms, there is a shortage of professionals in the pre-delivery and recovery rooms, for example. A lot happens while we are away. We need management that supports our assistance and understands the importance of being present in all scenarios in the sector. (OB2)

I believe there should be more nurses per shift, this way we would be able to carry out bureaucratic tasks and assistance better. (OB11)

Monitoring labor requires time, attention, and dedication, and it is impossible to provide adequate assistance with a few professionals. (OB12)

Personnel sizing that does not meet the needs of the service, according to the nurses' statements, can be considered a cause of suffering in the short and long term, as this context contributes to nurses being forced to prioritize some activities and not perform others, that they were trained to do and would like to be able to do. Furthermore, personnel sizing is directly related to the development of humanization actions, because when it is inadequate it can expose women to obstetric violence resulting from negligence and inadequate care. This can result in institutional violence that makes it impossible to fully implement the principles of humanization of labor and birth and prevents nurses from providing high-quality care ⁽³¹⁾.

■ FINAL CONSIDERATIONS

The present study allowed us to understand the perceptions of obstetric nurses about the work of these professionals in hospital obstetric centers in the city of Porto Alegre. The participants believe their work corroborates the recovery of physiological childbirth with the understanding that home and family midwifery has evolved to become a medical, hospitalized, and interventionist specialty. The inclusion of nurses appears as a possibility to guarantee good practices and actions based on scientific evidence, corroborating a model that respects the physiology of the process.

It can be inferred that the work of obstetric nurses contributes to the qualification of obstetric care, reducing interventions that impact maternal and neonatal health. Apparently, the work of these professionals faces challenges for the development of their full duties in the current hospital obstetric scenario of the analyzed context. The autonomy for providing care to natural childbirth based on legislation does not guarantee the execution of activities, as there are limitations caused by institutional influences and inefficient personnel sizing. It has been demonstrated that nurses do not assist childbirth as provided for in current legislation and which is internationally recognized as promoting better maternal and child outcomes. This results in a minor change in the predominantly interventionist care model.

As for the implications for care practice, this research can encourage comprehensive studies in other birth care settings, with the aim of understanding differences in the performance of obstetric nurses in obstetric settings.

There is an urgent need to train new obstetric nurses not only at a local level, but also nationally and globally, to promote greater safety in the parturition and birth process. It is necessary to develop precise personnel sizing methodologies for obstetric centers, considering comprehensive assistance to women in labor by professional nurses specializing in obstetrics.

One limitation of this study is data collection in an electronic environment. It is suggested that research on this topic be conducted in person, which could allow for a deeper understanding of the issues.

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■ Availability of data and material

Access to the dataset may be granted upon request to the corresponding author.

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