ORIGINAL ARTICLE

REVISTA ENFERMAGEM ATUAL IN DERME

THE PERCEPTION OF OBSTETRIC VIOLENCE BY OBSTETRIC NURSING RESIDENTS IN THE NORTHERN REGION

PERCEPCIÓN DE LA VIOLENCIA OBSTÉTRICA POR LOS RESIDENTES DE ENFERMERÍA OBSTÉTRICA DE LA REGIÓN NORTE

A PERCEPÇÃO DA VIOLÊNCIA OBSTÉTRICA PELOS ENFERMEIROS RESIDENTES DA ENFERMAGEM OBSTÉTRICA NA REGIÃO NORTE

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Submission: 05-02-2024
Approval: 30-12-2024

RESUMO
Objetivo: compreender a percepção dos residentes de Enfermagem Obstétrica sobre a violência obstétrica. **Métodos:** trata-se de um estudo do tipo descritivo exploratório, com abordagem qualitativa realizado com residentes de enfermagem obstétrica através de entrevista semiestruturada. As entrevistas foram transcritas na íntegra, e foram realizados o tratamento e análise dos dados. Em seguida foram estabelecidas três categorias: 1) Os significados da violência obstétrica em/na enfermagem; 2) O processo de trabalho da enfermagem obstétrica e as barreiras para o combate da violência; 3) A formação da enfermagem obstétrica: elo para mudança da violência obstétrica. **Resultados:** observa-se que a maioria dos residentes reconhecem a violência obstétrica e sabem como reduzir as práticas violentas nos cenários em que atuam, entretanto, a falta de autonomia e a falta de aceitação de mudança quanto as práticas por parte dos profissionais, se torna um obstáculo para esse combate à violência. **Conclusão:** o estudo proporcionou explorar os significados dos residentes sobre a violência obstétrica, além de destacar a importância da mesma, visto que é a ciência que prioriza o acolhimento, respeito à vontade da mulher e a educação em saúde, ferramentas que são imprescindíveis para o combate e mudança do atual modelo.
Palavras-chave: Violência Contra a Mulher; Internato e Residência; Obstetrícia; Humanização da Assistência.

ABSTRACT
Aim: to understand obstetric nursing residents' perceptions of obstetric violence. **Methods:** this is a descriptive exploratory study, with a qualitative approach, carried out with obstetric nursing residents through semi-structured interviews. The interviews were transcribed in full and the data was processed and analyzed. Three categories were then established: 1) The meanings of obstetric violence in nursing; 2) The obstetric nursing work process and the barriers to combating violence; 3) Obstetric nursing training: a link to changing obstetric violence. **Results:** most residents recognize obstetric violence and know how to reduce violent practices in the settings in which they work; however, the lack of autonomy and the lack of acceptance by professionals to change their practices are obstacles to combating violence. **Conclusion:** the study allowed us to explore the residents' meanings about obstetric violence, as well as highlighting its importance, since it is the science that prioritizes welcoming women, respecting their wishes and health education, tools that are essential for combating and changing the current model.
Keywords: Violence Against Women; Internship and Residency; Obstetrics; Humanization of Care**.**

RESUMEN
Objetivo: conocer la percepción de las residentes de enfermería obstétrica sobre la violencia obstétrica. **Método:** se trata de un estudio exploratorio descriptivo con enfoque cualitativo, realizado con residentes de enfermería obstétrica mediante entrevistas semiestructuradas. Las entrevistas fueron transcritas en su totalidad y los datos fueron procesados y analizados. Se establecieron tres categorías: 1) Los significados de la violencia obstétrica en la enfermería; 2) El proceso de trabajo de la enfermería obstétrica y las barreras para combatir la violencia; 3) La formación de la enfermería obstétrica: un vínculo para cambiar la violencia obstétrica. **Resultados:** la mayoría de los residentes reconocen la violencia obstétrica y saben cómo reducir las prácticas violentas en los ámbitos en los que trabajan; sin embargo, la falta de autonomía de los profesionales y de aceptación de cambios en las prácticas es un obstáculo para combatir la violencia. **Conclusión:** el estudio permitió explorar los significados que los residentes tienen de la violencia obstétrica, además de resaltar su importancia, ya que es la ciencia que prioriza la acogida a la mujer, el respeto a sus deseos y la educación en salud, herramientas esenciales para combatir y cambiar el modelo actual.
Palabras clave: Violencia Contra la Mujer; Internado y Residencia; Obstetricia; Humanización de los Cuidados**.**

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INTRODUCTION

The process of childbirth and birth has undergone significant changes over the years, especially in terms of care. In Brazil, from the end of the 19th century, when medicine began to expand the process of medicalizing childbirth and birth, there was a process that related differences in the types of care given to pregnant women without financial resources and more marginalized by society. These women, in most cases, had little access to medical and hospital care, in addition to the superior control of the patriarchy, which made all decisions regarding the woman's body, the number of children she would have, whether or not she would get pregnant, and other factors that made women even more submissive to men[1,2].

With the repercussion of feminist movements, Obstetric Violence (OV) began to be recognized by society in general. In Brazil, the term obstetric violence has been used in the country to refer to the concept of Disrespect and Abuse During Childbirth. This term was recommended to identify any act of violence directed at women during pregnancy, during and after childbirth or at their babies, carried out by professional care providers as well as by the health institution's protocol rules and routines. This significantly disrespects their autonomy, physical, psychological and moral integrity, their feelings, their options and preferences during the pregnancy-puerperal cycle[3].

In this context, nursing professionals must encourage and support women in their choices, both regarding the type of childbirth and their right not to be violated by unnecessary techniques and maneuvers (such as the Kristeller, episiotomy, guided pushing, among others), to be accompanied by a person of their choice throughout the pre-labor, labor and post-partum period and to have information about the procedures to be performed, only with their authorization when there is no risk to their lives[4].

According to the World Health Organization (WHO)[5], every woman has the right to a respectful, welcoming birth, maintaining dignity, privacy and confidentiality, with the guarantee of the absence of any harm or mistreatment. Furthermore, among the practices not recommended are: the routine use of episiotomy, trichotomy, enemas, routine oxytocin, among others. Thus, through the initiative to update the professionals working in the field, the aim is to change these practices that are harmful to women's health to humanized practices that respect the physiology of childbirth.

Residencies began with Law No. 11,129, of June 30, 2005, which instituted residencies in the professional health area and created the National Commission for Multiprofessional Residency in Health within the scope of the Ministry of Education (MEC). This action allowed the residency modality to be accepted as a lato sensu postgraduate degree[6].

The program aims to train future obstetric nurses to be included in the Unified Health

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System (SUS). At the end of the program, professionals who enter the program will be able to work from prenatal and delivery to birth and postpartum care, as recommended by the Rede Cegonha, which was renamed in 2024 as Rede Alyne Pimentel. The strategy created aims to reinforce comprehensive and humanized health care for women and children, from reproductive planning, through confirmation of pregnancy, safe delivery and birth, puerperium, up to the second year of the child's life with attention to growth and development[6-7].

Combating and reducing violence should focus on the humanization process in health institutions, with the participation of obstetric nurses (OBs), respecting the physiology of childbirth. In a cross-sectional study conducted by OB residents, it was observed that factors such as: free diet, freedom of movement, presence of a companion and use of non-pharmacological methods for pain relief are more frequently used when childbirth is assisted by an obstetric nurse[8]. Thus, proving that these are the professionals who prioritize humanization and respect for physiology in their practices.

It is understood that the perception of OB residents regarding the definitions of “obstetric violence” directly influences the way in which care is provided to women, since they are professionals who are being inserted into the service to provide care. In view of this, investigating their perception is of utmost importance so that, based on an understanding of the problem, conduct is based solely on evidence and they become agents of change in the current obstetric scenario, influencing professionals already working in the area, changing practices that are no longer recommended based on current research.

Therefore, the objective of the study is to understand the perception of Obstetric Nursing residents about obstetric violence.

METHODS

This is an exploratory descriptive study with a qualitative approach, carried out in the obstetric nursing residency program of a higher education institution in the state of Pará.

The study participants were twenty-three (23) nurses who were residents in obstetric nursing in the 1st and 2nd years of the program. Contact was made via messaging application, by invitation, and those who accepted were subject to the following eligibility criteria: 1) being a nurse; 2) being enrolled in the obstetric nursing residency at the Federal University of Pará. The exclusion criteria were: residents on leave or on vacation during data collection.

After this process, data collection was scheduled for the theoretical class period of the residency, which takes place on Monday, between June and September 2023, using a semi-structured script, with open and closed questions related to the residents' profile regarding gender, age, religion, undergraduate

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training institution, and year of graduation. The semi-structured interview script consisted of basic questions about the residents' profile and questions about their perception of obstetric violence in the field of labor and birth. In other words, the interview was developed in order to allow the spontaneous evolution of the participant's thoughts.

All 23 nurses approached agreed to participate in the interview, thus achieving 100% acceptance of the nurses approached. The interviews were conducted in a quiet and private place, in order to avoid embarrassment, with an average duration of 30 minutes each. The interview was conducted using a digital device, with the prior consent of each interviewee, in order to preserve the reliability of their respective statements.

The recordings of the statements were transcribed in full by the main researcher, to ensure the reliability of what the residents reported. These recordings and the respective texts will be stored for a period of five years, under the responsibility of the researcher, and after this period, they will be deleted, as provided for in Resolution No. 466/12 of the National Health Council.

Therefore, the content analysis was performed in the thematic modality, the organization of the analysis is formed by three stages: 1) pre-analysis, 2) exploration of the material and 3) treatment of the results, inference and interpretation[9].

The data were ordered, with the interviews transcribed in full. A floating reading and grouping were carried out, subjecting them to detailed and exhaustive analysis, comparing them with the scientific literature. In the background, the analysis units (units of meaning - MU) were selected, emerging through their frequency (repetition of meanings). Finally, in the last phase of the analytical process, the identification of the units of meaning made possible the last stage of the analysis, the categorization of the constructive elements and the regrouping of the meanings, based on the non-a priori categorization, which emerged in the context of the participants' responses, which supported the construction of the categories[9].

Through the processing of the results, the inference and interpretation allowed the identification of the units of meaning, the categorization of the elements and the regrouping of meanings, with the elaboration of the following categories: 1) The meanings of obstetric violence in/in nursing; 2) The work process of obstetric nursing and the barriers to combating violence; 3) The training of obstetric nursing: a link for changing obstetric violence.

The research was approved by the Ethics and Research Committee of the Institute of Health Sciences of the Federal University of Pará, according to protocol 5,739,983/2022, CAAE: 63246522.9.0000.0018, as recommended by Resolution No. 466 of December 12, 2012 of the National Health

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Council, which determines the Guidelines and Regulatory Standards for Research involving human beings.

During the data collection technique, the Free and Informed Consent Form was signed, a term that shows the agreement to participate in the research. Emphasizing the clarification on the theme; objectives, data collection, techniques and data analysis, such as risks, benefits and other subjects related to the research. To ensure privacy and confidentiality regarding the collected data, the participants were identified by the letter R (resident), followed by Arabic numerals (R1, R2, R3, ..., R23) to mention the research participants.

RESULTS

Among the research participants, 20 were female and 3 were male; in terms of age, 15 people were predominantly in the age range of 23 < 25 years, 6 were between 26 < 28 years and 2 were between 33 < 38 years. Regarding the training of the professionals, 15 were from public institutions and 8 from private institutions; according to the years of training, 12 people had 2 to 3 years of training and 11 people had 1 year of training.

The meanings of obstetric violence in/in nursing

The meanings of nurses resident in obstetric nursing with the relationship of obstetric violence in the fields of practice in which they work, express a situation arising from the pregnancy-puerperal cycle, configuring attitudes sustained by violence in pre-conception, prenatal, childbirth, puerperium and abortion care:

> *For me, obstetric violence is everything we do with or without the intention of harming a pregnant patient [...] for example: not providing quality care, not providing the information that the patient needs, whether during prenatal care or during the first consultation at the hospital or at a referral unit. (R3)*

> *I think it is any type of violation that steals, takes away or neglects the woman's right to have complete care during her pregnancy-puerperal period and even in the period before conception, when that woman is trying to get pregnant. I also believe that there may be moments of violence in this preconception care, in family planning and anything that makes her feel violated, embarrassed, coerced [...] (R10)*

The meanings of residents in EO provide the formulation of training strategies and also for professional practice, with new professionals in the job market.

Obstetric violence occurs through a direct relationship with the work context of health professionals, often enabling discrimination, neglect of care, and verbal violence against women:

> *Neglecting the pain that the patient is feeling, not only that,*

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> *but also phrases like: "Oh, you can handle it, when it was time to do it you didn't cry, you didn't scream" "Oh, that's normal, this pain is normal" and: "you have to relax" (R6)*

> *I see a lot of violence in the way patients are treated, in the way they are welcomed, in the way they talk. I'm just coming from an obstetric emergency room and we see some professionals, right, in the obstetrics area, not having the slightest tact when talking to women and being rude when dealing with them (R2)*

Obstetric violence, one of its nuances, goes beyond the physical component, but also in the psychological, sexual, institutional and structural fields:

> *For me, obstetric violence is the opposite of humanization, so these are acts by professionals that can harm both the woman and the baby, which is also the case of obstetric violence, right? Violence would be another issue, in the case of women during childbirth... so I think these are acts that the team may have made mistakes in, they can harm the woman in many ways, both physically and emotionally, as well as psychologically, and also the family, not just the woman because I think this greatly influences her support network (R4)*

> *This ends up being a type of violence, because you end up invading the woman's privacy, for example, entering a PPP room with ten students, this is very common, so I think that just the fact that it is full of students and residents is already a type of obstetric violence (R8)*

Residents mention that obstetric violence is established beyond physical violence, but also psychological, sexual, institutional and structural violence, which is established in professional practice and also in institutional regulations. These norms and practices sustain a violence that becomes veiled in the obstetric environment.

Violence is also expressed in obstetric nursing residents, suggestive of the work process of medical professionals and nurses, with obstetric interventions, such as episiotomy, Kristeller maneuver, excessive touching, routine use of oxytocin or without the consent of the parturient, with the intention of speeding up labor, and not acting in accordance with the physiology of labor, acting according to their ideological condition:

> *Performing a vaginal exam without informing her that you are going to do it, touching the woman's belly without telling her that you are going to do it, asking her to push without her actually being in active labor and having the need to perform an episiotomy (R16)*

> *Prohibiting the companion from choosing the pregnant woman's episiotomy, not providing analgesia when she asks for it, or preventing the pregnant woman from moving during labor, is the separation of mother and baby, not waiting for skin contact. (R23)*

The denial of women's rights to an active birth, their rights to a positive and successful experience, such as the free birth

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position; the expression of their feelings arising from birth; the separation of the newborn after birth due to protocol routines, meanings that permeate obstetric violence:

> *The birth position, when it is a birth assisted by nurses, you see the woman's freedom, but when it is a birth assisted by the medical team or by some other obstetricians, you see that gynecological position being imposed there, because it is easier for the professional, it is more comfortable. (R12)*

> *Preventing the woman from changing position, from expressing what she is feeling, right, even crying, asking her to be quiet, neglecting support, asking her to drink water, asking her to move, I think it is also like giving dirty looks, all of that. (R13)*

The speeches of resident nurses in obstetrics affirm the existence of obstetric violence in their daily lives in the fields of practice in which they work, with violence caused by professional practice:

> *During labor itself, we end up seeing some situations where the woman has no choice about what she wants to do during labor, sometimes because she didn't have this information during prenatal care, right? But sometimes we see that the way it's happening ends up being more comfortable for the professional, right? And some other situations (R2)*

> *Look, the biggest one I see every day, but sometimes I end up doing it too, but it's very difficult, I think I try to control myself a lot [...] it's that finger being placed on the perineum, like that, that circular movement to help the baby come, right? Both the doctor and the nurses (R7)*

The obstetric nursing work process and barriers to combating violence

Among the factors that hinder the integration of more humanized care are the lack of interest in professional development, conservatism and the lack of acceptance by health professionals of violent practices, according to the statements:

> *The lack of updating of the team, lack of updating of management, lack of updating of protocols, lack of updating of the multidisciplinary team and the lack of information for patients, not that there is no information, but the lack of information from professionals to patients. (R3)*

> *I think that one of the biggest obstacles is those professionals who have been in the service for a long time and they end up not updating themselves or developing professional vices, you know, and many times they fail to realize that a certain practice is no longer accepted, it is no longer necessary, you know (R20)*

The precariousness of prenatal services with the lack of access to information for pregnant women about obstetric violence, making them vulnerable during labor and birth.

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> *I believe that prenatal care is not effective, which is prenatal care where we will clear up all of the woman's doubts, where we will present all of these situations to her, professionals who also do not try to see the woman from a more humanized perspective, it is a more humanized culture in relation to this, I think mainly these, the issue of primary care even during prenatal care, of exposing the woman to this entire situation (R15)*

Pregnant women's lack of knowledge about obstetric violence, leading to greater professional hierarchy and overlapping knowledge, contributes to a more vertical relationship and power relations originating from the health professional with the woman, according to the statements:

> *First, I think that the lack of knowledge of patients, pregnant women, and their companions about what obstetric violence is, sometimes women have their rights suppressed, they are disrespected, but they don't know that they are being disrespected, they are vulnerable at that moment (R19)*

Impunity and the lack of laws that protect women during pregnancy are some of the most challenging barriers to ensuring an end to obstetric violence. A tangible solution is to encourage reporting to ombudsmen, which would ensure greater transparency in cases of violence, according to the following testimonies:

> *If there is punishment, the truth is that these practices still exist today because there is a feeling of impunity, it doesn't matter if the woman is suffering with what she is going through, this is part of normal labor, women are going through obstetric violence and they think that this is part of the job and it is not part of labor because in fact it is a system that sometimes leaves women intentionally uninformed, we end up seeing this type of situation a lot due to the misinformation itself (R2)*

> *A document actually supporting each conduct that was carried out and the justification for better monitoring (R16)*

The educational process, with pregnant women receiving health education, becomes an important strategy for confronting obstetric violence and disseminating knowledge through shared exchanges and dialogue between the professional and the woman. This fact contributes to the woman being informed and empowered regarding her rights for safe and successful care.

> *I think that from prenatal care onwards, we should inform the woman, inform the family, always try to encourage the partner to go to prenatal care, inform them about violence, what acts of obstetric violence are and prepare them (R4)*

Obstetric nursing training: a link to change obstetric violence

The need to discuss obstetric violence should begin in educational processes at

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universities. The academic environment should initiate this field of discussion to encourage reflection and a new meaning for the situations experienced by women and a new meaning for the work process. However, undergraduate education has not yet focused on important topics, such as obstetric violence, to promote a broader discussion. This debate often occurs in specialization courses, based on daily experiences in the care setting:

> *I think that in undergraduate studies, in academia, there is a huge weakness in showing, offering, enabling a more critical education, so that the subjects are addressed more. (R21)*

The limitation of the autonomy of residents and the power exercised within spaces of authority, such as maternity wards, this process encourages inertia, but it does not completely impede the professional's actions:

> *We don't have much autonomy in relation to this and when we see an intervention that would be violence and do something at the time, we just reflect on it, but at the time we can't do it because they don't give us the autonomy to intervene, sometimes even a patient that we are taking care of then another professional comes in and starts to intervene, so we don't have much autonomy in relation to this. (R9)*

> *I think the biggest one for me was the one I came across, the fact that we don't have an active voice in the team to be able to lead, this is wrong, we feel like we are interns, undergraduates, students still in college because we can't position ourselves as professionals (R10)*

> *We can't do much because we are residents and don't actually work in that field. We arrive and do it, if we question a practice it is as if it were an offense to them [...] we do not have freedom of action, we do according to what our preceptor thinks is correct, when we change preceptors it is a different attitude, we have to adapt according to the preceptor (R1)*

The turnover in the practice areas of resident nurses becomes an obstacle to team acceptance, in a short period, favoring hierarchy and professional blockage:

> *Whether the resident likes it or not, he is like a visitor to the workplace. My connection is not with the institution I am at, my connection is with UFPA, so as a resident I don't have much to do (R2)*

> *Look, it's the hierarchy, the higher-ups are in charge and those of us at the bottom of the pyramid can't do anything, so we can't go against the preceptor because we could end up being harmed in our evaluation or in the time we spend in that sector (R7)*

Among the benefits of residency for EO training are the recovery of women's protagonism and autonomy within health services. Therefore, encouraging humanized practices based on scientific evidence reduces the chances of violent practices in the maternity

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ward environment, according to the testimonies:

> *I think that the training of obstetric nurses is based on this, on a non-interventionist, more humanized technique (R9)*

> *Nursing has indeed been a pioneer in this issue of changing childbirth care, bringing a more humanized, more individualized perspective to that woman (R10)*

Constant updating provides both the resident who is constantly learning and the service with professional updating, new knowledge and integration with the team through continuing education, as per the testimonials:

> *As residents, we have this autonomy to carry out health education practices, right, with the team, so we bring new resources, so we are actually new people on the team, so we can bring new resources, new studies, and update ourselves because we are building our knowledge, so I think that through health education (R4)*

> *When we encourage residents through these debates and through discussion groups, case studies, things that happened in other care settings, we broaden the resident's perspective, right, and make them part of the system and change that reality (R17)*

DISCUSSION

Obstetric violence is a consequence of not belonging to one's own body and the phenomena related to it. From this intervention, the woman feels objectified, submissive to professional knowledge, disrespecting the physiological process, thus removing her protagonism during pregnancy, childbirth and puerperium[10].

For resident nurses, its meanings go beyond obstetric violence, mainly during childbirth. These meanings trigger the importance of discussing the topic in training, and thus enhance changes for the practice of new professionals in the job market. Thus, a professional aligned with healthy practices, based on scientific evidence, respect and humanization, has a positive impact on the quality of care.

Regarding knowledge about obstetric violence, it was reported that it encompasses all assistance and disrespect for women during abortion, showing that it is not a practice restricted to interventions that promote a lack of care for women, disrespecting and promoting numerous situations, behaviors and practices characterized as obstetric violence. The humanization of the entire process of pregnancy, childbirth, puerperium and even abortion must be respected and the will and protagonism of the woman must always prevail, since it is a unique moment that will be marked in the memory, whether through positive or negative assistance, and thus, it must be experienced in a more respectful and humane manner.

Among the factors to be considered in obstetric violence, it includes the entire

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pregnancy-puerperal cycle, encompassing the entire pregnancy, childbirth and puerperium, in addition to abortion. In a survey conducted with residents, obstetric violence can be defined as physical, psychological and verbal mistreatment, or even as unnecessary interventionist practices[11], which provides similar data regarding the topic of obstetric violence. It originates from the moment that the professional does not respect the woman's wishes and decisions, in addition to not prioritizing the physiological process of pregnancy, childbirth and puerperium.

The main characteristic of obstetric violence is that it is practiced by health professionals, manifesting itself through inhumane treatment and the abuse of medicalization of care, pathologizing natural reproductive processes of the female organism[12]. This is reflected in the services currently provided to women and their meanings on the care and process of the entire pregnancy-puerperal cycle, since many have already understood and expect this process of violence to be modified, resulting in the care of health institutions.

Regarding the interventions present in the practices of resident nurses, it was possible to observe the presence of episiotomy in most reports. This practice is still very common in maternity hospitals, despite the fact that there is already scientific evidence proving that it is not necessary for routine use. On the other hand, in births assisted by obstetric nurses, it is already possible to observe the reduction or eradication of this intervention to provide assistance during childbirth.

Episiotomy is one of the most frequent causes of maternal morbidity in the puerperium, since it exposes women to increased blood loss (hemorrhage), risk of infection, sexual dysfunction such as dyspareunia, urinary incontinence, vaginal prolapse, among other changes when compared to other types of perineal trauma[13].

One of the main challenges reported by resident nurses regarding coping with obstetric violence is the lack of acceptance of change by professionals. The denial of the need for professional updating and conservatism make the path to change more challenging. Education alone is not effective in changing unnecessary practices. This goes beyond knowledge, but involves the ideas of each health professional and their worldview, in order to ensure a form of obstetric care.

In this way, a professional can obtain positive knowledge in their training or even in continuing education in health, but still carry out unnecessary practices, since there is no due involvement and respect for women and for the quality of care. It is increasingly necessary for women and professionals to be active in confronting disrespectful behaviors that are not aligned with a positive birth. After all, even recognizing obstetric violence does not lead to change, so alignment with the issue and with the care of women allows professionals to be

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committed to their duty and mission to provide respectful and quality care[16].

In this sense, an important point is to recognize the autonomy of women, with the field of power. This recognition is crucial for daily changes in the work and care process within the scope of labor and birth.

In a study conducted with 20 obstetric nurses, it was possible to observe that one of the obstacles to improving obstetric care was the lack of interest and professional updating, including the absence of techniques and practices for caring for women. The lack of professional preparation makes obstetric care based on assumptions and outdated training, postponing the change in the obstetric scenario. In view of this, there is an undoubted need for professional training, based on training, workshops and lectures to improve care for women[14].

In view of this, it is possible to understand the need for Continuing Education in Health (PEH) in order to put into practice the objectives of transformation and redefinition of obstetric practice, as determined by the Alyne Pimentel Network. They also mention that PEH promotes the autonomy of nurses in their practice, since this training has a direct impact on professional improvement and the quality of care provided to SUS users[15].

To provide education with the aim of providing women and their families with prior knowledge about obstetric violence, in order to educate them about the stages of labor, pain, non-pharmacological methods, and practices that are no longer recommended for childbirth and postpartum care[16]. The birth plan is a crucial tool for prenatal health education. It is a document that aims to guarantee women's rights and express their wishes and desires at the time of childbirth, preserving their protagonism.

Through the residents' meanings, it was possible to observe that professional training currently still needs to advance. Most resident nurses reported and observed that approaches to obstetric violence, especially in undergraduate courses, are insufficient. Few had access to the topic in the academic environment. Regarding specialization through residency in obstetric nursing, some reported access through informal debates in practice institutions, but this knowledge is still not widely disseminated in specialization. Among the reports, some stated that they sought this knowledge through improvement courses and conferences that addressed the topic.

Among the challenges of residency in combating obstetric violence, all of the nurses interviewed reported the lack of autonomy as the main obstacle to professional action in the face of a situation of violence, making it difficult to position themselves in the face of situations experienced in the fields of practice.

The residency in obstetric nursing provides the opportunity for nurses to work in several fields, from primary care with prenatal care, medium complexity in high-risk prenatal

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care, and tertiary care in hospitals with care for women during labor, birth and puerperium and care for newborns, thus ensuring comprehensive care and monitoring[16].

This highlights the importance of obstetric nursing in combating violence, from health education measures in prenatal care to childbirth care, using non-interventionist measures, respecting the role of women and the physiology of childbirth, empowering them about attitudes and practices that are not recommended, with the aim of reducing harm to them.

FINAL CONSIDERATIONS

Through this study, we can understand the meaning of resident nurses in relation to obstetric violence, the recognition of practices that are not recommended in the training process and their implications for women's health. Nursing acknowledges the practices and techniques used with women in the current obstetric model, which have no scientific basis and are not recommended.

With this, we emphasize that the measures mentioned by the interviewees to confront and combat violence against women in the field of labor and birth range from good prenatal care with educational measures for the pregnant woman, companions, family members and the community in general, to reception in the hospitals and maternity wards of the woman's choice, always with a view to holistic and humanized care, with the woman as the protagonist of her own birth. Therefore, health professionals have an indispensable role in being part of this process as assistants and helpers, available to guarantee the woman's rights throughout the period.

Furthermore, residents mentioned the importance of creating a specific law to protect against violent acts during pregnancy, childbirth and the postpartum period. Although there are already public policies such as the Stork Network and recommendations for good practices, laws on violence against women that legally protect women, offenders who commit such acts do not feel threatened, since women are afraid and apprehensive about reporting the crime because the predominant class that carries out the practices has greater security and protection of their organs, thus making women vulnerable once again in their own bodies. Punishing professionals who commit violent acts against women, from verbal to physical violence, will ensure their rights.

Related to the professional practice of residents, it is of utmost importance to promote greater autonomy within the settings, so that they can be facilitators of humanized care, with the aim of empowering women and assuming their role as a fundamental part of the team. To this end, it is necessary to reorganize the minimum time for each sector, to provide better reception and acceptance by the team's professionals.

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Regarding practices, it was evidenced that residents still observe violent acts, offensive words towards women and the withdrawal of their rights in their fields of practice, such as the prohibition of companions or denial of care in maternity wards, showing that these attitudes still need to change through actions to combat violence.

It was also noted that nursing is fundamental to combat violence, since it is the science based on the humanization of care, where it is currently gaining more space through humanized movements and practices, reception, respect for the woman's wishes and health education are essential to combat and change the current model. In addition to collaborative care with other health professionals, who together have the objective of providing the best care to the mother-child binomial.

Finally, the research allowed us to explore the meanings of obstetric nursing residents about obstetric violence, in addition to highlighting the challenges and its importance for changing the current scenario, since the resident nurse is the future obstetric nurse who will work in institutions with the objective of promoting comprehensive and respectful care for women. Therefore, the importance of training residents from the perspective of obstetric violence is given.

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Support/Thanks: There is no support or thanks

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