ORIGINAL ARTICLE

Collaborative practices in normal delivery centers: a qualitative study with nurses

Práticas colaborativas em centros de parto normal: estudo qualitativo com enfermeiros

Prácticas colaborativas en centros de parto normal: um estúdio cualitativo com enfermeras

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How to cite this article: Belarmino AC, Rodrigues MENG, Vieira LJES, Silva MRF, Anjos SJSB, Ferreira Júnior AR. Collaborative practices in natural childbirth centers: a qualitative study with nurses. Rev. Eletr. Enferm. 2024;26:77017. https://doi.org/10.5216/ree.v26.77017 English, Portuguese.

Extract from the Master's Thesis: "Management and care challenges faced by obstetric nurses in natural childbirth center" (In Portuguese, "Desafios da gestão e cuidado desenvolvido pelo enfermeiro obstetra em centros de parto normal"), defended in 2020, in the Public Health Graduate Program at the Universidade Estadual do Ceará, Fortaleza, Brazil.

Received: 18 August 2023
Accepted: 20 October 2024
Published online: 30 December 2024

ABSTRACT

Objective: to investigate the experiences of nurses in relation to collaborative practices in natural childbirth centers in the light of the Sociology of Professions. **Methods:** qualitative study conducted with nurses who worked in natural childbirth centers in Ceará, Brazil. Telephone interviews were conducted from April to July 2020, and Nvivo® Pro 12 software was used to organize the information by thematic categorization. The results were discussed based on the Sociology of Professions. **Results:** thirteen nurses participated in the study, whose experiences gave rise to two thematic categories. Autonomy, decision-making power, self-worth, and professional recognition permeate collaborative practices, and power struggles and the medical team's lack of confidence in the nurses' competence represent challenges for implementing collaborative practices. **Conclusion:** despite small advances in autonomy, cooperation, and communication in natural childbirth care, there are still elements that hinder this form of action, that lie in socially constructed phenomena, which can compromise the results for women and their families.

Descriptors: Interdisciplinary Placement; Interprofessional Relations; Birthing Centers; Nursing Care; Obstetric Nursing.

RESUMO

Objetivo: *investigar as experiências de enfermeiros em relação às práticas colaborativas em centros de parto normal, à luz da Sociologia das Profissões.* ***Métodos:*** *estudo qualitativo realizado com enfermeiros que atuavam em centros de parto normal do Ceará, Brasil. Foram implementadas entrevistas por meio telefônico no período de abril a julho de 2020 e utilizado o Software Nvivo® Pro 12 para organizar as informações por categorização temática. Os resultados foram discutidos com base na Sociologia das Profissões.* ***Resultados:*** *participaram 13 enfermeiras do estudo, cujas experiências relatadas deram origem a duas categorias temáticas. A autonomia, o poder de decisão, a autovalorização e a valorização profissional permeiam as práticas colaborativas e a disputa de poder, a falta de confiança da equipe médica na competência dos enfermeiros representam desafios para a implementação de práticas colaborativas.* ***Conclusão:*** *apesar de pequenos avanços em autonomia, cooperação e comunicação na assistência ao parto normal, ainda persistem elementos dificultadores dessa forma de atuação, que residem em fenômenos socialmente construídos, o que pode comprometer os resultados para as mulheres e suas famílias.*

Descritores: *Práticas Interdisciplinares; Relações Interprofissionais; Centros de Assistência à Gravidez e ao Parto; Cuidados de Enfermagem; Enfermagem Obstétrica.*

RESUMEN

***Objetivo**: investigar las experiencias de enfermeras en relación con las prácticas colaborativas en centros de parto normal, a la luz de la Sociología de las Profesiones. **Métodos**: se realizó un estudio cualitativo con enfermeras que trabajaban en centros de parto normal en Ceará, Brasil. Se realizaron entrevistas telefónicas entre abril y julio de 2020 y se utilizó el software Nvivo® Pro 12 para organizar la información por categorización temática. Los resultados fueron discutidos con base en la Sociología de las Profesiones. **Resultados**: participaron 13 enfermeras, cuyas experiencias dieron lugar a dos categorías temáticas. La autonomía, el poder de decisión, la autoestima y la valoración profesional impregnan las prácticas colaborativas, y la lucha de poder y la falta de confianza del equipo médico en la competencia de las enfermeras representan retos para la aplicación de las prácticas colaborativas. **Conclusión**: apesar de los pequeños avances en autonomía, cooperación y comunicación en la atención al parto normal, aún existen elementos que dificultan esta forma de actuación, que residen en fenómenos socialmente construídos, lo que pueden comprometer los resultados para las mujeres y sus famílias.*

***Descriptores:** Prácticas Interdisciplinarias; Relaciones Interprofesionales; Centros de Asistencia al Embarazo y al Parto; Atención de Enfermería; Enfermería Obstétrica.*

INTRODUCTION

Maternal death related to childbirth is a serious global public health problem. Every year, around 300,000 women die from preventable causes of pregnancy and childbirth, which 99% of them in developing countries, mainly in North Africa, Sub-Saharan Africa, South Asia, and Latin America[1-3]. These deaths are mainly related to the number of unnecessary interventions, such as unindicated cesarean sections, which do not have favorable outcomes for mother and child[3].

In order to reduce these rates, countries such as Australia, England, Democratic Republic of Congo, and Brazil have recommended childbirth with minimal interventions, through care practices based on scientific evidence, carried out in other spaces, such as natural childbirth centers (NCCs). Trained nursing professionals and other members of the health team work collaboratively and contribute to daily care and to dealing with complications in the parturition process[2,4-6].

In Brazil, the Stork Network (*Rede Cegonha*, in Portuguese) strategy has encouraged the establishment of NCCs since 2011, with the work of a multi-professional health team, emphasizing obstetric nurses as the managers responsible for labor and childbirth[6].

From this perspective, NCCs are spaces structured with ambience, specific protocols and standards, trained health staff, and equipment aimed at assisting low-risk childbirth, physiological puerperium, and care for healthy newborns, from admission to discharge, as established by Ordinance No. 11 of 2015. It provides for a team of obstetric nurses, a nurse coordinator, one or two nursing technicians, and a maintenance worker to act in these spaces. In addition, other professionals, such as physicians, can act in emergencies[7].

This ordinance also describes three types of NCCs: type I and type II in-hospital facilities, which operate within the hospital area, and peri-hospital facilities, which are located close to hospitals. However, the main highlight in maternal and child health of this instrument is the use of practices based on scientific evidence that ensure minimal interventions, and the guarantee of essential rights to the health of women and families through collaborative professional actions[7].

According to the World Health Organization (WHO), interprofessional collaborative practices involve an active process of relational contact between individuals, with shared goals, partnership, interdependence, power, and flexibility for team collaboration[8]. In the obstetric field, it is defined as the cooperative effort between physicians, obstetric nurses, and obstetricians to share duties in a rewarding way and aimed at caring for women and families[9].

International efforts encourage the development of interprofessional collaborative practices as a tool for achieving excellence in health care, care processes, and quality of care[9]. Attitudes that contribute to changes in professional health processes, care models, and care itself are needed, aimed at achieving the Sustainable Development Goals on reducing maternal and child morbidity and mortality, as well as well-being and global health[3].

Although several studies have been conducted on NCC[4-6], little is known about care practices based on collaboration in different scenarios in Brazil, a country with continental dimensions, where the exercise of professions as a social practice can present particularities.

Considering that NCCs were conceived as a public health policy and as a way of promoting a collaborative model aimed at reducing interventions[6,10,11] and that different collaborative models can be outlined in NCCs in Brazil, it may be useful to carry out investigations in the light of Elliot Freidson's Sociology of Professions[12], in order to study the nuances that may still prevent collaborative practices between physicians and nurses within NCCs, from the perspective of the autonomy, ex-

pertise, credentialism, prestige, and social responsibility of these categories.

This research aims to investigate the experiences of nurses in relation to collaborative practices in natural childbirth centers, in the light of the Sociology of Professions.

METHODS

The study used a qualitative design[13] through critical content analysis of the participants' experiences, based on the Sociology of Professions[12]. This report was written following the recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ)[14].

The settings for this study were seven type II in-hospital NCCs and one peri-hospital NCC, licensed by the Brazilian Ministry of Health, located in the state of Ceará, Brazil. The NCCs selected are spaces for maternal and child care for women with normal risk pregnancies, for a population of 8,452,381 people in the state's five health regions[15]. Collaborative teams managed by obstetric nurses provide care to women during labor, delivery, childbirth, and the postpartum period with minimal interventions through humanized actions based on scientific evidence.

The selection criteria for key informants were: working for at least six months in one of the selected NCCs and having a graduate degree in obstetric and/or neonatal nursing. The exclusion criteria were: no answer to the phone call after five attempts with a two-day interval between each one; no response via the messaging app; termination of the contract with the studied NCCs during the course of data collection.

Due to the restrictions imposed by the coronavirus pandemic (Covid-19), telephone contact was used as a means of recruitment and verification of eligibility criteria, by one of the researchers, an obstetric nurse, from April to July 2020, and agreement on the date of the telephone interview, at the participant's home. This location was chosen because it offered greater privacy and ease of expression for professionals.

One of the authors requested a list of obstetric nurses at the unit and obtained consent through a document sent to the Brazilian Association of Obstetricians and Obstetric Nurses of Ceará, Brazil.

The first participant was invited by telephone, who indicated the second, and so the others, by snowball sampling[13]. This sampling technique allowed 27 nurses working in these settings to be reached. Of these, 13 agreed to participate, and 14 refused. The reasons given were lack of time and institutional reasons.

The study obtained the agreement of all the participants before the interview, and an informed consent was sent in advance by e-mail and messaging app. A participant confidentiality code was applied, using the letters EO (shot for Obstetric Nurse in Portuguese) and the respective number of each interview conducted.

A script with eight open-ended questions guided the interview. Four involved socio-occupational data, and four addressed care in the parturition process, namely: "Could you talk about your role as a team member at the natural childbirth center?", "What childbirth management practices do you carry out at the NCC?", "What care actions are carried out at the NCC?" and "What team management practices do you carry out at the NCC?".

Other questions were used to further explore the issue, such as: "Could you tell us more about that?" The interviews lasted an average of 31 minutes and were all audio-recorded and transcribed manually by three authors.

Theoretical saturation[16] was applied to define the sample and reached in the 13th interview.

Nvivo® software (version Pro 12, 2019, Lumivero, The United States) was used to organize the codes and thematic categories of analysis[17]. Sixteen codes were identified, which gave rise to four groups and two thematic categories.

The process of thematic content analysis was carried out in six stages, according to the model adopted[18]. The first stage consisted of becoming familiar with the testimonies by reading them, reflecting on the interviewees' statements and identifying potential codes and themes. The second stage involved generating the initial codes, documenting the meetings with triangulation by the researchers and building the coding structure. The next step was to search for themes and make notes detailing the development and hierarchy of concept and themes. These themes and sub-themes were analyzed by the researchers and framework adjustments were made in the fourth step. The fifth step involved triangulation by the researchers, with the team reaching a consensus on the themes, ending with documentation of the thematic nomenclature. In the last stage, the researchers performed the verification by means of a complete and detailed description of the coding and its analysis. This process also involved describing the context and generating a full report on the theoretical grounding, and methodological and analytical choices[18].

To analyze the results, the theoretical framework of Elliot Freidson's Sociology of Professions[12] was used. The author's concept of autonomy involves the relationships between professionals, with society and profes-

sionals in other areas who determine the control of work and its self-regulation through society, which involves credentialism and expertise. The concept of credentialism involves the constitution of credentials or titles, carried out by certifications obtained through educational associations and organizations, the constitution of professional legislation and professional class councils. The concept of expertise encompasses the knowledge proper to a specific profession, with its own education and appropriate training. These principles are based on professional status, society, and the State[12].

In compliance with the ethical guidelines for conducting research involving human subjects[19], the project was approved by the Research Ethics Committee of the State University of Ceará, under Certificate of Submission for Ethical Appraisal (Portuguese acronym CAAE) No. 67591117.5.0000.5534.

RESULTS

The participants ranged in age from 28 to 54 years, with a mean of 35 years. All of them had a graduate degree in obstetric and neonatal nursing and had been working for between 2 and 14 years, with a mean of 4.69 years. The participants' characteristics are shown in Table 1.

Table 1 - Socio-occupational characteristics of obstetric and neonatal nurses, Natural Childbirth Centers, Ceará, Brazil, 2020

Code	Sex	Age	Length of work
EO01	Male	40	02 years 4 months
EO02	Male	38	04 years
EO03	Male	29	02 years
EO04	Female	30	02 years 02 months
EO05	Female	32	05 years
EO06	Female	38	09 years
EO07	Male	42	14 years
EO08	Female	39	05 years
EO09	Female	29	02 years 8 months
EO10	Female	28	03 years 3 months
EO11	Male	32	07 years
EO12	Female	32	06 years
EO13	Female	54	06 years

Two categories emerged from the thematic analysis: *Collaborative practices in the routine of natural childbirth centers* and *Challenges for collaboration between professionals in natural childbirth centers*. The first category described competencies that are linked to collaborative practices in the practice of NCCs, whereas the second category sought to highlight some of the challenges that still make it impossible to implement collaborative practices in these spaces.

Collaborative practices in the routine of natural childbirth centers

Autonomy, decision-making power, self-worth and professional recognition, integration, and humanization of care are elements present in collaborative practices in natural childbirth centers.

Initially, this thematic category highlights the self--worth of obstetric and neonatal nurses as professionals who manage NCC care, with characteristics of professional autonomy, expertise, and practical capacity, aligned with elements of good childbirth care practices. It also highlight the humanization of actions, as advocated in the maternal and child care strategy named "Stork Network" (In Portuguese "*Rede Cegonha*") translated into the satisfaction of being able to carry out the "dream birth" for the parturient woman receiving care:

> *So, nurses have a good performance, a good level of performance in this part of childbirth, as we have a specialized course for this. I notice that nurses are highly valued, their services are very useful in natural childbirth centers, given that we carry out most deliveries, nurses. (EO1) [autonomy, professional recognition]*

> *I think that we have the most important role within the team. In the NCC where I work, the team is made up of physicians, nursing technicians, and nurses, but I think that our work is the most important because our work is to make sure that this woman has a physiological birth, has the birth she dreamed of and, that if it's not the birth she wanted, that I try, as the trained and qualified professional that I am, to make this birth happen in the best way and in the closest way to what she wanted. (EO2) [autonomy, decision-making power]*

> *As part of a team, yes. I believe that nursing plays a leading role of humanization, especially with regard to non-pharmacological methods of both pain relief and inducing childbirth. I believe that nursing is more linked to these two points, both the humanization of childbirth and the use of non-pharmacological methods. (EO4) [integration, humanization]*

The sub-themes of interaction and collaborative practices between the health team emerged from the reports, describing the development of actions between

the medical and nursing professions collaboratively, with situations that strengthen the autonomy of obstetric and neonatal nurses, building trust, respect, power of action, and strengthened working relationships between obstetric and neonatal nurses, nursing staff, and physicians:

> *My interaction with the medical team is wonderful, because obstetric nurses, I don't know why, but we have a great deal of power and respect from the whole team, especially the medical team, because we are the ones who literally take over the sector, who only call the physician if there are any complications, if we identify any risk to the patient; and the pediatrician, who we work together with, practically directly, because of the newborn. But the medical interaction is wonderful, totally different from care in the general emergency department, in the inpatient ward sectors, which I've been through, not to mention with the nursing staff, it's wonderful, wonderful! (EO10) [integration, respect, trust]*

Other reports listed the sub-themes of decision-making power, autonomy, and communication as examples of competencies for building partnerships between professionals in the studied NCCs. Health communication between professionals enables uniprofessional, non-collaborative models to be transposed towards more complex, collaborative models:

> *As a member of this team, the obstetric nurse has achieved a good relationship. There was none of the common disputes in units between doctors, who does what, where, no! We achieved relationships of partnership, respect, and autonomy. So, there was no power struggle, no disagreement; there was a partnership. So, that's it, we didn't have any problems in this respect, in accepting the obstetric nurse's conduct, mainly because, before putting it in place, I showed the technical management what we were going to do, and from then on, we worked in partnership [...] (EO7) [interpersonal relationship, respect, decision-making power, communication]*

> *We find it easy because the professionals are very present. If you want to ask a question, if you want an assessment from a medical professional, they're right there. Of course, there are also times when there are difficulties; it's like any other service, sometimes there are many surgeries and it's difficult to get an obstetrician there when you need one, but these are particularities that every service has. And, in general, we have good communication between the team of doctors and nurses. (EO2) [communication, trust]*

Other thematic points described the interpersonal relationship between health team professionals through the building of trust between medical and nursing staff, as well as the power of action developed by NCCs related to childbirth care activities:

> *I don't have any relationship difficulties with the team. We manage to help each other, to develop mutually. We manage to get involved and offer quality work, and I think that's what I value. Quality care for our puerperal women, parturients, whatever we have in the NCCs. I think the team interaction is really good, I don't have any difficulties with interpersonal relationships, on the contrary. (EO9) [interpersonal relationship, trust]*

> *We coordinate the nursing team, both in the maternity ward and in the childbirth center, always advising them on the hospital's rules and routines and together with the medical team. There, thank God, when we say: "It won't come out!" they're very respectful, they have a lot of confidence in our work. (EO6) [leadership, coordination, trust, respect]*

Challenges for collaboration between professionals in natural childbirth centers

In this thematic category, one of the participants described the difficulty of integration between physicians and obstetric and neonatal nurses that is still encountered in the development of care actions, which reflects the fragility of cooperation in obstetric care in the studied NCCs. Cooperation is one of the necessary skills for collaborative practices to take place:

> *We work, it depends a lot on the team, right? There are some, if we can really work as a team. And the team itself feels gratified when I'm there, because I really provide a solution, both in terms of care and management, because you know we end up managing as a whole, and it is really gratifying. (EO13) [diversity in the team]*

Similarly, another sub-theme highlighted the barriers faced by health teams working to achieve autonomy in the development of good labor and birth care practices. The dispute over power in childbirth care promotes weaknesses in collaborative practices. Significant progress has been made in building trust; however, some limitations depend on each professional, especially between physicians and obstetric and neonatal nurses, due to the power struggle between these professional categories:

It depends a lot on the person on duty, the team of the day, it varies a lot, but we've managed to make a lot of progress. Today we have a certain amount of autonomy, they respect us more. We already have this issue of "it's a regular risk, I'm monitoring it". So, when there's something like this, we just report it, but they follow up, suspecting our steps, but that's very much up to the on-call team, but the vast majority have already managed to have this autonomy, most of the time. (EO8) [power struggle, distrust]

We have the issue of two NCC beds, which are separate for the NCC, but because it's a high-risk maternity hospital and there are also residency programs in both medicine and nursing, it ends up not being very well delimited, because it's a single space. It's not a separate NCC, it's one that's within a single space. So, we monitor labor, the progress with notes on the partogram, assisting in labor itself, and immediate puerperium. (EO8) [nurses' professional performance]

DISCUSSION

From the obstetric and neonatal nurses' testimonies, it was possible to see that, although some practices allied to cooperation, such as interaction, autonomy, trust, and leadership, collaborative practices do not effectively occur in the labor and birth care experiences at the studied NCCs.

Collaborative practices are allied to interprofessional education, high governance health models, and quality health services for individuals, families, and communities[8].

Labor and childbirth care between obstetricians, neonatal nurses, and physicians working in the NCC are still fragile, and require greater advances in collaboration between these professionals. These results align with a study on intrapartum care collaborations between obstetricians and physicians, which showed parallel performances that converged on poor results[20].

This study emphasizes that autonomy and trust are required for progress in the development of collaborative practices; however, the reports also showed that there is no consolidation in this respect.

To achieve the implementation of collaborative practices, it is necessary to develop governance models, communication strategies, support policies, and conflict resolution for excellent care and improved health outcomes.

Regarding the autonomy of professional action, Freidson[12] states that there is generally superficial autonomy in the professions, in which the professional group carries out its own self-regulation, which society ensures.

Corporate professions such as medicine stand out for their technical autonomy, body of knowledge, prestige, and influence, while nursing is a semi-profession[12]. These elements may also contribute to the difficulties that still exist between these professions in developing collaborative practices.

In Brazil, the Law on the Professional Practice of Nursing No. 7,498, enacted in 1986, legitimized obstetric nurses as professionals responsible for labor, delivery, and birth care[6]. In turn, the training of obstetric nurses in Brazil, as in other countries, took place through graduate courses aimed at the care of regular risk pregnancies, based on good practices in labor and birth care, and in line with WHO recommendations[6,21].

These training credentials conferred by graduate courses are essential for developing labor and childbirth care practices, and give them the status necessary to stand out in society[12].

However, it is important to note that this legitimization of a professional class for obstetric nursing has achieved visibility as a state policy through the implementation of the Stork Network strategy and the election of obstetric nurses as responsible for managing NCCs in 2015. This legitimization and prominence are happening not only in Brazil, but also internationally since organizations such as the United Nations and WHO have encouraged the inclusion of obstetric nurses in the management of high-risk births[21,22].

According to the reports, the knowledge of care provided by obstetric and neonatal nurses for childbirth and newborns represents authority in an area that is in full development in Brazil and other countries, which contributes to improving care for women, maternal and child health indicators, the construction of the professional category of nursing, and the training of health teams in a collaborative manner[6,23-25]. Collaboration between professionals in childbirth care legitimizes that the prominence obtained by obstetric and neonatal nurses in the childbirth scenario can only be achieved by building integration and trust in their work with other professional categories, as Friedson says[12].

In this field, the professional competencies of obstetric and neonatal nurses are important elements to promote their power of action within the health team and, consequently, qualify their practices in the performance of activities and decision-making power in the face of complications in the delivery process[26,27]. The participants in this study listed some competencies, such as cooperation and decision-making skills in childbirth care, but also described restrictions in communication

skills and trust within the team. Furthermore, this study highlighted the need to build stronger relationships based on mutual respect, especially in the medical category.

In analyzing this problem, poor collaboration between physicians and nurses is a phenomenon that implies an increased risk for women and newborns in their care. In view of this, it is important to go beyond professional hierarchies and focus on the collaborative growth of the health team through elements of commitment, safety building, and trust[28]. On this premise, a Brazilian study on the prevalence of the technocratic obstetric model corroborates these statements. It described conflicts in obstetric practice, prejudices, and a lack of professional skills associated with deficiencies in professional integration and the practical sphere, contributing to this health model's prevalence[29].

Regarding professions in general, Friedson described that the credentialism of a profession emerges from its credentials formed through graduate courses, legislation, and class associations. Prerequisites for professional qualification are essential, such as having carried out at least 15 prenatal nursing consultations, 20 deliveries with complete monitoring of labor, delivery, and the puerperium, and 15 visits to the newborn[6] and its constitution as a professional class through the Brazilian Association of Obstetricians and Obstetric Nurses of Ceará. These actions determine skills and competencies that affirm the trust built within the health team and enable the construction of collaborative practices, especially with the medical category.

However, it is important to note that Freidson's studies point to the requirement of two minimum attributes to define a profession such as medicine: a body of knowledge and an orientation towards the ideal of services, with an inviolable labor market[12]. Without trust, autonomy, and decision-making power, care practices become fragile. At this point, obstetric nursing seeks to advance, taking on its own competencies and skills provided by graduate courses and residency programs, and assuming prestige in society as nurses who are fully qualified to carry out high-risk deliveries[6].

In order to achieve better results in obstetric and neonatal care, in addition to building trust, changes such as understanding the educational background of each component within the team, in each area of practice, and in each person's professional philosophy, are recommended. This is important at the beginning of each profession's educational training[20,30]. WHO recommends a culture change in health institutions, with interprofessional education and the implementation of collaborative practices for advances in health systems to occur[8].

Interprofessional education for integrating obstetric, neonatal, and medical nurses can improve communication, interaction, and cooperation within the team, considering attitudes and skills for qualified obstetric and neonatal care during the parturition process[9,20]. In addition, curricular mechanisms, effective communication strategies to ensure excellent health services and integration of the health and education system can contribute to improve the well-being and health of women and their families during the childbirth experience[6,8].

Other factors raised by the participants in this study were the significant differences between the various professional groups. The professional statute represents the position of both technical and legal authority in a profession's division of labor[12,20]. It is worth noting that nurses and midwives are the most numerous components of the health workforce in many countries and can contribute to universal health coverage. However, they must overcome obstacles in order to function effectively[31]. Autonomy and interprofessional collaboration need to be expanded and improved as essential elements of collaborative practices for excellent services, with the risk of compromising expanded health actions and limiting maternal and child health outcomes[32,33].

Therefore, according to the analysis presented, autonomy is a quality that gives power to the nursing profession, enabling professional status according to state and social control[6,12,22]. The professional autonomy needed to determine actions based on ethics, aimed at women's needs and ensuring well-being, quality of life, and respect in line with the United Nations Sustainable Development Goals, requires, in addition to professional ethics, the development of a body of knowledge, professionalism, and the organization of work to determine legitimate professional actions[3,7,34].

In addition, the testimonies listed professional training through specializations in obstetric and neonatal nursing as a requirement for the skills and development of competencies needed to assist women during labor and other care activities within the NCC. For Freidson, the need for specialization, credentialism, and differentiation within the group can be explained by the demands of the job market, which requires professionals with greater specialization and expertise to carry out work activities[12].

Internationally, the inclusion of obstetric and neonatal nurses working collaboratively in NCCs has reduced unexpected and unfavorable outcomes in the delivery process, such as the indication for a cesarean section, improving women's satisfaction and the quality of care,

and demonstrating the importance of these professionals in each country's health network. The Democratic Republic of Congo, Australia, England, Ghana, and the Netherlands, among other countries, have demonstrated a reduction in maternal and child mortality associated with these professionals' actions in women's care[2,4,5,23,27].

In the Brazilian context, the importance of obstetric and neonatal nurses in NCCs has been noted in recent years, as they are responsible for this line of care. Through the institution of the Stork Network maternal and child health policy, the Brazilian government has encouraged the expansion of the professional market for this category and its relevance in changing care processes and maternal and child health care[6,7].

However, it is important to note that the contributions of collaborative practices within these spaces are elements that promote significant changes in global health models. Collaborative models within the team in which obstetric and neonatal nurses are inserted are associated with better outcomes related to vaginal delivery, vaginal delivery after cesarean section, breastfeeding, lower rates of cesarean section, prematurity, low birth weight, and neonatal death[33].

Building trust is another aspect highlighted in the reports of the obstetric and neonatal nurses interviewed as one of the premises defined in the obstetric nursing profession, in which professionals have specific knowledge in their area of specialization to develop obstetric and neonatal care actions, to determine when to intervene in the work and the competencies of each one, as well as their limitations. Furthermore, health communication is another key element for physician-nurse collaboration and defining important actions to change concepts, routines, and fragile health models[6].

Analyzing these statements, the poor relationships between team members at certain times represent obstacles to building collaborative practices. Nurses must be legally trained to carry out these functions and have the skills to build their professional identity, as they are responsible for the NCC care and management. Furthermore, obstacles and limitations to the full development of work activities, such as conflicts, also contribute to reduced results and the need to overcome them[6]. It is noteworthy that difficulties in action between health team professionals have been noticed, for example, in the Covid-19 pandemic, with significant improvements in the humanization of childbirth, decision-making, and achieving goals among team professionals[35].

Regarding the limitations found in this study, it is worth highlighting the technique of contacting people by telephone for interviews due to the Covid-19 pandemic, which caused inconveniences in terms of the time available to explain the objectives and read the research's informed consent, for later participation. However, this technique made it possible to contact NCC participants from all over the region of Ceará, allowing us to learn about these facilities, as well as their strengths and challenges.

CONCLUSION

The experiences of nurses in collaborative practices in natural childbirth centers, according to the analysis of the Sociology of Professions, still need progress, such as, for example, in the autonomy of actions in obstetric care. However, there are credentials and expertise that enhance the area of obstetric and neonatal nursing, and advances in health practices in labor and childbirth care, described through cooperation and communication in health.

Funding

This research did not receive financial support.

Conflict of interests

None.

Contributor roles - CRediT

ACB: conceptualization; data curation; formal analysis; investigation; methodology; project administration; software; visualization; writing – original draft; and writing – review & editing.
MENGR: data curation; formal analysis; visualization; writing – original draft; and writing – review & editing.
LJESV: supervision; validation; visualization; writing – original draft; and writing – review & editing.
MRFS: supervision; validation; visualization; writing – original draft; and writing – review & editing.
SJSBA: supervision; validation; visualization; writing – original draft; and writing – review & editing.
ARFJ: conceptualization; investigation; methodology; project administration; software; supervision; validation; visualization; writing – original draft; and writing – review & editing.

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