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Amplifying voices on obstetric violence: recommendations for advocacy by an obstetric nurse

Ampliando vozes sobre violência obstétrica: recomendações de advocacy para enfermeira(o) obstetra

Expandiendo las voces sobre la violencia obstétrica: recomendaciones para la advocacy por enfermera(o) obstetra

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Abstract

Objectives: Explore women's and the general public's demands to improve the quality of obstetric care. Discuss respondents' suggestions to improve obstetric care, and propose recommendations for nursing advocacy in matters of obstetric violence. **Method:** A multi-site online survey (in three cities in Brazil's southeastern region) hosted by *Opinio* platform exploring the respondents' opinions. Data was analyzed by descriptive statistics and thematic analysis. **Results:** Respondents (n=414) aged 33-37 years (26%), including women (75%) with more than 15 years of schooling, who are married (45%) and with one child (35%), demonstrated a knowledge gap on obstetric violence and women's rights. Newspapers, radio, and television were cited as the main sources of information. Family support was a suggested strategy to deal with obstetric violence. For the renewed praxis, collective education on obstetric care rights (53.1%) and humanized care (38.2%) were suggested to mobilize professional power to consolidate humanization in care. Central analytical themes included situations faced by women and an idealized context of practice. **Conclusion and implications for practice:** Discussion in organizations increases humanization and shared governance. Recommendations proposed for advocacy are consistent with the global perspective of women's health promotion and social leadership.

Keywords: Education, nursing; Health advocacy; Professional competence; Professional practice; Violence against women.

Resumo

Objetivos: explorar as demandas das mulheres, bem como do público em geral, para melhorar a qualidade da assistência obstétrica; discutir as mudanças potenciais sugeridas pelos respondentes para tal prática assistencial. **Método:** pesquisa multicêntrica realizada por meio da plataforma *Opinio*, explorando opiniões dos participantes de três cidades da região Sudeste do Brasil. Tratamento dos dados por estatística descritiva e análise temática. **Resultados:** respondentes (n=414) na faixa etária 33-37 anos (26%), incluindo mulheres (75%) com mais de 15 anos de escolaridade, casadas (45%) e com um filho (35%), revelaram lacuna de conhecimentos sobre a violência obstétrica e os direitos da mulher. Jornal, rádio e televisão são as principais fontes de informação. O enfrentamento da violência obstétrica dar-se-ia por apoio familiar. Para a práxis renovada sugeriu-se a educação coletiva sobre direitos aos cuidados obstétricos (53,1%) e o atendimento humanizado (38,2%) mobilizando o poder profissional para consolidar a humanização. Temas analíticos centrais incluíram situação vivenciada pelas mulheres e contexto idealizado de prática. **Conclusão e Implicações para a prática:** o debate incrementa a humanização e a governança compartilhada. Recomendações propostas para *advocacy* coadunam com a perspectiva global da promoção de saúde das mulheres e liderança social.

Palavras-chave: Advocacia em Saúde; Competência Profissional; Educação em Enfermagem; Prática Profissional; Violência contra a Mulher.

Resumen

Objetivos: explorar las demandas de las mujeres, así como del público en general, para mejorar la calidad de la atención obstétrica; Discutir los posibles cambios sugeridos por los encuestados para esta práctica de cuidado y, Proponer recomendaciones para la promoción por la enfermera en cuestiones de violencia obstétrica. **Método:** investigación multicéntrica realizada a través de la plataforma *Opinio*, explorando las opiniones de los participantes de tres ciudades en el sureste de Brasil. Tratamiento de datos mediante estadísticas descriptivas y análisis temáticos. **Resultados:** demandados (n-414) de 33 a 37 años (26%) incluyendo mujeres (75%) con más de 15 años de escolarización, casado (45%) y con un niño (35%) reveló una brecha de conocimiento sobre la violencia obstétrica y los derechos de las mujeres. El periódico, la radio y la televisión son las principales fuentes de información. La confrontación se basaría en el apoyo de la familia. Para la renovada praxis, se sugirió la educación colectiva sobre los derechos de atención obstétrica (53,1%) y la atención humanizada (38,2%) movilizar el poder profesional para consolidar la humanización. Los temas analíticos centrales incluyeron una situación experimentada por las mujeres y un contexto idealizado de práctica. **Conclusión e implicaciones para la práctica:** el debate aumenta la humanización y la gobernanza compartida. Las recomendaciones propuestas para la promoción son coherentes con la perspectiva mundial de la promoción de la salud y el liderazgo social de las mujeres.

Palabras clave: Competencia Profesional; Defesa de la Salud; Educación en Enfermería; Práctica Profesional; Violencia contra la Mujer.

INTRODUCTION

In the international setting, the nursing profession is facing a unique political moment through global movements such as NurseManifest[1] and Nursing Now[2], which call for greater political activism, following a challenge launched by Canadian nurses for advocacy actions for the health (health advocacy) of populations and for no more than one patient[3]. The repercussion of these movements in Brazil is reflected through the Charter of Brasilia[2], which among its main goals highlights the development of leadership and the dissemination of practices based on nursing scientific evidence. These goals are related to the nurses' active voice and their presence in social spaces receptive to the innovation of practice, professional competence for decision-making, and policy formulation. Altogether, such movements confirm the social relevance of this research in the current political moment, as well as for Brazilian nursing.

The international literature on the nurses' political education in Canada and the United States (in pioneering advocacy in the health of socially marginalized women[4]) indicates that formal education is a unique space in which the political identity of nursing students is defined[5-6]. The incorporation of such curricular content remains inconsistent, as about 91% of American nursing students do not engage in political activism, probably mirroring the political engagement of their teachers[5]. Some teachers seek to instill a sense of political responsibility in the new generation of nurses[7]. We stress that we do not identify evidence concerning curricular content for nursing education that is specifically about advocacy teaching in Brazil.

For the practice of political advocacy, clinical judgment is required to produce change at the individual level, in addition to political skills to collaborate with internal or external stakeholders in the health care sector at the micro-, meso- and macro-organizational levels[4]. In university education, opportunities to identify areas of greatest demand, and therefore to build such a political identity, are numerous. Among them is the protection of women's human rights as a focus on the definition of international policies for aid and techno-scientific cooperation.

The internationalization of education and research offers other possibilities. The solid Brazil-Canada scientific partnership[8] and Canada's Feminist International Assistance Policy[9] for global activities that protect human rights, social inclusion, and equity, served as milestones for an international strengthening of nursing research[10], pursuing the Ryerson Research Chair in Urban Health's activities in the area of violence against women. The research explored themes present in the collective experiences in Brazil regarding the implementation of the Program of Humanization of Prenatal and Childbirth (PHPN)[11]. In this article, we report those results, and recommend advocacy actions to nurses as a translation of empirical knowledge for practice[12] in order to protect women's rights[a] and curb situations of obstetric violence (OV)[13], thus expanding nurses' roles in knowledge dissemination[14].

LITERATURE REVIEW

Obstetric violence threatens the rights to life, health, and physical integrity[15-16], It includes coercive or unconsented technical procedures, refusal to administer analgesics, and neglect during childbirth, as well as the lack of confidentiality, privacy violations, refusal of hospitalization in health organizations and retention of women and their newborns in organizations after childbirth, due to an inability to pay[15-16]. As identified in different countries[17-19], curbing this form of violence constitutes a governance issue in health systems. It is a mandatory condition for respecting and protecting women's human rights and fulfilling promises to implement public policies based on civil rights[20], including in situations of humanitarian crises[21] experienced by pregnant women seeking political asylum.

Brazilian studies have documented such violence[22] through unexplained and unauthorized procedures (27.3%),[23] the refusal of permission for companions (9.3%)[24-25], and a high rate of cesarean sections and premature births[26], recording the impact on the health of individuals, families, communities, and societies[25], Latin American political activism, especially the Brazilian movement of humanization of childbirth, is still insufficient to curb such violence[27]. Due to obstacles in accessing care, as well as the greater reproductive risk among Afro-descendant women, socially vulnerable women are neglected[28-29]. These difficulties are explained by the invisibility of and resistance to the recognition of obstetric racism, which are reflected in the health services provided[30-31].

Obstetric violence is also part of the list of violations of women's human rights, and is often underreported — or worse, not reported at all — due to embarrassment, or fear that aggressors want revenge[32]. In Brazil, the implementation of the Stork Network has led to the installation of centres to support the development of best practices in obstetric and neonatal humanized management and care[33-35], and the network also promotes spaces to support maternal and child health, incorporating experiences and new obstetric technologies[36]. Humanization is implemented within an articulated network of health services extensive to one's family by the program called HumanizaSUS[37] (Unified Health System (SUS)). This program informs political actions to ensure the improvement of access, coverage, quality, and humanization of obstetric and neonatal care, integrating prenatal actions and monitoring of children in the primary care network and maternity hospitals. Specific guidelines[38] also pertain to the confrontation of violence against the child from conception, through humanization in welcoming, active and sensitive listening of the couple during prenatal care, monitoring the gestational process, and growth and child development. The effective implementation of humanization programs[34,39] in the SUS reinforced the defence of the rights to humanized care by nurses, teachers, and researchers. In all areas of professional activity, nurses can play the role of educators

on civil rights, with a view to improving quality of life, including health education.

It should be noted that we did not identify international evidence on population awareness about a similar national program, considering the pioneering of the PHNP, which makes it impossible to make comparisons. Thus, the novelty of this research is in listening to perceptions of Brazilian society about the existence of PHPN and pointing out areas of change so that its implementation can occur in a close alliance between clients and health professionals, to support changes in interdisciplinary care practice and the management of health services.

The research explored themes present in the collective experiences in Brazil regarding the implementation of the PHPN[11]. The conceptual bases of PHPN[11] constituted the conceptual framework that guided this research. Seeking evidence to support changes to increase the quality of care, an online survey answered the following guide questions: (a) What are the requests made by women and the general public[b] to improve the quality of services provided by health and social service professionals, as well as by existing community resources to support women dealing with obstetric violence?; and (b) What do women and the general public recommend to health professionals to modify obstetric violence practices?

The research aimed to: (a) explore the demands of women, as well as of the general public, to improve the quality of obstetric care; and (b) discuss the potential changes suggested by the respondents for such care practice.

METHOD

This research was exploratory, inspired by the approach of critical ethnography that reflects the examination of culture, knowledge, and actions. This type of ethnography deepens and refines ethical commitments to develop and act based on the commitment of values in the context of political agendas, including those of the power dynamics among individuals[40]. The research was conducted through an online platform[41] to expand the reach-out to potential participants, and was implemented in three cities in southeastern Brazil between July, 2019 and February, 2020. Considering the complexity and breadth of the research, we present a cut-out of the data according to demands for improving the quality of health services, as well as identify community resources related to support to women victims of OV and recommendations to health professionals by women and men, representing the civil society.

Women and the general public participated in the online survey, recruited through the publication of ads containing the link to the *Opinio* platform, which were posted in health institutions and on Facebook and Twitter pages that led to wide dissemination on social networks. Ads were also emailed to individuals from the co-investigators' professional and social networks. Due to the spontaneous participation of the respondents, in response to the direct or indirect invitation also received by the collaborators in the recruitment, the selection method was the non-probabilistic one, combined with the "snowball" method, compatible with the online research[41]. The criteria of inclusion applicable to this cut-out were being at least 18 years of age at the time of the research, and deciding to voluntarily participate in the research by answering an online questionnaire. The exclusion criterion was to identify oneself as of Indigenous origin. The original forms of data collection, to be answered by women, and the other, for the general public, were prepared by the Canadian team and reviewed by the Brazilian team for their semantic properties, in order to ensure its regional linguistic characteristics and adequacy to the level of popular language. In sum, the method of work included English-Portuguese translation, with regional adaptations.

These questionnaires explored the respondents' opinions on questions related to OV and the improvement of prenatal care and care in labour and delivery, and presented three common questions of sociodemographic identification (age, gender, and years of schooling) and two additional questions for women (number of pregnancies, number of children, and marital status). The other, multiple-answer questions explored: (a) How to provide information about the violence that women may face when they are assisted in health organizations during pregnancy, labor and childbirth; and (b) Who would be the person(s) with whom they would seek support and help if a woman suffered any form of moral, emotional, or physical violence during labour and childbirth? Three open questions explored the respondents' perceptions of: (a) local women's knowledge of OV and women's rights for safe and respectful obstetric care; (b) professional actions to use their power and authority to provide better quality of care to women during labour and delivery; and (c) actions proposed to modify all professional practices that may lead women and partners/companions to suffer some form of violence against women in labour and childbirth.

Data collection occurred in the application of online questionnaires available in Portuguese and hosted by the *Opinio* platform of the Canadian university. The platform generated a final report in which sociodemographic data and quantitative results were compiled and later analyzed by descriptive statistics[42]. The text of the open answers was submitted to critical reading and then to procedures recommended by the thematic analysis technique[43]: identification of emerging ideas, after repeated readings of the compilation of written answers; reflection on such ideas organized into groups; and the identification of categories and creation of possible themes to answer the research questions.

For this cut-out, the findings' thematic analysis was preceded by the interpretation of the quantitative-qualitative results, enabling its integration with the specific answers in the form of suggestions for the modification of professional practice. Such suggestions were manually explored in the contents of the report produced by the *Opinio* platform, focusing on the main idea presented by the comments, suggestions, and recommendations. This methodological procedure was

conducted to explore the trend of qualitative findings by a preliminary, not in-depth reading, followed by a review of the understanding of the findings, and resulting in the identification of groups of ideas (e.g. suggestions and comments). Two central analytical themes were produced: (i) situation experienced by women, including subthemes; availability of information; level of misinformation about obstetric rights; and required help; and (ii) idealized context of praxis with subthemes; and the use of professional power and prospective change of praxis, which guided the exploration of the corpus for analysis[43].

The research protocol was reviewed and approved by the Research Ethics Board of the Canadian University, REB No. 2019-063, and by the Brazil's National Research Ethics Commission, No. 3461,935, and met the ethical requirements established for studies involving human subjects. Free and informed consent was obtained on the basis of the principles of implicit consent. Implicit consent was understood by the respondent to be accessing the online platform *Opinio* and clicking the link provided in the advertisements, indicating that the consent was implied and granted by the respondent after reading the informed consent form, although it was not expressed verbally or in writing.

RESULTS

In each city, two samples of respondents were constituted for the online survey, following an international research trend[44] with women and the general public, totaling six subsamples. It is worth mentioning the attraction of the interest of 700 individuals in accessing the questionnaires in these research sites, of which 60% (n=414) implicitly consented and responded. Of these 414 respondents, 342 answered the specific questionnaire for women, and another, intended for the general public, was answered by 56 women and 16 men. In the following paragraphs, descriptive statistics refers to the calculation of frequency and percentage of the results compiled by the two described questionnaires. Regarding the age group, 26% reported belonging to that between 33-37 years. In the three women subsamples of the research sites, 75% reported having more than 15 years of schooling, 45% were married, and 35% had only one child.

Demands to improve the quality of obstetric care

For the question: "Where is information available about the violence that women may face when they are assisted in health organizations during pregnancy, labour and childbirth?", we obtained 785 answers among the seven possible alternatives of choice, and more than one answer could be indicated. The answers were: only occasionally does the local newspaper, radio, and television talk about this problem (n=165; 21%); community groups defending women's rights talk about this problem (n=157; 20%); only Facebook, Instagram, and Twitter have posted about this problem (n=149; 19%); among women, we talk a lot about this problem (n=147; 18.7%); no one talks about this problem (n=77; 9.8%); a local non-governmental organization (NGO) taught us about this problem (n=46; 5.8%); and professionals from community health centres teach us about this problem (n=44; 5.6%).

As for the question "What do local women know about obstetric violence and women's rights for safe and respectful obstetric care?", 22% (n=91) reported not knowing how to answer. Women reported a knowledge gap on the subject among the women's population (n=272, 65.7%), as well as the general public (n=51; 12.3%), as illustrated below (free translation):

> *Few women in the community at large know and talk about it. My mother suffered obstetric violence in her three deliveries and she never knew how to name it. In the first, they used forceps, she had postpartum hemorrhage, and was much abused in childbirth. In the second, she heard jokes about the fact that she was afraid of normal delivery (due to the experience of the former), in the third, she had preeclampsia and was abused as well.* (Woman, Belo Horizonte)

> *Many women here do not even recognize obstetric violence, believing that the procedures adopted are safe, adequate, and normal, such as episiotomy.* (General public, Niterói)

> *I think almost nothing... When I had my three children, all caesarean sections, no one had told me anything. I could only hear women saying that when they went to have babies, they heard the nurses saying, "You're in pain, okay?" when it came time to do it didn't hurt, didn't call anyone... things of that level.* (Woman, Rio de Janeiro)

For the question "If a woman suffers any form of moral, emotional, or physical violence during labour and childbirth and wants support, whom would she most likely ask for help?", among the alternative answers, were: friends, women's protection police station, family, religious leader, health professionals, no one could help, and others. In the three cities, more than half of respondents (56.3%) opted for family, followed by friends (13.1%) and the women's protection police station (10.7%). The option "others" encompassed the church, police, NGOs – perceived as places offering psychological and legal support services – home visits, follow-up groups (face-to-face or virtual), and individual listening. A respondent warned about the importance and courage to denounce (free translation):

> *I do not know exactly, I would seek to report on social networks and seek to inform me about the respective protection networks. I suffered obstetric violence in both deliveries, not knowing that it was about it.* (Woman, Belo Horizonte)

Another question was "What should professionals do to use their power and authority to provide better quality of care to women at the time of labour and childbirth?" A total of 404 suggestions were provided, based on respect, empathy, listening to and guidance of women, as well as conducting professional training

focused on the humanization of care, exemplified in the following statements (free translation):

> *Empower women over their rights and support them in their choices.* (Woman, Belo Horizonte)
>
> *Combat all kinds of violence and seek to sensitize the professionals around them to do the same.* (General public, Belo Horizonte)
>
> *They must first respect the woman and her family, their decisions, beliefs, customs, and choices. They should deconstruct that health professionals have full power and authority over the health of those they provide care to. They should be less interventionist and medicalizing in situations that do not require such an approach.* (Woman, Niterói)
>
> *Reassure and respect parturient, ensuring their rights.* (General public, Niterói)
>
> *To guide on women's rights, on the current legislation and also how is the process of care, especially when it is the first pregnancy. I believe that knowledge about the process is a determining factor to prevent the abuse of power of some professionals and the consequent obstetric violence.* (Woman, Rio de Janeiro)
>
> *Provide the best care, explain all procedures, and let the patient choose the best option for her treatment and guide it clearly. Forward to therapy, take care of the physical and emotional well-being of the woman.* (General public, Rio de Janeiro)

Potential changes in care practice

Regarding the question "What should be done to modify the professional practices that lead women and partners/companions to experience any form of violence in labour and childbirth?", the respondents indicated 361 proposals for changes. The trend of suggestions, for the most part, indicated the need to educate women, professionals, health managers, and society, highlighting the expressions of a mixture of appeals for social justice and ethical-professional accountability (free translation):

> *Through denunciation / practice of evaluation of the health organization with instruments that these organization itself could provide, service channels, evaluation forms, interviews before discharge, etc.* (Woman, Belo Horizonte)
>
> *Broad discussion in society, training of professionals, discussion in schools, tougher laws, intervention in the medical lobby.* (General public, Belo Horizonte)
>
> *It should be modified, from the cultural and educational teachings. The system today still teaches that women are weak, and this modification comes from the cradle. It comes from teaching and changing standards. By changing the way we're born, we're changing the world.* (Woman, Niterói)
>
> *A change in different areas of life, not just in the doctor. A change in work, training, care practices, there is no way to act on this problem with isolated policies, and gender, education, vocational training, body and sexuality information policies, etc. should be considered.* (General public, Niterói)
>
> *Increased investment in health, better awareness of the roles of all involved, less unhealthy environment, supervision of auditors, external auditors.* (Woman, Rio de Janeiro)
>
> *Wide dissemination on the subject. Many women suffer violence and have no conscience because where she lives it always happened and no one has ever complained. Awareness work has to be done for professionals to change and patients start charging and reporting.* (General public, Rio de Janeiro)

The core of the results lies in the strain of information available to provoke women's rights claims, suggesting a process of collective education for the prevention of their demeanor, with the expansion of political literacy. Quantitative data were: (a) informing women, the family, society, and professionals about rights to obstetric care (n=692; 53.1%); (b) offer humanized care (n=452; 38.2%); and (c) changing the culture of silence, favoring the denunciation, supervision, and correction of professional practice (n=103; 8.7%).

Two central themes emerged from the thematic analysis: (i) The situation experienced by women, including the subthemes availability of information, level of (dis)knowledge about obstetric rights, and required help. This perceived ignorance led to requests for expanded education actions on such rights, which is the greatest demand of respondents. It was revealed that most women are devoid of information on the characterization of OV. The collective perception of the unquestionable decision-making power of the health professional over women's bodies is added to the lack of knowledge to identify and recognize OV. Denouncing and obtaining legal support to prevent undue practices and acts from happening requires the mobilization of communication channels with broad social dissemination. Disseminating and alerting the women's population and society about the debasement of women's rights involves systematized, integrated, and continuous educational activities in different social spaces (e.g. schools, primary health care unit).

(ii) Idealized context of praxis with the subthemes: use of professional power and prospective change of praxis. The evidence drew an idealized context of praxis in which the use of professional power for the prospective change of praxis would be possible with humanization actions. The operationalization would be due to mass educational actions for extensive knowledge of the existence of the PHPN in a scenario of opportunities to solidify the nursing advocacy and disseminate knowledge, thus corroborating the results of other studies in several areas underlying health promotion[45] on respect for women's rights and against gender violence[46-48]. Actions articulated in social spaces in which prevention is a priority for the humanization of multidisciplinary care are

associated with structural issues and available resources, in addition to the sharing of responsibilities between professionals and administrators[49]. Prevention could also benefit from the redesigned action of the public relations professional who, instead of caring for organization interests, would promote the voices of socially marginalized clients to echo their claims in society, resulting in effective action in solving issues of gender violence in middle-income countries[50].

The Figure 1 below illustrates the integrative summary of the evidence that leads the thematic analysis, which in turn signals multidimensional implications in praxis.

DISCUSSION

This section discusses only the results and central findings that were analyzed (and not those in their raw state). The evidence produced by this research indicates that women, professionals, families, and health managers require support to produce a cultural change in obstetric care.

The situation experienced by women can be modified by community mobilization; increased control by the community to reduce health inequities can effect change in the distribution of power[51]. The results indicate the need for community empowerment, as it represents the fundamental basis for encouraging mutual support and capacity-building support to have access to services, as well as the verbalization of concerns to increase own control over women's lives[52]. Thus, the results indicate the relevance of advising existing groups to create mechanisms for the defence of women's rights based on local/state monitoring of PHPN implementation and on reported cases of OV, as well as promoting the broad debate on obstetric rights, neglect of obstetric care, or violations of PHPN. It should also be noted that the implementation of international policies reinforcing the universal human rights of women and children guide the improvement of the quality of life of individuals and communities[53].

Corroborating our results, it is important to emphasize that human rights at birth have become a global discussion centred on scientific evidence, compassion[54], and the recognition that women as citizens play a powerful role in health promotion and mutual support[55]. Although there are few studies in the area of women's community empowerment and rights in this specific area, nurses and other professionals defending their clients recognize significant initiatives led by women[55-56]. Therefore the importance of promoting women's health and their involvement in the health promotion movement is certainly through innovative advocacy and communication actions[52,56]. Educating women in the pregnancy-puerperal cycle promotes empowerment through increased self-esteem and autonomy[56] to opt for physiological delivery[57], breaking the cycle of silence[58] and reducing institutional violence[59].

In parallel, a change in praxis is aimed at increasing humanized care. In this context, it should be emphasized that nursing, in the context of global changes (e.g. geographic mobility, technological advances, political and social changes)[60-61] uses critical media for such empowerment. This is based on differentiated work, especially of nurses with critical thinking skills while humanizing care[55,61]. Such action can narrow the distance between PHPN, legislation, and obstetric care[59], requiring the specific training of health professionals with a solid basis in ethical, gender and human rights contents for solid changes to happen[23].

By educating themselves on political issues, nurses can promote the empowerment of their clients and their communities,

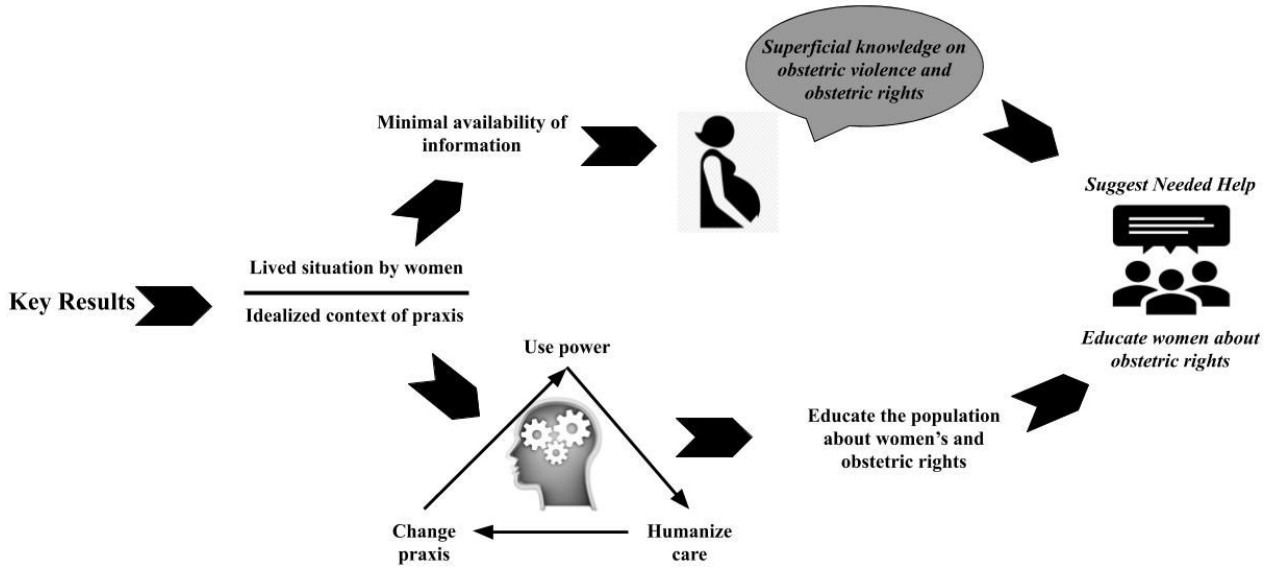

Figure 1. Synthesis of the amplified voice of women and the public inspiring the renewed praxis.
Source: Elaborated by the authors.

since gender equality and women's empowerment are among the Sustainable Development Goals[62]. Although apparently taken into consideration by governments, there is a warning that they are being concealed[63]. Engagement, enthusiasm, skills, support, and organizational receptivity are predictors of advocacy among nurses[64], in addition to personal interest in political issues and participation in professional organizations that would justify the inclusion of the theme in curricula[65].

Added to the perception of little authority to modify care norms and the nurse's interest in advocacy, this practice remains incipient[66] in Brazil, even though it is still focused on the health system's outcomes for improvements to individual health[66]. The criticism of the views of neoliberal policies associated with health disparities in Brazil explain the obstacle to nurses' involvement in the political struggle against precarious working conditions caused by cost reduction measures[67] that diminish the quality of care. As a result of the limited participation in the governmental health policy-making, nurses' voices are silenced[66]. It is therefore justified to educate nurses for their political role as a protagonist. Thus, this research considered that any educational process should stimulate a desire for action towards social change that addresses inequality and oppression[68]. The best way to help others identify a problem, as well as understand it, is through the development of critical judgment from which solutions can be formulated[69].

The approach to OV requires the synergy of national multidisciplinary actions and international initiatives[70] and the involvement of civil society to meet the demands to improve the quality of health care for women and children at birth[71]. Undeniably, it is a public health problem[72] characterized by physical, sexual, and verbal abuse, exacerbated by stigma and discrimination, the non-observance of standards of professional practices, low-quality relationships between women and professionals, and the limited conditions of health care systems[73]. Nevertheless the puerperal women declare satisfaction with nurses' performance in the reception service[74], despite the symbolic inter-professional violence restricting the activities of nurses in the obstetric centre[75]. It is therefore essential to strengthen, in the undergraduate nursing programs, the role of critical education, which promotes students' understanding of competencies for advocacy.

Changes in the obstetric care model scientifically supported by a collaborative model are proposed, with the participation of nurses who are obstetricians in care and clinical decision-making during the delivery phases[76]. Nurses' managers are agents for the implementation of evidence-based nursing practice, offering a culture and supportive environment to raise the quality of care by translating evidence into innovation[77].

It is possible to affirm that this research contributes to scientific knowledge in the area of advocacy by proposing a knowledge translation in the form of recommendations for the advancement of evidence-based practice[12] both in education and practice, primarily by nurses in the multidimensional humanized obstetric care. The ultimate importance is to transform the view of the population by drawing paths to actions and strategies so that nurses can advocate for women's human and obstetric rights. Such avenues can also inspire the same renewal for the multi-professional team. The analysis and interpretation of the evidence collected in this research resulted in the formulation of original recommendations (see Charts 1- 4), the contribution of which may constitute an object for the design of a series of teaching and research projects, as well as effect a social impact and the evaluation of services. The focus is on the context of PHPN implementation, content, and stakeholder consultation, which corroborate the results on the complexity of the program and policy formulation process in the face of conflicting pressures[78]. Due to the nature of their contents, the recommendations serve as inspiration for a posteriori reflection by the readers, and the original contributions of this research can serve to implement multiple initiatives related to the practice of advocacy.

CONCLUSION AND IMPLICATIONS TO PRACTICE

Three methodological limitations should be highlighted. The first is that the data compiled in the report generated by the *Opinio* platform did not allow for the correspondence of the answers to the gender of the respondent, nor to their identification. No identification also occurred on the narrative answers to the open questions, thus hindering the qualitative analysis provided by the 56 women who answered the form intended for the general public. The second limitation is the impossibility of achieving a representativeness of the diversity of women in their experiences in health services less responsive to gender issues. The third limitation is the non-identification of online respondents, which made it impossible for natural experts to participate[79] to verify the interpretation of qualitative findings. Thus, the trend of qualitative findings can be partially transferred to other social contexts, since it may be inapplicable to the social diversity of the Brazilian women. However, this research strictly met the criteria of scientificity when observing issues of culture, gender, language, advocacy, and standards of respectability, in addition to incitement to discourse.[80]

It was intended to hear the voices of women and the general public about improvements to the quality of obstetric care. The evidence supports the proposition of recommendations for advocacy by nurses and the redesign of institutional practices. The operationalization of the recommendations can encourage the development of political thought that is convergent with the demands of society to obtain conditions for the sustained exercise of decision-making due to collective political literacy. By raising awareness about the fundamental prevention of OV in various social spaces, we would ensure the continuance of the debate on increasing extensive humanization and shared governance. The set of multidimensional recommendations

Chart 1. Advocacy recommendations for nurses. Objective 1: To train nurses in advocacy for women's health promotion, with emphasis on the protection of their rights and for the extensive implementation of PHPN. (Authors' original creation, 2020)

Priority action	Integrated strategies of implementation
- Collaborate for the development and availability of educational resources with the Brazilian Association of Obstetric Nurses and Obstetricians (ABENFO), the Brazilian Nursing Association, the Federal Council of Nursing and the Regional Councils of Nursing, through programs (online and face-to-face), regardless of nurses' areas of professional practice.	- Develop new instruments, methods, and approaches for socially inclusive educational work related to women's rights, responding to the particularities and diversity of women cared for in the primary, secondary, and tertiary health care system in the continuous pregnancy-labour-postpartum-childbirth-puerperium.
- Promote university education, in-service education and professional development activities to increase the political literacy of nurses.	- Create a mentoring/coaching system in the area of political literacy for nurses and students to expand networks of relationships, support specific demands, and stimulate updating/continuing education processes.
- Create practical opportunities for students to develop advocacy skills in macro-systems.	- Increase the exposure of teachers and students to practical examples of advocacy performed by nurses to redirect political actions.
- Collaborate with legal professionals to provide nurses with specific training on potential unethical conduct, professional errors, and unintentional damages, in addition to implications of processes of legal suing of the professional practice, with an emphasis on obstetric nurses.	- Review, in undergraduate and graduate programs, the possible redirection of the process of the academic-scientific production to address the social impact and results in the quality of obstetric care, due to the political work of nurses engaged in the defence of women's rights and the PHPN.
- Lead quantitative-qualitative evaluation projects of the social impacts of women's rights advocacy and training by nurses focusing on respect for diversity, person-centred care, decreased gender inequality, and balance in power relations.	- Facilitate simulations for students and nurses to provide them with tools for advocacy.
- Strengthen undergraduate nursing programs, the role of critical education that promotes students' understanding of competencies for nursing advocacy.	- Systematize with the administration of health organizations new standardized administrative practices of accountability/professional engagement for the advocacy of women's rights.
	- Stimulate the implementation of permanent in-service education for the administrative staff on the PHPN recommendations.

Chart 2. Advocacy recommendations for nurses. Objective 2: To raise the level of knowledge of civil society about the rights of women who use prenatal and obstetric services to make it a collaborator in the surveillance of PHPN implementation. (Authors' original creation, 2020)

Priority action	Integrated strategies of implementation
- Establish intersectional collaboration between the Municipal and State Departments of Health, Education, and Social Assistance and Human Rights; Ministry of Women, Family, and Human Rights; Secretary of Labour, with religious and community leaders, and residents' associations to create strategies for building community capacity for citizen leadership and popular participation in PHPN.	- Establish a partnership between the professional media, the business sector, and ABENFO for integrative actions for the production and dissemination of information material on women's rights.
- Design health promotion actions for women who are workers in collaboration with the National Association of Occupational Health Nurses.	- Popularize knowledge about the characterization of OV and the recognition of its indicators through the production and dissemination of educational material, with accessible language including synonyms used by common sense.
- Decode for popular language the legal language present in PHPN, disseminating it among women, as well as among professionals in the areas of health, social services, and education.	- Establish partnerships with primary health care professionals, especially community health agents, producing educational videos and video clips aiming to fill in gaps in knowledge of PHPN among women and families registered in the Family Health Strategy.
- Collaborate with the authorities of the Civil Police and Military Police to implement programs to raise awareness of their troops regarding PHPN.	- Create a complaint service about OV in health services, which can go beyond the listening offered by the ombudsman office.
- Establish a partnership with the entertainment sector for the dissemination of educational campaigns for civil society.	- Develop a checklist on situations characterizing disrespect for women's rights, extended to OV, to be shared at the first prenatal consultation, and discussed in subsequent consultations.
- Promote safe spaces to denounce OV and violence against women, in general.	violê

Chart 3. Advocacy recommendations for nurses. Objective 3: Redesign alliances with civil society groups in the area of defense of women's rights to amplify women's voices and implement extensive actions to raise awareness of socially vulnerable women's groups. (Authors' original creation, 2020)

Priority action	Integrated strategies of implementation
- Promote education for women from the standpoint of peer education, about their roles and contributions as informed users about women's/ obstetric rights, from a perspective of popular participation, citizenship, meanings of grouping/ collective engagement, and advocacy of groups, among others.	- Ensure the functioning of groups of pregnant women in health care units with regular follow-up and participation of professionals from other areas related to the multiple dimensions of women's rights.
- Advise existing groups for the creation of mechanisms to defend women's rights based on local/state monitoring of PHPN implementation and on reported cases of OV.	- Collaborate with information technology and communication professionals, as well as with the telecommunications business, for the development of applications for smartphones and videos for individuals without internet access, but who have electronic devices.
- Promote the broad debate on obstetric rights, neglect in obstetric care, or violations of PHPN.	- Disseminate mechanisms and protocols for reporting cases of OV.
	- Provoke internal discussions in health care organizations about the effect on its reputation, due to cases of violence against pregnant women when accusations reach the public knowledge.

Chart 4. Advocacy recommendations for nurses. Objective 4: Mobilize the human and cultural capital of communities/civil society and their vulnerable groups to reconstruct traditional meanings regarding the naturalization/trivialization of exposure to OV. (Authors' original creation, 2020)

Priority action	Integrated strategies of implementation
- Propose multi-/inter-disciplinary university outreach projects focused on the young and adult women population, concerning the undoing of their social realities and experiences of the gestational and childbirth process.	- Advise teachers and students in the secondary and university education system for the creation of a student health commission focused on peer education on women's rights.
- Establish continuous, independent community forums on women's rights advocacy in synchrony with the Municipal Health Councils' meetings.	- Create a work agenda with representative groups of the university, civil society, and vulnerable groups to define proposals to be submitted to municipal, state, and national health conferences.
- Collaborate with researchers in the areas of political, social, and health sciences to conduct evaluation research and produce criticisms based on knowledge and monitoring the implementation of PHPN.	- Translate scientific knowledge produced by local research into educational material, re-signifying the popular culture of the trivialization of OV, to provide tools for collective political literacy in the different spheres of society.

for advocacy – its objectives, priority actions, and integrated strategies – are consistent with the global perspective of women's health promotion. Thus, we would strengthen nurses' capacity for transformative social leadership to respond to the expectations of civil society.

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[a] The term "women's rights" includes rights to access services from prenatal to puerperium (including maternal and child services) in which they receive professional care during prenatal, childbirth/birth and puerperium.

[b] In the original research, the term "general public" referred to anyone who could answer the online form, since pregnancy is a social phenomenon that encompasses different members of society, regardless of gender, age, marital status, and family situation. This led some women to choose to respond to this form and not the other, which was exclusive to women.