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Childbirth assistance: nursing professional as an advocate for the parturient

Assistência ao parto: profissional de enfermagem como advogado da parturiente

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ABSTRACT
Understanding the perspective of nursing professionals on childbirth assistance in a teaching hospital in western Paraná from the standpoint of advocacy for the parturient. Qualitative research with nursing professionals conducted through in-person and voice-call interviews from December 2019 to July 2020. Data were analyzed through thematic content analysis. Twenty professionals participated, including five nurses and 15 nursing technicians. Five categories were identified: privacy and comfort; guidance on childbirth and the parturient's choices; presence of a companion; autonomy of nursing in the birthing process; and inappropriate practices. The assistance to the parturient indicated advances in using appropriate practices. In this regard, the nursing professional acted as an advocate for the parturient, defending her against inappropriate practices that, although less prevalent, still permeate the childbirth and delivery scenario.

Keywords: Health Advocacy. Nursing. Pregnant Women. Humanization of Assistance. Parturition

RESUMO
Compreender a perspectiva de profissionais de enfermagem sobre a assistência ao parto em um hospital-escola do oeste do Paraná na ótica da advocacia da parturiente. Pesquisa qualitativa, com profissionais de enfermagem, realizada por meio de entrevista presencial e de ligação de voz, entre dezembro de 2019 e julho de 2020. Os dados foram analisados pela análise temática de conteúdo. Participaram 20 profissionais, 5 enfermeiras e 15 técnicas de enfermagem. Foram identificadas cinco categorias: privacidade e conforto; orientação sobre parto e as escolhas da parturiente; presença do acompanhante; autonomia da enfermagem no processo de parto; e práticas inadequadas. A assistência à parturiente apontou avanços no uso de práticas adequadas. Concernente a isso, o profissional de enfermagem se mostrou como advogado da parturiente, defendendo-a de práticas inadequadas que, embora menos presentes, ainda permeiam o cenário de parto e nascimento.

Palavras-chave: Advocacia em Saúde. Enfermagem. Gestantes. Humanização da Assistência. Parto

INTRODUCTION

Upon the transition from home to hospital, the childbirth and delivery process, once a natural occurrence, led the medical profession to control it through interventionist techniques. Consequently, women lost their autonomy and protagonism in childbirth[1].

The institutionalization of childbirth aimed to reduce maternal and infant mortality through more resourceful assistance, but it favored an increase in obstetric violence and contributed to the rise in elective cesarean sections[2].

Disregarding the rights of pregnant women can have negative physical and emotional effects on these individuals. In this context, the assistance provided by the nursing team during childbirth influences the parturient's lived experience. Having a healthcare professional, such as a nurse, to accompany labor and convey confidence reduces anxiety, fear, and distress during childbirth, making the woman more secure in decision-making[2].

Obstetric nursing has been crucial for humanizing the childbirth and delivery process and is grounded in scientific evidence to employ appropriate practices in assistance, aiming to promote the autonomy of the parturient and enable a positive experience for the woman and her family in the parturition process[3,4].

Acting in the prevention of obstetric violence, nursing informs pregnant women about their rights, provides easily understandable guidance, reduces unnecessary invasive procedures, and engages in qualified listening[5]. Nurses should encourage patients to participate in their care to ensure that their decisions are respected[6].

Among the recommendations of the World Health Organization (WHO) are the respect for the right to privacy and confidentiality, free choice of a companion, pain relief techniques, free intake of liquids and food, among others, which transform childbirth and delivery into a positive experience and reduce the risks of complications[7]. Nevertheless, current obstetric care, in some realities, relies on the technicist-biomedical model, applying interventions that ignore the physiology of childbirth[3].

Hospitalization disrupts patients' support networks, making them vulnerable, necessitating nurses to advocate for them to ensure their rights and provide positive care experiences[6]. Some professionals advocate through guidance provided to patients and families, promoting patient autonomy and supporting their decisions, preserving individual beliefs and values[8].

Health advocacy is considered an ethical issue in nursing, defending patients' rights and can be exercised in various ways according to the culture, characteristics of each individual, and nurses' work environment[8]. Thus, the research's guiding question is: What is the perspective of nursing professionals on childbirth assistance in a teaching hospital in western Paraná from the standpoint of advocacy for the parturient?

Therefore, the study's objective was to understand the perspective of nursing professionals on childbirth assistance in a teaching hospital in western Paraná from the standpoint of advocacy for the parturient.

METHODOLOGY

This is a qualitative approach study conducted in the obstetric center of a teaching hospital in the western region of the state of Paraná, Brazil, between December 2019 and July 2020, following the recommendations of the Consolidated criteria for reporting qualitative research (COREQ).

Inclusion criteria were being a nurse or nursing technician and working in the obstetric center for more than five months. The criterion for involving a minimum period of service referred to the need for the professional to be

familiar with routines and childbirth assistance. Professionals on leave during the data collection period, whether for vacation or medical leave, were excluded.

Participant selection was based on convenience, and invitations to participate were made by phone or in-person contact when possible, given the restrictions imposed by the COVID-19 pandemic. Twenty nursing professionals participated, including 5 nurses and 15 nursing technicians.

A nursing undergraduate conducted interviews, both in-person (five interviews) and via voice calls through the WhatsApp application (15 interviews), with an average duration of 50 minutes each. A semi-structured interview script was used, starting with the triggering instruction "Tell me about nursing assistance to women in labor and delivery", followed by "Describe the assistance you provide to these women". Additional requests were made to deepen the interviews to identify advocacy actions.

The script covered assistance and guidance provided, aspects related to the birth plan, presence of a companion, privacy and comfort, communication between professionals and parturients, such as adequate information communication about the healthcare team's conduct plan, choice of delivery method, and birthplace, food and fluid intake during labor, interventions, pain relief strategies, choice of the location and position for delivery, among other choices.

Participants were advised about the need for the interview to take place in a private location. Data recording occurred through audio recording and was transcribed, respecting the integrity of the spoken content. Transcriptions were sent to participants for verification, and none requested changes. The theoretical saturation phenomenon allowed data collection to conclude.

The pilot interviews (the first three, in-person) were included in the analysis as they met the depth required to address the study's objective. Data were analyzed using the thematic content analysis technique. In the pre-analysis, a floating and interpretive reading of the dataset was conducted, followed by an exhaustive reading to define thematic units. During material exploration, text reduction, classification, and definition of categories were performed. In results processing and interpretation, data confirmation for thematic category agreement and robustness was sought.

The study is part of a multicenter project titled "Rede Mãe Paranaense from the user's perspective: women's care in prenatal, childbirth, postpartum, and child", approved by the Human Research Ethics Committee of the State University of Londrina under opinion no. 2,053,304.

Those who agreed to participate in the interview signed the Informed Consent Form, sent by email. To ensure anonymity, participants were identified by letter(s) followed by cardinal numbers according to the interview participation order. The letter E was used to refer to a nurse, and TE for a nursing technician. For example: E1, TE1.

RESULTS

Initially, the characterization of the participating professionals will be presented (Table 1), followed by the thematic categories identified in the study.

Table 1. Characterization of study participants - Cascavel, Paraná, Brazil

Participant	Sex	Age	Time working in service	Time working in the institution	Education	Role	Obstetrics specialist
N1	F	45	14 years	14 years	N	N	Yes
N2	F	36	6 months	6 months	N	N	In Progress
N3	F	28	10 months	2 years	N	N	No
N4	F	42	18 years	18 years	N	N	Yes
N5	F	44	5 months	6 months	N	N	No
NT1	F	47	7 years	14 years	NT	NT	Not Applicable
NT2	F	39	1 year	1 year	NT	NT	Not Applicable
NT3	F	41	8 years	8 years	NT	NT	Not Applicable
NT4	F	47	23 years	23 years	N/NT	NT	Yes
NT5	F	37	3 years	3 years	NT	NT	Not Applicable
NT6	F	40	19 years	19 years	NT	NT	Not Applicable
NT7	F	43	11 years	11 years	N/NT	NT	Yes
NT8	F	48	13 years	18 years	N/NT	NT	Yes
NT9	F	43	13 years	16 years	NT	NT	Not Applicable
NT10	F	42	19 years	19 years	N/NT	NT	Yes
NT11	F	50	18 years	30 years	NT	NT	Not Applicable
NT12	F	49	2 years	2 years	N/NT	NT	No
NT13	F	34	10 years	11 years	NT	NT	Not Applicable
NT14	F	41	13 years	19 years	NT	NT	Not Applicable
NT15	F	54	18 years	19 years	NT	NT	Not Applicable

Legend: N – nurse; NT – nursing technician.

Source: Research data.

All participants (nurses and nursing technicians) were female. The average age was 42.5 years, ranging from 28 to 54 years. The duration of work in the obstetric center ranged from 5 months to 23 years (average: 10.5 years). However, most had been working in the service for 10 to 19 years (12 professionals). The longest tenure in the institution was 30 years, and the shortest was 6 months (average: 12.4 years).

Among the five participating nurses, two had a specialization in obstetrics, and one was pursuing it. Among the 15 nursing technicians, five had a degree in nursing, one was pursuing it, and four had already completed a specialization in obstetrics.

The study identified five thematic categories: privacy and comfort; guidance on childbirth and the parturient's choices; presence of the companion; autonomy of nursing in the birthing process; and inadequate practices.

PRIVACY AND COMFORT

The precarious physical structure compromised the privacy and comfort of parturients and their companions. There is insufficient space and bathrooms (particularly with a shower), multiple people in the delivery room (companions, professionals, and students), and overcrowding. In these conditions, the

nursing professional has limitations to alter, control, or advocate on behalf of the parturients. The nurse seeks to minimize the woman's exposure with strategies such as using screens.

> Our space is tiny […] we have 15 patients, one bathroom for them to shower, one bathroom in the room […], the stalls have curtains […], we put up a screen […] we try to expose as little as possible […]. (N2)
> When you're performing a procedure on a patient, you're next to the companion of another […], many gave birth in the corridor, with the companion of others right there […]. (NT3)
> […] it ends up exposing the patient […], the companion wanting to watch the birth of someone they're not accompanying […] we deal with overcrowding […]. (N3)
> […] a lot of staff […] resident […] doctor […] student […] the technician […] the nurse […] the pediatrics resident […] the pediatrician […] the delivery room is supposed to be silent, and […] that doesn't happen […]. (NT11)

GUIDANCE ON CHILDBIRTH AND THE PARTURIENT'S CHOICES

The level of guidance provided to women regarding childbirth was identified as inadequate, linked to prenatal care quality, compromising rights and choices. An increase in elective cesarean sections was noted, supported by the state law of Paraná (No. 20,127, dated January 15, 2022), starting from the 39th week of gestation, upon maternal desire.

> …very few patients sought any information about labor […] who know their rights […]. (N4)
> They are not prepared [for childbirth], prenatal care does not prepare them […]. (NT10)
> They are unaware of obstetric violence […] whatever is done is correct […] there is a significant flaw in prenatal care. They do not know how much they will dilate and what type of delivery they will have. (N2)
> With the law allowing them to choose a cesarean section, there has been a significant increase […] we stop and advise, but the vast majority want a cesarean section. (NT7)

The dorsal recumbent position (on the bed, the woman flat on her back) was most frequently chosen for giving birth. Positions like hands-and-knees lateral (side-lying), and squatting were accepted when encouraged by the birthing team. Knowledge and the choice of a birthing position represent an unknown right. However, by informing about this, even during labor, nursing professionals are advocating for the possibility of choosing positions that favor childbirth—an essential right for women.

> Their choice is mostly the dorsal position, due to lack of information. As soon as we explain, during labor, they accept hands-and-knees, side-lying, squatting. (NT7)

Nevertheless, some women indicated having information about appropriate and inappropriate childbirth practices when exposed to lectures, consulted content online, or accessed other communication channels. They vocalized what they did not want.

> Patients nowadays are more informed; they seek information about their rights; they question […] they research. (NT8)
> Episiotomy, they don't want […] cervical checks

> are rarer… induction, they resist a lot. […] it has improved a lot […] they are more informed. (NT3)

Through a birth plan, a woman can inhibit obstetric violence, but its presentation in the studied service, as well as the pregnant woman's prior visit to the birthing environment, was infrequent.

> When she has a birth plan, it means she sought guidance […] knows about the violence that can occur […], that through this birth plan, she can be protected […]. (N4)
> A very small number come to inquire about the environment, and few come with a birth plan, which would be ideal. This is education, starting in basic health […]. (NT1)

Healthcare team professionals in the obstetric center showed different attitudes when receiving the birth plan. Above all, nursing professionals see the presentation of the birth plan by the woman as positive because, besides meaning they are informed about the childbirth and delivery process, it promotes nursing advocacy actions, as stated in her plan.

> The nursing team likes [the birth plan] […] we think it's good because they come in more informed. (NT3)
> Some [doctors] mock, as if the pregnant woman were fantasizing, as if she did not have the right to decide about childbirth. (N3)
> Doctors do not respect; they make jokes. I've seen a doctor crumple [the birth plan] and throw it away. (NT10)

PRESENCE OF A COMPANION

The presence of a companion chosen by the woman was perceived as a factor of emotional support, tranquility, security, and encouragement for childbirth. The companion can assist in pain relief strategies, perform massages, walk, shower, enhancing actions that benefit and advocate for women's care during the labor period. However, the companion can inhibit labor progress if she/he has no connection or affinity with the woman. This choice does not always happen spontaneously or as planned by the woman.

> She feels welcomed, protected […] labor becomes more pleasant, exciting […] strengthens the bond. (NT6)
> They participate, help a lot. […] most [women] become much calmer […] more secure. (N1)
> The companion is there providing support […] in food, hydration, positions […]. It's not always her choice […] it's not whom she wanted, whom she trusts, and this hinders labor progress […]. (N4)

AUTONOMY OF NURSING IN THE BIRTHING PROCESS

Nursing professionals described actions that grant them autonomy and allow them to advocate for the care of the parturient, based on supportive attitudes and emotional comfort for both the parturient and the companion for a proper childbirth. Among the actions are guidance on labor, the importance of diet, positions, and strategies for pain relief, as well as positions for childbirth, presented in language tailored to the understanding of the parturient.

> Nursing provides assistance […] explains what will happen during labor and what can help have a smoother delivery. (NT15)
> … gaining trust […] emotionally supporting her […] helping the companion to support and assist in this moment. (N1)
> … therapeutic bath, music therapy, walking, they can have the baby standing, sit-

> ting, lying down, kneeling, squatting, hands-and-knees, whatever they find best […]. (NT12)
> … back massage […] walking, squatting, and doing movements with the ball […] eating. (NT6)

Building a connection, creating a suitable environment for childbirth with comfort measures (dimming the lights, music therapy), and encouraging the companion's participation in childbirth and delivery are shown as sensitive and empathetic care, strengthening and ensuring nursing assistance based on appropriate practices.

> … tries to make them as comfortable as possible, … make the environment cozier, leave only half-light […]. (NT2)
> … put on music … ask where she wants to give birth […]. (NT15)
> … until the umbilical cord stops pulsating, we put it on the mother's chest, skin-to-skin contact […] encourage the father to cut the umbilical cord […] most accept and get emotional […]. (NT11)

INADEQUATE PRACTICES

Nursing professionals pointed out a decrease in inadequate practices or interventions compared with previous periods, but they are still present. The admission of a woman to the service without evidence of labor often implied labor induction, causing anxiety and longer hospitalization. They mentioned the use of oxytocin and amniotomy, especially in the second stage of labor.

> Institutional protocol […] 40 weeks or more, not in labor, we induce with misoprostol. (N1)
> In the past, doctors used oxytocin in all cases […]. Currently, they use it when the patient is in the active phase of labor, and contractions are not at an adequate interval. (NT6)
> Ruptures [amniotic sac] almost at the time of delivery […] with 9 cm dilation or complete […]. (NT5)
> … it [amniotomy] is still frequent […] if the baby is not well positioned […] it greatly hinders the baby's positioning […]. (N3)

Various people often performed vaginal examinations. Professionals who still practiced episiotomy and the Kristeller maneuver wanted the parturient in the delivery room, in the lithotomy position.

> … they go there to do […] too many examinations. However, many patients want to know how much dilation […]. If the patient had more information, this would decrease. (NT1)
> It's because of the insistence of one attending or another [episiotomy] […], most let the delivery happen, and if the perineum tears, they suture it. (NT9)
> … we used much more [Kristeller maneuver], … today we refuse it, "no, I don't do it. If you want to do it, you do it" […]. (N4)
> There, we have a doctor that every delivery we have to take to the delivery room; he does not want it to be born in bed […]. (N5)

The role of the nursing team as an advocate for the parturient to prevent the use of inadequate childbirth practices or minimize discomfort when performed, especially regarding vaginal examination, unnecessary use of oxytocin, and transfer to the delivery table, was evident. It is worth noting that doctors in the studied service performed the mentioned practices.

> … we say: no need to touch again, just touched, to the Medicine students […] and they say "oh, but I want to see," and we don't let them; they impose

> themselves, and the parturients become defenseless there […]. So, we try to defend them […]. There's an attending who won't let [delivery] happen on the bed […]. But we try to bypass […] call only during the expulsive period […]. (NT7)
> … I explain to them that the touch, she can only accept one person to touch, and I explain that the touch will not change anything […], for labor, it changes nothing […] that the touch is an exam to see the position of the head […]. (N1)
> I try to assess if the patient really needs oxytocin […] question the residents […] ask: "Wait a little." (N4)

Guiding women and dialogue with the medical team (related to scientific evidence) were also strategies used by nursing to advocate for the parturient. However, some doctors did not change their practice.

> When about to administer oxytocin, in some cases, we say that she can refuse if she does not want it […]. (N2)
> … I guide that there is no need to examine every hour […] try to protect them in some way. […] Few complain about the touch […], they should speak more […]. (N4)
> … there's an attending who, if we turn off the light, he comes and turns it on. If we play music, he turns it off […] the coordinator brought several studies to him, already talked to him, we try to question […]. (NT11)

DISCUSSION

Inadequate physical structure and high demand for care can hinder obstetric assistance, compromising the privacy and comfort of parturients and companions in shared rooms[10,11]. Women and companions have the right to access a private physical space during childbirth and delivery, with basic facilities including a bathroom, an area to change clothes, dividers/curtains, and a screen to ensure privacy, as well as a comfortable chair for the companion[7]. In prepartum and postpartum rooms, a bathroom with a shower is necessary[12].

Respectful care is recommended, with support measures, information, and the right to dignity and privacy during childbirth[7]. In the studied institution, obstetric procedures also serve educational purposes, hence the presence of students, in addition to professionals and companions, including those of other parturients[13], which may compromise privacy.

On one hand, when informed, parturients demonstrate knowledge about labor and delivery; they recognize and request qualified obstetric assistance[14]. On the other hand, misinformation and the professionals' lack of attention to maternal questions during prenatal care make parturients susceptible to inappropriate decisions during labor and delivery[15].

Studies confirm insufficient information about labor and delivery during prenatal care. One of them revealed that 63.5% of women did not receive guidance on natural childbirth or cesarean delivery[15]. In another study, 21% chose cesarean section to avoid pain[16]. Both studies showed women prefer vaginal delivery, 71% and 77.6%, respectively, contrary to the statements of the professionals in the study at hand.

Although vaginal delivery is indicated as a preference, the lack of knowledge among parturients, interventionist practices during delivery, medical disinterest in natural childbirth, and the commodification of childbirth contribute to the increase in cesarean sections in Brazil[17].

In this regard, it is worth noting that when nurses provide information to women about childbirth and delivery, considering appropriate practices, it is possible to ensure that

they decide based on knowledge, consequently preventing obstetric violence and reducing unnecessary cesarean sections[6]. When nurses provide information, they are also advocating for appropriate and respectful childbirth based on the informed decisions of the woman[8].

Health education for women and families during prenatal care aims to raise awareness about the type of delivery, with natural childbirth recommended. Regarding cesarean section, it is an intervention whose indication must be justified for medical reasons[11]. However, Law No. 20,127/2020, from the state of Paraná, Brazil, which guarantees women the right to choose cesarean section from the 39th week of gestation[18] and induction at 40 weeks, represents a setback to the health of the mother-child pair and does not respect the WHO recommendation to wait for delivery until 41 weeks[7].

Women in labor require dignified and respectful care and should be involved in all decision-making processes of assistance[19], including the right to freely choose the place and position for childbirth[7]. WHO and the Ministry of Health (MS) encourage movement and the adoption of comfortable positions during this process[6,19], individualized care, and respect for the preferences of the parturient[7]. It is noted that nursing care in this study aligns with these guidelines.

Previous information about childbirth to women, together with the development of a birth plan, constitutes resources for respecting their rights[20]. Through the birth plan, professionals know the woman's choices, enabling personalized care. In this way, women gain autonomy, protagonism[21,22], and empowerment during labor and delivery, with a reduction in fear and insecurity, as their preferences are contained in this instrument[23]. However, women who present it—to ensure their right to choose, defend themselves against obstetric violence, and guarantee their autonomy—still face hostility from some healthcare professionals[22].

The presence of the companion and the guidance provided by nursing professionals allow parturients to feel more confident and at ease[24]. Techniques for pain relief, after being presented by professionals, can be carried out by the parturient and her companion[7]. This condition has an impact on the satisfaction of both the companion and the woman[25]. Additionally, the companion can be an ally of nursing in advocating for the care of women in the birthing process.

Professionals working in maternity care must possess relevant knowledge about the physiology of labor and delivery to avoid interventionist techniques and procedures commonly learned and practiced during their training[26]. In a hospital setting, women are vulnerable to interventions such as vaginal examinations within an interval shorter than four hours and conducted by different professionals, amniotomy, Kristeller maneuver during the expulsion phase, routine use of episiotomy, administration of misoprostol and/or synthetic oxytocin to expedite labor and unnecessary cesarean section. These interventions contradict recommendations from the WHO and the MS[7,19,27].

Women in labor require dignified and respectful care and need to be involved in decision-making processes[19] regarding interventions, including the decision about the birthing location. Asking a woman in labor, with normal progression, to move to a delivery room is unpleasant for her and unnecessary for the professional[7]. This practice disregards the woman's autonomy and imposes the professional's control over the birthing body[11].

With obstetric nursing, there was a greater use of beneficial care practices and, consequently, a reduction in harmful practices inappropriately employed in labor and delivery care[4]. However, medical superiority and hierarchy still enable the use of practices that disregard the right of women to receive dignified and respectful care[11].

Nursing professionals, driven by scientific knowledge, advocate for the parturient, ensuring

quality, respect, and safety in the labor process. In this sense, the nursing professional acts as an advocate for the parturient to inhibit unnecessary or harmful interventions in obstetric care—a role identified as "Y-nurse" competence[28].

When the parturient disagrees with medical conduct, the nurse can mediate the conflict between her desires and medical opinions, advocating on her behalf[28,29]. For this to happen, the parturient needs adequate information about the birthing process to accept (or disagree with) a particular practice, and the nurse must engage in dialogue with the doctor about the benefits and/or risks involved in the established conduct, as well as in her refusal[29]. Information is an essential resource in labor care, and the pregnant woman needs to receive prior guidance regarding dilation, contractions, pain relief, and the care practices adopted during labor and delivery[30].

The relevance of obstetric nursing's participation in the birthing process, especially in preserving the physiology of labor[4], advocating for women's rights, and providing appropriate care[6,8], is evident. However, some healthcare professionals resist new policies and recommendations for childbirth care, where the biomedical model prevails[31].

Women in the parturition process have the right to be treated with respect, and professionals should seek to build a trusting relationship with them[19]. In this regard, the nursing team stands out through actions in labor care, particularly in using non-pharmacological and non-invasive methods for pain relief, such as therapeutic bathing, lumbosacral massage, and free ambulation[32]. These methods help with analgesia and reduce anxiety levels[24].

Moreover, nursing excels in adhering to recommendations for appropriate childbirth practices, providing clear and relevant information about labor, non-pharmacological pain relief, the right to choose a companion[7], oral fluid and food intake during labor for low-risk women[7,19], among other aspects. Quality care for the parturient implies an opportunity for a positive experience from prenatal care, where the nurse can perform actions within their practice throughout the pregnancy and postpartum period[33]. The goal is to promote comprehensive and continuous care, encompassing physical and emotional health (skills identified in the nursing professionals in this study), as well as incorporating advocacy actions in nursing care[6,8,28].

According to the Y-nurse[28], nursing, in the daily care routine, has the conditions to solve or act differently, that is, from the nursing perspective and not from the perspective of physicians. Presumably, sensitivity, empathy, care, and other attributes commonly identified in nursing practice are the differentiators that can enhance the role of this professional in advocating for the parturient.

The research was limited to studying the reality of obstetric care at a maternity center belonging to a teaching hospital in the western region of Paraná, which serves as a reference for high-risk deliveries in the 10th Regional Health Department (RS) of the state, composed of 25 municipalities.

As a contribution, the study identifies the role of the nursing professional as an advocate for the parturient, defending childbirth anchored in appropriate practices. This reinforces the autonomy and importance of the profession to drive changes in multiple birthing scenarios.

CONCLUSION

The childbirth assistance, from the perspective of nursing professionals, indicates advances in using appropriate practices. Changes in the physical structure of the studied service are necessary to ensure privacy and comfort for the parturient and her companion. For assistance centered on women's choices, the need for guidance on the birthing process, their rights, and

the importance of a birth plan during prenatal care is highlighted.

In this study, the nursing professional emerged as an advocate for the parturient, defending her from inappropriate practices that, although less prevalent, still permeate the childbirth and delivery scenario. The nursing professional also encouraged actions that empower the parturient in the birthing process.

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