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Knowledge of nurses of primary care about obstetric violence

ABSTRACT | Objective: to investigate the knowledge of nurses in primary health care about obstetric violence. Method: a descriptive-exploratory study with a qualitative approach, developed with seven nurses from two basic health units in the Federal District, Brazil. The data were collected from recorded interviews, transcribed and analyzed through content analysis. The research was approved by the Research Ethics Committee of University Paulista under opinion nº 3.604.615 (CAAE 19781019.0.0000.5512). Results: the topic is approached incipiently and often without the expected quality. It was also identified that professionals are unprepared on the subject so that there is a good source of information for pregnant women during prenatal care. Conclusion: it becomes necessary to incorporate the theme in the undergraduate nursing course, in addition to better training of professionals for a satisfactory approach to the theme in the context of primary health care.

Keywords: Violence; Obstetrics; Nursing; Women; Primary Health Care.

RESUMEN | Objetivo: investigar el conocimiento de las enfermeras en atención primaria de salud sobre violencia obstétrica. Método: estudio descriptivo-exploratorio con enfoque cualitativo, desarrollado con siete enfermeras de dos unidades básicas de salud en el Distrito Federal, Brasil. Los datos fueron recolectados de entrevistas grabadas, transcritas y analizadas a través del análisis de contenido. La investigación fue aprobada por el Comité de Ética en Investigación de la Universidad Paulista con el dictamen nº 3.604.615 (CAAE 19781019.0.0000.5512) Resultados: el enfoque del tema es incipiente y, a menudo, sin la calidad esperada. También se identificó que los profesionales no están preparados sobre el tema, por lo que existe una buena fuente de información para las mujeres embarazadas durante la atención prenatal. Conclusión: se hace necesario incorporar el tema en el curso de pregrado en enfermería, además de una mejor capacitación de profesionales para un enfoque satisfactorio del tema en el contexto de la atención primaria de salud.

Palabras claves: Violencia; Obstetricia; Enfermería; Mujeres; Atención Primaria de Salud.

RESUMO | Objetivo: investigar o conhecimento de enfermeiros da atenção primária à saúde acerca da violência obstétrica. Método: estudo de caráter descritivo-exploratório com abordagem qualitativa, desenvolvido com sete enfermeiros de duas unidades básicas de saúde do Distrito Federal, Brasil. Os dados foram coletados a partir de entrevistas gravadas, transcritas e analisadas mediante a análise de conteúdo. A pesquisa foi aprovada pelo Comitê de Ética em Pesquisa da Universidade Paulista sob o parecer nº 3.604.615 (CAAE 19781019.0.0000.5512). Resultados: a abordagem do tema acontece de forma incipiente e muitas vezes sem a qualidade esperada. Identificou-se ainda que existe despreparo dos profissionais sobre o assunto para que haja uma boa fonte de informações para as gestantes durante o acompanhamento pré-natal. Conclusão: torna-se necessário incorporar a temática no curso de graduação em Enfermagem, além de uma melhor capacitação dos profissionais para uma abordagem satisfatória acerca da temática no contexto da atenção primária à saúde.

Palavras-chaves: Violência; Obstetricia; Enfermagem; Mulheres; Atenção Primária à Saúde.

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INTRODUCTION

The history of childbirth and birth has been gradually transformed over time. In Brazil, until the 19th century, it was centered on women and traditionally carried out by midwives. In the mid-twentieth century, it was progressively institutionalized, with the transformation of the role of women from subject to object, culminating in the medicalization of the female body.¹

The institutionalization of childbirth meant that this event required the use of technologies during assistance in situations classified as high risk to the mother and newborn, resulting in a reduction in maternal and neonatal death rates. However, these practices came to be seen

as mechanized, fragmented and dehumanized by the excess of interventions, curtailing female autonomy at the time of delivery, becoming, in the feminist and obstetric field, an event of a violent and rights-violating character.²

Thus, childbirth and birth in the physiological and natural context is one in which the use of medicalization and interventions is not necessary, providing women with the experience of labor in a natural way in which the release of hormones takes place within the physiology of the process.³

However, it is known that inhuman attitudes in childbirth care are frequent in both the private and public sectors. In this context, the term obstetric violence is used in Brazil to describe the various

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forms of violence that occurred in the care of pregnancy, childbirth, postpartum and abortion. This is understood as the appropriation of the body and reproductive processes of women by health professionals who express themselves through dehumanizing relationships, abuse of medicalization and pathologization of natural processes, resulting in loss of autonomy and ability to freely decide about their body and sexuality, negatively impacting women's quality of life.⁴

Based on this, several actions were implemented as a way to prevent obstetric violence in health practices. The "Rede Cegonha", a strategy of the Ministry of Health, is one of them and aims to program a series of care to guarantee women the right to reproductive planning and attention to pregnancy, childbirth and the puerperium, to ensure safe birth, the satisfactory development and quality of life of children up to two years old and the reduction of maternal and child mortality. In addition, the Rede Cegonha is not only practiced within the maternity space, but also within the scope of primary health care in order to educate the pregnant woman about her guarantees during all her care and advocate a qualified professional approach.⁴

Thus, the performance of the nursing team in assisting women during the gestational period is important, since throughout the prenatal consultations there is a strengthening of the bond between the pregnant woman and health professionals.⁵ In this context, prenatal care should, in addition to being a space for tracking pathologies and situations of gestational risk, be responsible for educational actions. It should also promote to pregnant women a greater appropriation of physiology and about the importance of normal birth, deconstructing the common sense of negative experiences transmitted socially.⁶

In view of this, the present study is justified given the need to be aware of the nurses' approach to pregnant women during prenatal consultations on the theme

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of obstetric violence. Thus, it is understood that the assessment of knowledge and the identification of forms of violence is a way to recognize the existence of the problem. From this perspective, the question that guided this investigative propo-

sal stands out: what is the knowledge of nurses in primary health care about obstetric violence?

Therefore, this study aims to investigate the knowledge of nurses in primary health care about obstetric violence.

METHODS

This is a descriptive-exploratory study with a qualitative approach, carried out in two basic health units (Unidades Básicas de Saúde - UBS) in the Federal District, Brazil.

Nurses who met the following inclusion criteria participated in this study: performance in the Family Health Strategy (Estratégia de Saúde da Família - ESF) teams at UBS for at least 6 months. Nurses who were less than 6 months old in FHS teams were excluded; worked in UBS other than those in the study and those who did not have any formal employment relationship with the institution. The determination of the number of participants followed the information saturation criterion.

Data collection took place in October 2019, in two stages. In the first, it was possible to know the daily functioning of the institution and obtain the necessary information for the invitation and beginning of data collection. In the second step, a semi-structured interview script was applied to each participant, divided into two parts: the first, with the nurses' identification data (sex, age, education level, time in the profession, time working at the UBS and working hours) and, the second, with the guiding questions related to the research objective.

The average time for the interviews was 30 minutes and the participants were at the beginning or end of their working hours. The guiding questions were: What is your understanding of Obstetric Violence? and How do you see the issue of obstetric violence?

In view of the nurses' privacy, the interviews took place individually, in a private room at the institution, at a time

agreed in advance with the participant (beginning or end of working hours) and those responsible for the institution. The speeches were obtained by an audio recorder and with the nurses' concession, by signing the Free and Informed Consent Term (ICF).

The speeches were transcribed and analyzed through the content analysis proposal, which is organized in the following phases: pre-analysis, material exploration, treatment of results, inference and interpretation.⁷

In the pre-analysis, there was a fluctuating reading, followed by the constitution of the corpus, according to the proposed objective. For the exploration of the material, coding was performed using similar words or phrases in the speeches. In the treatment of results and interpretation, it was possible to group the fragments of the narratives, in order to visualize the information obtained in full, as well as to cover the predicted inferences.

Ensuring nurses' anonymity, alphanumeric coding was used (ex: E1, E2, E7) where E, corresponds to the Nurse and the numerals to the order of the interviews.

Ethical aspects were respected, as required by Resolution No. 466/2012, of the National Health Council, which deals with research on human beings. The project was submitted to and approved by the Research Ethics Committee (Comitê de Ética em Pesquisa - CEP) of Universidade Paulista (UNIP) under opinion No. 3,604,615 (CAAE 19781019.0.0000.5512), of September 27th, 2019.

RESULTS AND DISCUSSION

Seven (7) nurses were interviewed who develop their professional activities in two UBS in the Federal District, of which 85,7% were female and the average age corresponded to 44 years. Regarding the level of education, 14,3% had only a nursing degree and 85,7% a *latu sensu* graduate. As for working time in Nursing, 71,4% have worked in the profession for

more than 10 years and 28,6% for less than 10 years. Regarding working time at UBS, all of them (100%) have been working for more than 3 years. Regarding the working hours of professionals, 85,7% have a working day of up to 40 hours per week and 14,3% more than 40 hours per week.

The Brazilian model of childbirth care has been built on the basis of humanization initiatives and successful experiences in childbirth and birth care. The main objectives of this model are the reduction of maternal and child morbidity and mortality, abusive rates of caesarean sections and other unnecessary interventions, allowing women to experience the experience of pregnancy, childbirth and birth with safety and dignity.¹

However, the term obstetric violence is defined as any conduct, act or omission performed by health professionals, both in a public and private institution that, directly or indirectly, leads to the misappropriation of women's bodily and reproductive processes. It is expressed in inhuman treatment for negligence in assistance, social discrimination, verbal violence (rude treatment, threats, reprimands, screams, intentional humiliation), physical violence (including not using analgesic medication when technically indicated), sexual abuse and psychological violence. It also occurs in the inappropriate use of technologies, interventions and unnecessary procedures in the face of scientific evidence, resulting in a cascade of interventions with potential risks and consequences for the health of the woman and / or her child.⁸

Thus, the results obtained through the interviews indicate a superficial understanding of nurses in primary health care about obstetric violence and the practices that are considered, as observed in the statements:

It is everything that deviates from the normality expected in cycles, right! For example: physical violence or in a gynecological/obstetric examination she feels that she

has been assaulted or mistreated, both in physical examination and in emotional and psychological matters. [...] (E2)

Well, there's a lot. There is that grosser violence, but there is one that I even witnessed with the question of saying " ah, when it was time to do it, it was easy " or " he went in, now he has to leave ". The pregnant woman does not deserve it and cannot hear it. In addition, letting a delivery go through and extending too much for not wanting it to happen on your shift and let this pregnant woman evolve until she doesn't give anymore and the baby goes into suffering. [...] (E3)

The use of forceps has already fallen to the ground and was not seen like that, but nowadays it has changed a lot. Verbal violence at the time of childbirth with the parturient and psychological violence are also examples. I see obstetric violence as the lack of conditions during childbirth and humanization as violence, as it was supposed to be such a beautiful moment and it becomes such a sad and ugly moment. (E5)

I think it is when the mother does not want a normal delivery and is disrespected. At the time of delivery, some trauma such as climbing on the mother. It often rises on top of the mother's belly to help expel the baby and not welcome this mother properly during this delivery. (E7)

In addition, a discourse on the definition of mistaken obstetric violence was identified, the discourse being more relevant for cases of violence against women in the general context, as can be seen:

So, I think obstetric violence is extremely important and it must be addressed in all consultations,

both obstetrics and family planning consultations. Some maneuvers that I know as obstetric violence are: physical aggression, psychological aggression, domestic aggression that this happens a lot. Another thing that I think encompasses obstetric violence is domestic violence, where single women who already have children, usually their partners do not take over and they are very fragile. So this is obstetric violence. I observe this a lot during prenatal consultations and throughout labor. Loneliness during prenatal and childbirth makes the woman feel very fragile. (E4)

However, only one nurse was able to reproduce a broader concept on the topic:

Obstetric violence is all forms of inducing childbirth in which the woman's interest and will are neglected, disrespected or not allowed. There we have the episiotomy without verbalizing, the sterilization without verbalizing, inducing the patient to deliver faster or with a surgical approach when she is physiologically able to have a normal delivery, or also, when the woman is not even aware of her rights. (E6)

That said, the personal and institutional barriers that members of the nursing team face prevent qualified assistance. This fact highlights the need for a better investment not only in training, but also in the permanent qualification of these professionals, as well as in the reorganization of services so that assistance protocols are incorporated in order to improve the quality of service to the target population.⁵

Thus, the qualification of the professionals responsible for the care of pregnant women and the actions developed by them in prenatal care is a way of un-

derstanding institutional practice, as well as highlighting the need for strategies that favor the effective participation of professional nurses in obstetric care.⁵

Thus, keeping in mind that the approach to pregnant women offered in primary health care is able to offer greater professional contact, the beginning of a new phase of learning and the formation of a bond, it is essential that nurses receive and reassure this patient in the best way, solving her doubts, presenting her rights as a woman and pregnant woman in order to make these prenatal consultations a welcoming and pleasant environment for the patient.⁹

As for the misunderstanding evidenced by the definition of obstetric violence, it can be understood that violence against women can be characterized as any action or omission based on gender that causes death, injury, physical, sexual or psychological suffering and moral or patrimonial damage to women, and it can be practiced by people, with or without family ties, who are or consider themselves related, united by natural ties, by affinity or by express will, including those sporadically aggregated.¹⁰

However, when it comes to obstetric violence, this is understood as a specific form of gender violence, since there is an arbitrary use of knowledge by health professionals to control the bodies and sexuality of parturient women. It consists of an expression that groups the forms of violence and damage originated in professional obstetric care, fitting in this concept, all the acts practiced on the body of the woman and the newborn without the proper consent or information provided to the patient.¹¹

In this perspective, health education is fundamental both for the practice of sharing experiences and for creating the professional-patient bond. Teaching is not simply the transfer of certain knowledge, but it is possible to build it through trust and strengthening of relationships.⁸⁻⁹

Thus, health education becomes an instrument that allows pregnant women

to expose their possible doubts and questions aiming at reducing uncertainties through health guidelines, also enabling the construction of autonomy during pregnancy and contributing to the promotion of their empowerment.⁹⁻¹⁰

That said, one interviewee reported that at the UBS where he develops his professional activities, meetings for pregnant women are held from time to time where they seek to address the issue more clearly and easily understandable for women to better understand the subject. In addition, the professional encompasses other types of violence and believes that it influences the life of the pregnant woman and how she will conduct this pregnancy, as seen:

We also addressed this issue in lectures. When we give lectures to pregnant women from risk groups, they are our biggest target audience, addressing this issue within risk groups where there is a greater weakness. (E4)

Over the three trimesters that make up the gestational period, the changes suffered by women trigger feelings of fear, insecurity, and anxiety arising from expectations related to concerns about pregnancy, childbirth, the puerperium and the care of the newborn. Having knowledge of the vulnerability that many women may be subject to at this stage of their lives, usually related to unsafe information, health education for pregnant women is essential in an attempt to reduce the negative repercussions of fragility in the face of doubts and apprehensions that may be submitted.⁹

Therefore, the creation of educational groups for pregnant women is an essential strategy for the promotion of maternal and child health, since it can grant these women empowerment, in order to provide the development of their own strategies through active reflection. that reinforces the importance of prenatal care and prepares them to manage the care

of their health and that of the newborn through their insertion in a welcoming environment that has the necessary resources to facilitate learning.^{9,11}

However, it was identified through the testimonies deficiency on the subject, in addition to difficulties in making this approach more understandable for pregnant women, as observed:

I believe that we need some work more focused on this, for even the professionals to approach this with the pregnant woman in a clearer way, so that they know what it is, and so that they can report or complain, seek help. I feel that I have a deficiency in relation to knowledge about this issue of obstetric violence to identify the clearest and most appropriate way to approach this issue. Even in my education, I don't remember that we dealt with this topic a lot and, specifically, obstetric violence, we don't deal with this term with pregnant women, even because I don't remember using that term in college. (E1)

Based on this, the training of nurses, according to the National Curriculum Guidelines (Diretrizes Curriculares Nacionais - DCN), is generalist and should provide knowledge, skills and attitudes to meet the person's health needs, considering local regional indicators within the scope of the Unified Health System (Sistema Único de Saúde - SUS) to act in several areas and health services, in a critical, reflective and ethical manner. 12 In this perspective, the World Health Organization (WHO), the Pan American Health Organization (PAHO) and the Ministry of Health have been emphasizing the area of women's health in order to reduce maternal and neonatal morbidity and mortality rates, and thus, expand the performance of the nursing team to achieve qualified assistance in the pregnant-puerperal cycle.⁵

That said, in this area there is an opportunity to act as an educating agent who, in order to empower, needs to know its population and context. Thus, identifying these characteristics of childbirth and birth assistance in parturient women is a way of indicating necessary actions so that childbirth and birth are anchored in the human rights of women who are cared for in the public health system.⁴

However, it is clear from the statements that nurses, despite having a certain understanding of obstetric violence and having addressed some possible consequences for women, report that they are favorable to the practice of practices considered abusive and violent in certain situations during labor, as can be seen:

I believe that excessive or abrupt touch and without guiding the patient, what will be done is violence [...]. However, in urgent cases I think it is valid to use everything for the patient. (E2)

In urgent cases, I think the practice of some maneuver considered obstetric violence is valid, for example the episiotomy. Now, you have to assess the need. (E3) Episiotomy if necessary, you have to do it, understand? I'm not a nurse who thinks she has to obey this whole humanized delivery thing. Episiotomy ... there comes a time that you have to do, that is necessary. I think it helps a lot, even if afterwards she may feel a little more pain from the surgery and the stitches and everything, but the episiotomy for the baby's passage is very important when the expulsion is difficult. I'm in favor and I don't think it's violence, no. (E4)

In cases of urgency, if that urgency is perceived as a risk to the mother or the child or both, I believe that maneuvers considered obstetric violence are valid, as the principle of beneficence and non-

-maleficence must prevail, I think not it may be the rule. (E6)

I think the use of some maneuver considered obstetric violence in a moment of urgency is valid, after the baby has docked and cannot get out. You will have to do it, otherwise you have to assess the risk and benefit, both for the child and the mother. (E7)

In addition, there was a report by a professional that in cases where the woman says she is a victim of obstetric violence, a rigorous investigation is needed to find out if there really was violence or if there are personal interests on the part of the woman, as noted below:

As its [obstetric violence] started to be more publicized and investigated, sometimes it may have given a superlative value to that because sometimes there may be a patient who did not have obstetric violence, but she wants to cause a fact that occurs to make gains secondary. So, I think it has to be investigated very well when a complaint is made and the facts are ascertained. I don't think violence at any time is valid and if it is violence, even in urgent cases, it should not be used in any case. (E5)

However, there was a report by a nurse addressing that even in emergency situations, this situation should not be used to carry out practices considered obstetric violence:

I think that in an emergency, everything that is possible for you and the patient to get out of the emergency situation should be used, but the use of violence is not justified in any case. At first, violence doesn't save, right? (E5)

In obstetric practice in Brazil, as in other countries, childbirth assistance is still typi-

cally organized as an assembly line, where the woman goes through different locations according to the stages of her labor, which ends up interfering in the physiology and in the development of the delivery process.¹³ However, the practice based on scientific evidence consists of using the best available results from methodologically consistent studies in national and international literature to guide clinical decision in health care. In Brazil, the evidence-based practice movement is better grounded in medicine, and in the area of nursing it is still in the ascension phase.¹⁴

Thus, the use of scientific evidence, in the obstetric and perinatal area, has been standing out in Brazil and in the world, due to the need to modify the childbirth care paradigm, which still uses mainly the previous experience of professionals and non-updated

books. In addition, there are numerous movements, mainly on the part of obstetric nursing, so that the best scientific evidence is used in the provision of care to women and the newborn.¹⁴

Therefore, the violence perpetrated on female bodies violates universal human rights categories, violating a series of prerogatives ensured by the Brazilian State, such as: the dignity of the human person, equality, health, the principle of legality and even the protection of motherhood and childhood.¹¹

CONCLUSION

The results of this study reveal that the understanding of nurses in primary health care about obstetric violence is fragile, and its approach is carried out in an incipient way. In addition, it was also identi-

fied that professionals are unprepared on the subject so that there is a good source of information for pregnant women during prenatal care.

In view of this, it is necessary that knowledge about the theme should be part of the nurses' daily understanding, in addition, health education tends to address issues unknown to this population and, thus, inform them about the rights that should be respected at any time within the scope of its service.

With regard to the limitations of the study, it is believed that it is related to the performance of the study in only two UBS, since the expansion to other health units could provide an expanded analysis on the theme. Thus, new research with the theme is suggested to understand the context of nurses' performance in the PHC context on obstetric violence. 🐦

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