

## Obstetric violence in the abortion process

### Violência obstétrica no processo do abortamento

### Violencia obstétrica en el proceso del aborto

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**Abstract:** Objective: To analyze health care practices in the abortion process typified as obstetric violence. Methodology: Qualitative and descriptive study, conducted in a public hospital in Brazil with 15 health professionals of medium and higher education. The data were collected in person, through a semi-structured interview script. The profile was analyzed by simple descriptive statistics and the questions opened by the thematic content technique proposed by Bardin. Results: It was evidenced that health professionals had insufficient knowledge about obstetric violence at the time they restricted it to childbirth or abortion, physical/verbal typing and identified only doctors and nurses as the main perpetrators. The practices that denote obstetric violence are related to the allocation of women in the process of abortion in the same environment as pregnant women and puerperal women and when issuing value judgments at the time of care. Conclusion: There is a need for permanent education so that the professionals can assist in a humanized and qualified way.

**Keywords:** obstetric violence; abortion; comprehensive health care; women's health; nursing.

**Resumo:** Objetivo: Analisar as práticas assistenciais de saúde no processo do abortamento tipificadas como violência obstétrica. Metodologia: Estudo qualitativo e descritivo, realizado em um hospital público no Brasil com 15 profissionais de saúde de nível médio e superior. Os dados foram coletados presencialmente, através de um roteiro de entrevista semiestruturada. O perfil foi analisado pela estatística descritiva simples e as questões abertas pela técnica de conteúdo temática proposta por Bardin. Resultados: Evidenciou-se que as práticas que denotam violência obstétrica relacionam-se a alocação das mulheres em processo de abortamento no mesmo ambiente que gestantes e puérperas e ao emitirem juízos

de valor no momento da assistência às mulheres. Conclusão: Há necessidade de educação permanente para que as/os profissionais possam assistir de maneira humanizada e qualificada.

**Palavras-chave:** violência obstétrica; aborto; assistência integral à saúde; saúde da mulher; enfermagem.

**Resumen:** Objetivo: Analizar las prácticas de atención a la salud en el proceso de aborto tipificadas como violencia obstétrica. Metodología: Estudio cualitativo y descriptivo, realizado en un hospital público en Brasil con 15 profesionales de salud de nivel medio y superior. Los datos fueron recogidos presencialmente, a través de un guion de entrevista semiestructurada. El perfil fue analizado por la estadística descriptiva simple y las cuestiones abiertas por la técnica de contenido temática propuesta por Bardin. Resultados: Se evidenció que los profesionales de salud presentaron conocimiento insuficiente sobre violencia obstétrica en el momento en que la restringieron al parto o aborto, a la tipificación física/verbal e identificaron solo a los médicos y enfermeras como los principales perpetradores. Las prácticas que denotan violencia obstétrica se relacionan a la asignación de las mujeres en proceso de aborto en el mismo ambiente que gestantes y púerperas, y al emitir juicios de valor en el momento de la asistencia. Conclusión: Hay necesidad de educación permanente para que los profesionales puedan asistir de manera humanizada y cualificada.

**Palabras clave:** violencia obstétrica; aborto; asistencia integral a la salud; salud de la mujer; enfermería.

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## Introduction

Despite the greater access to sexual and reproductive health, the fertility rate fell from 3.92 to 2.90 in poor women in recent decades, which resulted in a mean of 1.7 children per woman in Brazil. <sup>(1)</sup> However, this decrease did not reduce the number of abortions, especially among the most vulnerable women, unveiling the official registry of 24.8 thousand abortions in the Unified Health System (UHS), between the years 2010 and 2019, mostly in the Northeast, and 721 deaths in Brazil between 2009 and 2018 as a result of complications. <sup>(2)</sup>

Part of this data is due to the conditions of socio-cultural, economic and political vulnerability in which women are involved, the low quality of care, the absence of empathic process and the failure of communication between health professionals and violence

perpetrated by the health team, constituting the current phenomenon entitled obstetric violence. Considered as a global problem, obstetric violence can be defined as any violent act based on gender that results in mental, sexual, patrimonial or physical damage, causing the suffering of the woman, through threats, coercion or arbitrary deprivation of liberty, which may occur during prenatal, childbirth, postpartum and abortion situations. This problem affects women of different ages and can be characterized by neglect in care, physical, verbal, psychological and even sexual violence committed by health professionals, in the pregnancy-puerperal cycle and in abortion situation, the latter being the focus of this study. <sup>(3)</sup>

Violence against women is socially naturalized, especially in obstetric care, where there is a greater process of expropriation of their body and suppression of their autonomy in situations of induced or provoked abortion. One of the evidences is the hostile and humiliating treatments to women in this process. <sup>(4)</sup>

Situations of obstetric violence are also perceived at the international level, considering the use of the term Abuse in healthcare to describe negligence, psychological, verbal, physical and sexual abuse committed in the space of care for pregnant women, parturients and puerperal mothers <sup>(5)</sup>. In addition, a Nordic study described that approximately 13 to 18 % of women reported suffering practices belonging to obstetric violence. <sup>(6)</sup>

It is evident that women in the process of abortion suffer abuse in public and private health institutions with some frequency, characterizing an exponential increase in obstetric violence with sequelae and death, requiring intervention with brevity. <sup>(7-8)</sup> Brazilian research reveals that 25 % of women suffered some kind of violence during labor, childbirth, postpartum or abortion, and some of these acts or actions are naturalized by women themselves, due to the lack of adequate knowledge about the phenomenon. <sup>(9)</sup>

Another study pointed to a high percentage of maternity hospitals that perform unnecessary interventions, characterized by: 63.5 % of use of venous catheter, 4.3 % of use of uterotonic drugs and 86.3 % of maintenance of the lithotomy position, practices clearly framed in obstetric violence and that happen in cases of abortion. <sup>(10)</sup>

In Mexico, obstetric violence is discriminatory, as health professionals repress women's cultural practices through: neglect; lack of privacy during procedures; use of unnecessary technologies; verbal and psychological abuse; and denial of female autonomy about the decision and preference about her body. <sup>(11)</sup>

In this sense, it is urgent to change health care practices, in order to respect the particularities, pains, vulnerabilities and subjectivities of each woman who experiences the process of abortion, without judgments and focusing on humanization and scientific evidence. <sup>(12)</sup> The present study is justified as it intends to explore an object of great social magnitude, with high mortality rates and complications that affect the quality of life of women, especially those who abort.

Given the above, the following question arose: What are the health care practices developed in the abortion process typified as obstetric violence? Thus, the objective was: to analyze health care practices in the abortion process typified as obstetric violence. Therefore, the social and scientific relevance of the research focuses on the need for greater understanding and deepening on the subject, the improvement of health care practices for women in the process of abortion, which should be centered on humanization, quality and female protagonism.

## Method

This is a qualitative and descriptive study, centered on the constructivist paradigm, which has a dynamic character, manifested through the development of concepts, from facts and opinions, enabling a format that goes beyond something predictable and measurable. <sup>(13)</sup>

The study was conducted in a public hospital located in Brazil. This service assists the local population and neighboring municipalities, offering obstetric and pediatric care. It has 105 hospitalization beds, 10 of which are Neonatal Intensive Care Unit (NICU), 25 semi-intensive, 5 in the In-hospital Center for Normal Delivery (CND) and has a reference maternity in the region.

The study participants were the health professionals of technical and higher level, chosen by convenience sample, respecting the following inclusion criteria: being admitted or hired by the institution, having assisted women in the process of abortion. The exclusion criteria were: being in the process of illness or service leave for any other reason. It is noteworthy that the researchers did not previously know or had ties with the participants of the study. All participants who assisted women in the abortion process were invited and only 15 met the inclusion criteria, constituting the eligible population of the study.

After approval by the Ethics Committee of the State University of Santa Cruz, a meeting was held with the Coordinator of Permanent Education and the Nursing coordinator of the hospital, in which the responsible researcher clarified together with her team composed of two scholarship students duly trained for the collection, a professor in women's health, a master's student in nursing and a care nurse on the objectives of the research and how it would be performed. Then, all were presented to the hospital team, when they could explain again about the research, then occurring the first approach with the participants.

Before beginning the interview, the participant was informed in detail about the objectives of the research, with presentation and subsequent signature of the Informed Consent Form (ICF), demonstrating his/her consent to participate in the study.

Data collection was carried out in person, in November 2022, respecting the current protocols of the pandemic caused by the COVID-19 and the interest of the participant, using as an instrument a semi-structured interview script, involving open questions, such as: "Have you ever witnessed any situation of mistreatment of women in the process of abortion made by health professionals (rudeness, threat, shouting or humiliation, jokes, malicious comments, laughter for no reason)?", "What procedures do you usually do when watching women in the process of abortion?", "Have you ever performed or seen someone perform an unnecessary intervention to the woman in the process of abortion?", recorded on a digital device. The interviews lasted an average of 20 minutes and the closure of the collection was by theoretical saturation of the data.

Then, all interviews were transcribed for further reading and analysis by the thematic content technique proposed by Bardin, through the phases of: pre-analysis: moment in which all interviews were transcribed and carefully read; exploration of the material: phase in which the interviews were read in depth and codified; treatment of the results and interpretation: stage that involves the categorization of the themes presented in the speeches of the participants. <sup>(14)</sup>

The study followed Resolutions No. 466/2012 and No. 510/2016 of the National Health Council (NHC), which ensures the rights and duties of all participants and provides for the researcher-participant relationship. <sup>(15-16)</sup> All participants were named by a letter "I"

followed by a cardinal number to ensure anonymity. Finally, the material collected and analyzed will be archived for a period of five years, being excluded after this period.

### **Results and Analysis**

The study included 15 health professionals, since this number corresponds to 100 % of those who assisted women in the process of abortion, 13 female and two male, the age interval ranged from 26 to 50 years. With regard to color/ethnicity, seven self-declared as brown, five black and three white. As for religion, eight called themselves Catholics, three Evangelicals, one Protestant, one Spiritist and two have no religion.

Regarding the professional profile, seven had technical level, all nursing technicians, and eight higher level, six being a nurse, a doctor and a nutritionist. The length of training ranged from two to 24 years, and the period of operation in the hospital ranged from six months to one year. After characterizing the profile, there was the attentive reading of the participants' testimonies, codification of the themes presented in the discourses in relation to the research questions and the definition of a category. This category shows that the care practices for women who have experienced the abortion process are loaded with prejudices and stigmas with value judgement by the health professional, devaluing complaints and causing devaluation of the user's needs, as detailed below:

#### ***Prejudice, stigma and devaluation of women in the abortion process: the demonstration of obstetric violence***

Health care practices characterized as obstetric violence are manifested by keeping women in the process of abortion in the same space as parturients, newborns (NB) and pregnant women, something identified below:

I don't the place they stay is cool. They stay here in the kangaroo ward. Where we receive the NB. So I think it's not ideal. It shouldn't be here (I11).

I think women in the process of abortion shouldn't be in the same room with other women. This is one thing I would change (I9).

I think that whoever constructed this hospital has no idea of motherhood. There're so many things that should be changed and the first step is that the patient victim of abortion, whatever induced or not, if she lost the dream of her life, shouldn't be near pregnant women or children (I13).

This hospital should offer more privacy, they commonly stay here in the E.R., with women in labor [...] they often waiting while in fasting for the curettage, among women giving birth, where they're in a moment of loss (I8).

I think they should have a separated room. They're only separated when here is too crowded (I3).

The aforementioned reports highlight the importance of hospital infrastructure for a satisfactory embracement of women in the abortion process. The physical condition of the places where pregnant women, parturients, postpartum women and women in the process of

abortion are cared for should be the best possible in order to ensure respect for their rights, something that is not perceived in the study.

Moreover, it was possible to observe that health professionals potentiate their prejudices, beliefs, stigmas and opinions in the most diverse way, during their practices, constituting obstetric violence and causing harm to women in the process of abortion, as indicated below:

You already have six children, so one less makes no difference, you have six, you will get six (I10).

I think that instead of raising awareness that she can do whatever she wants with her body, there should be awareness that a fetus is also a living being, that, from the moment it became fertile, its heart is already starting to beat, it begins to feel (I4).

Regardless of the personal and religious perspective of any health professional, there is a clear violation of the existential rights of women who experience the process of abortion, through a behavior that goes beyond the limits of impersonality. When the health professional makes a value judgment about the performance of a woman's abortion, he/she acts recklessly concerning the individual values of the user.

Associated with this, it is evident that there is a difference in the treatment of women when abortion was provoked. The actions of the health professional point the woman in the process of abortion in a threatening, aggressive or stigmatizing way, as observed in the following statements:

I go according to what I perceive in the patient, if I see that she is bad, crying, sad, you get moved by the situation, even offer some comfort. But when you see that the patient doesn't care, good luck. I just do what I have to do, which is to give vital signs, medication, look at the bleeding, and that's it. Because I saw she has no affection, there was no feeling of losing the baby (I2).

I have witnessed several times some professionals questioning: the patient is crying there, what if she induced the abortion and is pretending? Is she performing so that we treat her better and feel sorry for her? (I13).

I already witnessed a doctor, he entered the room and said that, if she continued screaming, he would leave (I9).

The subjective presumption of the professional is the reference to determine the care for women in abortion situation. Again, there is a characterization of obstetric violence, since care becomes in practice an arbitrariness of the professional rather than a duty existing in a dialectical relationship with the right of women, free from any form of discrimination.

Thus, it becomes easy to understand that: if duty becomes a choice, the woman becomes dependent on the wills of the one in charge of caring for her. This gives the power to threaten and refuse to comply with the health guarantee, causing irreversible damage, impossible to be corrected by law.

Moreover, women in the process of abortion are constantly discredited, and cannot express their feelings because their assistance tends to be neglected, as noted below:

Sometimes I see people here who mentions pain, we have to pay attention if they're only pretending (I14).

## Discussion

It is known that obstetric violence is not perpetrated by a single type of health professional, and can be committed by any professional assisting the woman during the abortion process, including doctors, nurses, anesthetists, nursing technicians, receptionists, administrators and others, as evidenced in the results of this study. It is noted that technical-level professionals, most often defined as receptionists and health, such as nursing technicians, doctors, nurses and nutritionists were the professional categories found perpetrating obstetric violence in the abortion. <sup>(17)</sup>

In this context, the way the woman who experiences the process of abortion is received in the service will affect her comfort and satisfaction, whose doubts will often not be clarified, in addition not to being welcomed and respected, resulting in the intensification of physical and psychological suffering. In addition, situations related to inadequate infrastructure of institutions impair the assistance provided to women in the process of abortion, with emphasis on sharing the environment of hospitalization with pregnant women and parturients with alive children, which tends to hinder the confrontation and overcoming. Allocating women who aborted along with pregnant women, parturients, postpartum women and their NBs is something reckless and considered obstetric violence, since such situation can cause depression, trauma and even influence these women not to seek health service. <sup>(18)</sup>

Although obstetric violence is quite recurrent in Brazil, it is still a little known and discussed topic, especially when related to abortion, having been gradually incorporated into the process of formation of health professionals in the last 5 to 10 years, which can contribute to its expansion. <sup>(17-18)</sup>

Moreover, obstetric violence goes through various levels of complexity, from primary, secondary to tertiary care, not being restricted to hospital environments. This type of violence against women in the abortion process occurs in public and private spaces of assistance, requiring immediate intervention to mitigate it. <sup>(19)</sup>

It is also emphasized that the practices typified as obstetric violence represent a serious violation of human rights and, therefore, should be understood as a public health problem that affects the citizenship and protagonism of women in the abortion process, demanding rapid confrontation. <sup>(20-22)</sup>

It should be noted that obstetric violence is also a worrying social phenomenon and ends up being increased when women experience abortion, often manifested through unnecessary questioning by the health team, with treatment focused purely on the procedure, with reprimand and judgments, lack of psychological support beyond organizational and structural issues such as lack of inputs or adequate beds and disproportionate number of staff to provide more adequate assistance. <sup>(7)</sup>

There are also practices related to the delay and/or denial of care to women who miscarried with the intention of discovering the causes, whether it was intentional or not; moreover, there are also intimidation, invasive procedures without the consent of the woman, most often without anesthesia. <sup>(23)</sup>

Research carried out in an institution of reference to abortion showed the presence of institutional, psychological, religious and negligent obstetric violence, which is closely related to issues involving individual values and moral judgments of health professionals,

being manifested by acts of recrimination and disrespect on their part. The use of personal values in care contributes to the naturalization of discriminatory and violent practices. Thus, it is essential to work with the conditions of vulnerability of women who are in the process of abortion, being necessary to deconstruct moral and religious values of health professionals, allowing these users to be assisted with respect and humanization. <sup>(24)</sup>

It is noteworthy that the care practices for women in the process of abortion that have a highly punitive character, without considering social desires and ills, are highly exclusive and inappropriate. <sup>(25)</sup> Considering the typification of induced or spontaneous abortion to determine the type of care conduct is something that should be fully curbed in the care of these women. Denying analgesic and anesthetic during the procedures and minimizing complaints is unacceptable in assisting women in the process of abortion. <sup>(26-27)</sup>

Study conducted with residents in obstetric nursing of a philanthropic institution points to the presence of negligence, disrespect, imposition of values, moral judgment, breach of confidentiality, invasion of privacy and refusal to care for women in the process of abortion, demonstrating the hierarchy and authority of professionals in institutional routines as a form of threat to the right to life, health, physical and psychological integrity. <sup>(26)</sup>

Reports of professionals who work in maternity hospitals demonstrate the difficulty they have in dealing with women in the process of abortion, as they put prejudice, discrimination and punishment as a priority in the care provided, demonstrating the need to train professionals to deal with this problem in a respectful way. <sup>(28)</sup>

Finally, expanding the knowledge of health professionals about forms of care for women in the process of abortion will be fundamental to overcome obstetric violence and allow care to be performed based on embracement, problem-solving, respect and fulfilled by the best scientific evidence. <sup>(29-30)</sup> Therefore, health professionals should offer the care free of judgments to women in abortion, exercising the empathic approach, making the process less difficult and painful.

The limitation of the study focuses on the object, the process of abortion, although obstetric violence includes women during prenatal, childbirth and postpartum. In addition, the small number of participants results from the health professionals of the place chosen for the study not having assisted women during the abortion.

## **Conclusions**

The investigation shed light on the existence of practices classified as obstetric violence, evidenced by the statements of health professionals. An important practice includes placing the woman in the abortive process in the same space as the pregnant woman, the puerperal woman and the newborn, which resulted in the exclusive treatment of users who opted for induced abortion. Moreover, these practices lead to an assistance impregnated with beliefs, prejudices, stigmas, opinions and judgments, minimizing the complaints presented by the affected women.

Therefore, it is evident the urgent need for a more solid and effective intervention by managers and coordinators of health services. It is essential to implement clear policies and protocols to prevent occurrences of obstetric violence in the daily work of health teams. Likewise, greater awareness and training of medical personnel is required to ensure respectful, compassionate and impartial treatment for all users regardless of their pregnancy



decisions. The construction of a safe and empathetic care environment is essential to ensure the well-being of women in this process.

The research contributes to Women's Science and Health, because it presents the practices of obstetric violence in women who go through the abortion process, allowing us to act on the social constructs, among health professionals, improving the care provided.

### **Bibliographical references**

1. Fundo de População das Nações Unidas. [Internet]. No Dia Mundial de População, UNFPA aponta queda de fecundidade no Brasil entre mulheres mais vulneráveis; 2019 [citado 2019 dez 20]. Available from: <https://brazil.unfpa.org/pt-br/news/fundo-de-populacao-da-onu-aponta-fecundidade-no-brasil-entre-mulheres#:~:text=Conforme%20mostra%20o%20documento%2C%20entre,%2C41%20para%200%2C77>
2. Bomfim VVBS, Arruda MDIS, Eberhardt ES, Caldeira NV, Silva HF, Oliveira ARN, et al. Mortalidade por aborto no Brasil: Perfil e evolução de 2000 a 2020. *Research, Society and Development* [Internet]. 2020;10(7):1-8. doi: 10.33448/rsd-v10i7.16866
3. Guimarães LBE, Jonas E, Amaral LROG. Violência obstétrica em maternidades públicas do estado do Tocantins. *Estudos Feministas* [Internet]. 2018;26(1):e43278. doi: 10.1590/1806-9584.2018v26n143278
4. Brito CMC, Oliveira ACGA, Costa APCA. Violência obstétrica e os direitos da parturiente: o olhar do Poder Judiciário brasileiro. *Cad. Ibero-Americanos de Direito Sanitário* [Internet]. 2020;9(1):120-40. doi: 10.17566/ciads.v9i1.604
5. Lukasse M, Schroll AM, Karro H, Schei B, Steingrims-Dottir T, Parys AV, et al. Prevalence of experienced abuse in healthcare and associated obstetric characteristics in six European countries. *Acta Obstetricia et Gynecologica* [Internet]. 2015;94:508-17. doi: 10.1111/aogs.12593
6. Swahnberg K, Schei B, Hilden M, Halmesmaki E, Sidenius K, Steingrims-Dottir T, et al. Patients experiences of abuse in health care: a Nordic study on prevalence and associated factors in gynecological patients. *Acta Obstet Gynecol Scand* [Internet]. 2007;86(3):349-56. doi: 10.1080/00016340601185368
7. Pedrosa AAB, Silva LS, Nunes GFO, Pimentel MC, Lima JKS, Matos KKC. Situações de violência obstétrica vivenciadas por mulheres em processo de abortamento. *Rev Saúde* [Internet]. 2017;43(3):1-8. doi: 10.5902/2236583428449
8. Goes EF, Menezes GMS, Almeida MC, Araújo TVB, Alves SV, Brito e Alves MTSS, et al. Vulnerabilidade racial e barreiras individuais de mulheres em busca do primeiro atendimento pós-aborto. *Cad. Saúde Pública* [Internet]. 2020;36(1):1-13. doi: 10.1590/0102-311X00189618

9. Zanardo GLP, Uribe MC, Nadal AHR, Habigzang LF. Violência obstétrica no Brasil: uma revisão narrativa. *Psicol Soc [Internet]*. 2017;29:e155043. doi: 10.1590/1807-0310/2017v29i155043
10. Bittencourt SDA, Vilela MEA, Marques MCO, Santos AM, Silva CKRT, Domingues RMSM, et al. Atenção ao parto e nascimento em maternidades da Rede Cegonha/Brasil: avaliação do grau de implantação das ações. *Ciênc saúde coletiva [Internet]*. 2020;26(3):801-21. doi: 10.1590/1413-81232021263.08102020
11. Flores YYR, Ibarra LEH, Ledezma AGM, Acevedo CLG. Social construction of obstetric violence of Tenek and Nahuatl women in Mexico. *Rev. Esc. Enferm. USP [Internet]*. 2019;53(9):1-7. doi: 10.1590/s1980-220x2018028603464
12. Moura RCM, Pereira TF, Rebouças FJ, Costa CM, Lernades AMG, Silva LKA . Cuidados de enfermagem na prevenção da violência obstétrica. *Enferm. Foco [Internet]*. 2018;9(4):60-5. Available from: <http://revista.cofen.gov.br/index.php/enfermagem/article/view/1333>
13. Soares SJ. Pesquisa científica: uma abordagem sobre o método qualitativo. *Rev Ciranda [Internet]*. 2019;1(3):168-80. Available from: <https://www.periodicos.unimontes.br/index.php/ciranda/article/view/314>
14. Bardin L. *Análise de Conteúdo*. São Paulo: Edições 70 LDA; 2016.
15. Brasil. Ministério da Saúde. Resolução n.º 466, de 12 de dezembro de 2012. Aprovar as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Brasília: MS; 2012. Available from: <https://conselho.saude.gov.br/resolucoes/2012/Reso466.pdf>
16. Brasil. Ministério da Saúde. Conselho Nacional de Saúde. Resolução nº 510, de 7 de abril de 2016. Trata sobre as diretrizes e normas regulamentadoras de pesquisa em ciências humanas e sociais. Brasília: MS; 2016. Available from: <https://conselho.saude.gov.br/resolucoes/2016/Reso510.pdf>
17. Sturza JM, Nielsson JG, Andrade EP. Violência Obstétrica: uma negação aos Direitos Humanos e a saúde sexual e reprodutiva da mulher. *Revista Juris Poiesis [Internet]*. 2020;23(32):389-407. Available from: <http://periodicos.estacio.br/index.php/jurispoiesis/article/viewFile/8643/47967016>
18. Santos BF, França LN, Wandekoken KD, Machado PS, Andrade LMF. Violência Obstétrica frente ao abortamento em um hospital de referência em Vitória/ ES, Brasil. 2022; 24(2): 7-14. doi: 10.47456/rbps.v24i2.35795
19. Conceição RGS, Simões AV, Rodrigues VP, Machado JC, Penha JMN, Balbinote FS. Assistência qualificada no pré-natal como prevenção da violência obstétrica: Revisão integrativa. *Research, Society and Development [Internet]*. 2021;10(8):e34910817505. doi: 10.33448/rsd-v10i8.17505

20. Ribeiro LM, Souza LG, Silva WT. Violência obstétrica: uma questão de saúde pública e a violação dos direitos fundamentais da mulher. *Research, Society and Development* [Internet]. 2022;11(14):e331111436321. doi: 10.33448/rsd-v11i14.36321
21. Zanchetta MS, Santos WS, Souza KV, Pina VR, Hwu H, Stahl H, et al. Ampliando vozes sobre violência obstétrica: recomendações de advocacy para enfermeira(o) obstetra. *Esc. Anna. Nery Rev. Enferm* [Internet]. 2021;25(5):e20200449. doi: 10.1590/2177-9465-EAN-2020-0449
22. Sampaio J, Tavares TLA, Herculano TB. Um corte na alma: como parturientes e doulas significam a violência obstétrica que experienciam. *Estudos Feministas* [Internet]. 2019;27(3):e56406. doi: 10.1590/1806-9584-2019v27n356406
23. Santos VC, Moraes AC, Souza ZCSN, Silva IAR, Ramos RRS, Santos JS. Violência Obstétrica na Perspectiva de Raça/Cor: Uma Revisão Integrativa. 2020;31:1-19. Available from: [https://repen.com.br/revista/wp-content/uploads/2021/08/REPE\\_n\\_2020\\_v31\\_Violencia-Obstetrica-na-Perspectiva-de-Raca-Cor.pdf](https://repen.com.br/revista/wp-content/uploads/2021/08/REPE_n_2020_v31_Violencia-Obstetrica-na-Perspectiva-de-Raca-Cor.pdf)
24. Souto SLU, Ferreira JDL, Ramalho NMG, Lima CLJ, Ferreira TMC, Maciel GMC, et al. Nursing Care for Women in Situation of Unsafe Abortion. *International Archives of Medicine* section: Obstetrics & Gynecology [Internet]. 2017;10(214):1-13. doi: 10.3823/2484
25. Zecca GA, Polido CG. Enfermagem e a humanização do gestar e parir: revisão de literatura acerca da violência obstétrica. *Enfermagem Brasil* [Internet]. 2022;21(2):166-78. doi: 10.33233/eb.v21i2.4854
26. Menezes FR, Reis GM, Sales AAS, Jardim DMB, Lopes TC. O olhar de residentes em Enfermagem Obstétrica para o contexto da violência obstétrica nas instituições. 2020;24:1-14. doi: 10.1590/Interface.180664
27. Brandt GP, Souza SJP, Migoto MT, Weigert SP. Violência obstétrica: a verdadeira dor do parto. *Revista Gestão & Saúde* [Internet]. 2018;19(1):19-37. Available from: <https://www.herrero.com.br/files/revista/file2a3ed78d60260c2a5bedb38362615>
28. Santos LCA, Dias LLC, Ribeiro WA, Paula E, Castro K, Sobral AC, et al. Humanização na assistência de enfermagem à mulher em situação de aborto. *Revista Científica Saúde e Tecnologia* [Internet]. 2022; 2(1):1-14. doi: 10.53612/recisatec.v2i1.67
29. Paula E, Alves VH, Rodrigues DP, Felício FC, Araújo RCB, Chamilco RASI, et al. Violência obstétrica e o atual modelo obstétrico, na percepção dos gestores em saúde. *Texto & Contexto-Enfermagem* [Internet]. 2020;29:e20190248. doi: 10.1590/1980-265X-TCE-2019-0248
30. Paynter M, Norman W, Martin-Misener, R. Nurses are Key Members of the Abortion Care Team: Why aren't Schools of Nursing Teaching Abortion Care?. *The Canadian*

Journal of Critical Nursing Discourse [Internet]. 2019;1(2):17-29. doi: 10.25071/2291-5796.30

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