

Perceptions of Professionals Perceptions After Training for the Care of Women in Abortion Situations

Percepção de Profissionais Após Capacitação para o Acolhimento de Mulheres em Situação de Abortamento
Percepción de Profesionales Tras la Capacitación para la Acogida de Mujeres en Situación de Aborto

RESUMO

Objetivo: Conhecer as percepções de profissionais da Rede de Atenção Primária após capacitação sobre o acolhimento de mulheres em situação de abortamento. **Método:** Estudo qualitativo, exploratório-descritivo, realizado com 5 profissionais de uma Unidade Básica de Saúde do município de Porto Alegre (Brasil). A pesquisa está vinculada ao projeto de extensão "Acolhimento para Situações de Abortamento na Atenção Primária à Saúde" que ofereceu capacitação à profissionais que atuam no atendimento de mulheres no território. Resultados: A análise emergiu em duas categorias temáticas: "Percepções sobre o acolhimento de mulheres em situação de abortamento" e "Proteção profissional, legislação e conduta pós capacitação". **Conclusão:** O debate sobre o aborto desafia estruturas estabelecidas culturalmente. Os cuidados de saúde envolvem concepções pessoais e religiosas. Assim, os direitos sexuais e reprodutivos são negligenciados, impedindo a garantia de acesso das mulheres aos cuidados de saúde.

DESCRIPTORES: Atenção Primária à Saúde; Saúde da Mulher; Relações Profissional-Paciente; Acolhimento; Aborto Legal; Atitudes e Prática em Saúde.

ABSTRACT

Objective: To understand the perceptions of Primary Care Network professionals following training on the care of women in abortion situations. **Method:** A qualitative, exploratory-descriptive study conducted with five professionals from a Primary Health Care Unit in Porto Alegre (Brazil). The research is linked to the extension project "Care for Abortion Situations in Primary Health Care," which provided training to professionals working in the local healthcare service. **Results:** The analysis yielded two thematic categories: "Perceptions on the care of women in abortion situations" and "Professional protection, legislation, and post-training conduct." **Conclusion:** The debate on abortion challenges culturally established structures. Healthcare involves personal and religious conceptions; thus, sexual and reproductive rights are neglected, hindering women's guaranteed access to healthcare.

DESCRIPTORS: Primary Health Care; Women's Health; Professional-Patient Relations; User Embrace; Legal Abortion; Health Knowledge, Attitudes, Practice.

RESUMEN

Objetivo: Conocer las percepciones de profesionales de la Red de Atención Primaria tras una capacitación sobre la acogida de mujeres en situación de aborto. **Método:** Estudio cualitativo, exploratorio-descriptivo, realizado con cinco profesionales de una Unidad Básica de Salud del municipio de Porto Alegre (Brasil). La investigación está vinculada al proyecto de extensión "Acogida para Situaciones de Aborto en la Atención Primaria de Salud", que ofreció capacitación a profesionales que actúan en la atención de mujeres en el territorio. **Resultados:** Del análisis surgieron dos categorías temáticas: "Percepciones sobre la acogida de mujeres en situación de aborto" y "Protección profesional, legislación y conducta poscapacitación". **Conclusión:** El debate sobre el aborto desafía estructuras establecidas culturalmente. Los cuidados de salud involucran concepciones personales y religiosas; por lo tanto, los derechos sexuales y reproductivos son descuidados, impidiendo la garantía de acceso de las mujeres a los servicios de salud.

DESCRIPTORES: Atención Primaria de Salud; Salud de la Mujer; Relaciones Profesional-Paciente; Acogimiento; Aborto Legal; Conocimientos, Actitudes y Práctica en Salud.

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INTRODUCTION

Abortion is defined as the termination of a pregnancy up to the 22nd week of gestation^(1,2). The World Health Organization (WHO) defines unsafe abortion as procedures intended to terminate a pregnancy when performed by individuals without technical skills and/or in unsuitable settings, or both⁽³⁾.

Unsafe abortion is one of the leading causes of preventable maternal death in Brazil, making the reduction of maternal mortality a persistent challenge⁽³⁾. Guaranteeing the right to safe abortion is a public health issue, as restricting or banning abortion does not prevent it from occurring but instead increases rates of unsafe abortion and, consequently, maternal morbidity and mortality⁽¹⁾.

An average of 230,000 women are hospitalized each year in Brazil due to complications from unsafe abortion, which accounts for 5% of all hospital admissions among women of reproductive age⁽⁴⁾. In countries where abortion has been legalized or where non-criminal-

ization policies are in place, unsafe abortions are less common, and the maternal mortality rate is significantly lower⁽⁵⁾.

In 2021, DATASUS recorded just over 130 legal abortions performed on girls up to 14 years of age, while the number of live births to mothers in the same age group exceeded 17,400 during the same period^(6,7). The importance of Primary Health Care (PHC) is evident in a context where only a very small number of women have access to essential health care⁽⁸⁾.

The care provided in PHC is often insufficient, inadequate, and even discriminatory, especially when it comes to women in situations of social or economic vulnerability or when analyzed through the lens of race and skin color⁽⁹⁾. The potential of health centers and their professionals could be harnessed to significantly reduce maternal deaths related to unsafe abortions, in accordance with Brazilian protocols and WHO recommendations⁽¹⁰⁾.

This study is linked to a research and outreach project proposed by the au-

thors and carried out in collaboration with a Basic Health Unit. The outreach project offered the community training for Primary Health Care professionals through a partnership with the organization Bloco A, which structured and developed the AMPARA course—Support for People Experiencing Abortion and Post-Abortion Care. Thus, this study sought to understand the perceptions of health professionals following training on supporting women experiencing abortion.

METHOD

This was a qualitative, exploratory-descriptive study that followed the Consolidated Criteria for Reporting Qualitative Research (COREQ), a 32-item instrument designed to provide a complete and transparent report of qualitative research involving interviews⁽¹¹⁾.

Five professionals working at a Basic Health Unit in the city of Porto Alegre (Brazil) were included. The inclusion criteria were: having participated in

the university extension project, having completed the training, and having been working in the Primary Care Network for at least 6 months. The establishment of a minimum period of practice with the population is justified by the need to include professionals who are immersed in the service, have experienced its challenges, and have established ties with the unit's management and staff.

The training consisted of the AMPARA course, developed by the Feminist Organization Bloco A in partnership with the *Safe Abortion Action Fund* and the Feminist Collective on Sexuality and Health. Following the training, the professionals participating in the study were invited in person to take part in the research and to sign the Informed Consent Form.

Data collection was conducted through semi-structured interviews regarding experiences with professional services and practices related to the topic, as well as the process and outcomes of the intervention. Copies of the interview transcripts will be retained by the researchers in charge for five years and then destroyed. Data analysis was conducted in five stages, according to Minayo (2012).

The project was registered on the Plataforma Brasil and submitted to two Research Ethics Committees (CEP) under approval number 6,166,044 and CAAE 70133523.6.0000.5347. It was necessary to obtain approval from the Ethics Committee of the Federal University of Rio Grande do Sul and also from the Municipal Health Secretariat of Porto Alegre (Brazil).

RESULTS

The mean age of the professionals was 37 years, ranging from 25 to 47 years. Regarding their educational background: two physicians (2), one female nurse and one male nurse (2), and one community health worker (1), for a total of five professionals, with only one woman in the group. The average length of service was

three years, ranging from 10 months to 7 years. Of the five participants, three held postgraduate degrees.

Analysis of the interviews yielded two thematic categories: "Perceptions regarding the care of women experiencing abortion" and "Professional protection, legislation, and conduct following training." Participants will be referred to by code as follows: C1, C2, C3, C4, and C5.

Perceptions regarding the care of women experiencing abortion

The care provided to women seeking abortion is related to the mastery of skills that enable the recognition of such cases. In this study, when asked about the cases they had handled in their practice, the professionals initially stated that they had not treated women who wished to terminate a pregnancy or who would even be eligible for a legal abortion.

Personally, I've never handled a case like that, you know? I've never had that kind of experience; it's never come up for me (C1).

...I don't really have any experience (...) neither with abortion nor with this desire to voluntarily terminate a pregnancy—I don't usually see those cases either (C4).

After stating that they had never encountered cases of abortion in their professional careers, some participants backtracked and revised their statements. Even though they knew these cases could involve induced abortions, the professionals avoided verbalizing this possibility, preferring more palatable and socially acceptable narratives, such as reporting them as miscarriages or eventual acceptance of unwanted pregnancies

I haven't seen any so far... Actually, I saw one yesterday, but it was a spontaneous abortion (C4).

Here's what I've experienced: women who had an unplanned pregnancy and, when they came in for an appointment, honestly didn't know at first. They didn't know if they wanted to continue with the pregnancy. But I welcomed them, made them feel at ease, and both carried their

pregnancies to term. And then one ended up losing her child, but it wasn't on purpose—it wasn't intentional. It just happened. (C1).

In the cases that come here, in none of the times I've provided care have I encountered situations that would require referrals related to sexual violence or abuse. The only one was a teenager who was given the appropriate referrals through the system. Anyway, this type of situation isn't very common in this area (C2).

It was noted that the protocol for the first prenatal care visit does not typically include informing women about their sexual and reproductive rights or the criteria for accessing legal abortion. For this to happen, they must explicitly request this information, by disclosing sexual violence and expressing a desire for termination.

Okay, I'll be honest: I don't mention "options" [emphasis on "options"] like that from my perspective, you know? I don't get into that, you know? I ask if it was planned or not, how she's feeling right now, and regardless of the answer, I let them speak, let them steer the conversation from there. And honestly, I don't give my opinion in terms of options—whether she wants to continue the pregnancy or not—I don't go there (C1).

Of course, we're not going to ask, "Are you thinking about having an abortion?" but we get a sense of it as we go along... in my experience, most pregnancies—even those that aren't planned—are accepted. I haven't yet encountered a situation where a woman has expressed a desire to terminate the pregnancy (C5)

The approach taken by professionals in asking whether the pregnancy was planned and/or wanted may not be effective in ensuring that women who wish to terminate their pregnancy are identified. Qualified and targeted counseling would present options to women, regardless of each woman's initial account.

Professional protection, legislation,

and post-training conduct

In the interviews, the professionals justified the omission of this information by citing the intention to provide a “neutral” reception—one that did not lean “one way or the other”—but which, in practice, seems to exempt the professional from the responsibility of providing the information necessary for clients to make informed and autonomous decisions about their health:

Anyway, so I did my intake work, right? Not biased one way or the other. But I welcomed them, made them feel at ease, and both went on to carry their pregnancies to term (C1).

...I've always been careful not to judge the person, to listen to her, to let her express her needs, her fears, and her desires. Not to force any opinion on her like that (C3).

It's clear that these professionals believe discussing sexual and reproductive rights falls outside the scope of their work. They confuse this task with expressing their personal opinions or beliefs. What should be a matter of impartiality and the guarantee of human rights often seems to be interpreted as “offering” or encouraging a stigmatized procedure. The responsibility falls on women to request information they are unaware of, creating an insurmountable barrier to accessing their rights to qualified counseling and abortion as provided by law, and thus preventing the primary health care unit (UBS) from recognizing this demand within its jurisdiction. Another relevant point mentioned in the interviews was the limited time allocated for prenatal appointments, cited as yet another justification for not addressing the issue with women.

We have a twenty-minute prenatal appointment. So, we'd have a lot to cover, but unfortunately it seems that [for] the municipality, providing an adequate prenatal consultation as it should be is not a priority. We have to adapt to our reality. (C5)

Table 1. Results of the questionnaire administered during data collection.

Question	%	
Pregnancy resulting from sexual violence is a case in which termination of pregnancy is permitted	YES: 100% NO: 0%	All participants answered YES
To exercise the right to terminate a pregnancy resulting from sexual violence, it is necessary to present a police report, a forensic medical examination, or a court order	YES: 0% NO: 100%	All participants answered NO
Abortion counseling is permitted in primary health care	YES: 100% NO: 0%	All participants answered YES
Counseling is also permitted in cases that do not meet the referral criteria for legal abortion	YES: 100% NO: 0%	All participants answered YES
Counseling on safe abortion in primary health care can help reduce maternal mortality	YES: 100% NO: 0%	All participants answered YES
Abortion counseling is part of comprehensive women's health care in primary health care, along with information on contraceptive methods and STI prevention	YES: 100% NO: 0%	All participants answered YES
I know the criteria for accessing legal abortion	YES: 100% NO: 0%	All participants answered YES
I avoid providing information about available options as much as possible for fear of facing criminal charges for doing so	YES: 0% NO: 100%	All participants answered NO
I have already referred people to a legal abortion service	YES: 0% NO: 100%	All participants answered NO
The correct course of action when a pregnant woman expresses a desire to terminate her pregnancy is to counsel her on the risks of unsafe abortion and refer her to prenatal care	YES: 80% NO: 20%	4 out of 5 participants answered YES
I make it a practice to inform all pregnant women I see about the available options	YES: 20% NO: 80%	4 out of 5 participants answered NO
I believe that abortion should be prevented, even through legal measures	YES: 60% NO: 40%	3 out of 5 participants answered YES
I believe that abortion is murder/a sin	YES: 40% NO: 60%	3 out of 5 participants answered NO
I routinely educate the pregnant women I care for about sexual and reproductive rights and the laws that protect them	YES: 60% NO: 40%	3 out of 5 participants answered YES
I try to encourage continuing the pregnancy even when it is unwanted, by discussing the benefits of continuing the pregnancy	YES: 40% NO: 60%	3 out of 5 participants answered NO

According to the response table above, all participants stated that they are familiar with the laws and criteria for legal abortion. All reported knowing that abortion counseling is part of comprehensive women's health care and that it is permitted in all cases, helping to reduce maternal mortality. No participant stated that they feared criminal liability for informing clients about their available options.

The interviews revealed some possible explanations for the discrepancy between the professionals' knowledge

and their actual behavior. We seek to explore the reasons behind the dynamics present in clinical encounters that lead to the invisibility of the cases noted above and the consequent failure to refer patients to specialized services or provide adequate follow-up for more challenging situations. If professionals know that qualified counseling has positive impacts, why don't they provide it?

The questionnaire responses, combined with the interview statements, show that professionals do not fear criminal liability—especially after

completing the course—but rather the potential social sanctions involved. Although they possess knowledge of criteria, legislation, rights, and professional ethics, there appears to be a perception of potential negative consequences for the worker's health and for social cohesion and support among team members when a professional decides to provide ethical care for unwanted pregnancies. In contrast, failing to provide guidance does not seem to result in adverse consequences in the perception of these workers. The interviewed professionals include protective statements in their discourse that express fear of institutional violence and fear of judgment among their peers.

We know we can do this [inform the women], but we feel kind of... you know? More because of how the rest of the team might judge us, right? (C4).

Well, what I know is that I can't encourage someone to have an abortion. Girls under 13 have the right, right (...) But then I believe it depends a lot [emphasis on "a lot"] on the professional [to provide guidance on harm reduction or clarify who is entitled to a legal abortion] (...) But I have to choose my words very carefully (C4).

Concerns about how the client will receive this guidance were also cited as a challenge and a possible negative consequence of the change in conduct, as perceived by the professionals:

I'd say it's really hard to broach this kind of subject because there are other situations where we're advising the client and end up conveying a different message than what we intend to convey. So I believe it's a subject I'd have a hard time discussing with the person (C2).

I think that often we don't realize that [the pregnancy of] a teenager under fourteen is actually [the result of] rape, but we focus more on the high-risk pregnancy and end up overlooking this situation of violence (C5).

It is evident that social punishments and the negative consequences perceived by professionals, along with

a lack of institutional support, are determining factors in how care for these women is provided. Although professionals possess the necessary knowledge to offer qualified counseling to girls and women, this knowledge alone is not sufficient to bring about the necessary changes.

So, personally, [compared to] before the course, my approach wouldn't change, you know? Neither before nor after—I've never let anything personal influence my consultations. I've always been, and strive to be, as professional as possible, regardless of age. I always treat it as a matter of medical routine—in the sense of doing my job as a doctor and not judging or anything in that sense, regarding age, right? (...) And honestly, I don't give my opinion in terms of a choice, like, 'Do you want to continue this pregnancy or not?' I don't get involved in that (C1)

Another problem identified as a possible reason for inadequate care is the lack of coordination between services, demonstrated by Primary Health Care (PHC) professionals' unfamiliarity with how referral hospitals operate and the procedures performed there. This lack of knowledge and difficulty in communication leads to a lack of confidence in the continuity of care.

There was this patient I treated [for a miscarriage] who went to the hospital, and they told her, "Oh no, we can't see you right now—you haven't fasted." And she's a nurse. She said she went back the next day, having fasted, and they told her, "Oh no, it's too crowded here—it's not going to work." A pregnant nurse—in her fourth pregnancy, no less—and she didn't have access to care. She talked to me; she felt terrible, devalued. I can only imagine what it would be like for a teenager under 14 (C5).

(...) I believe that since there aren't transparent, established referral pathways in the system, you end up giving the person a "solution"—in quotes—it's not quite the right word, but to illustrate, you offer a solution without explaining where or how, and that can frustrate the user:

"Oh, you said it was possible, that it's provided for—so how am I supposed to do this?" right? Even with normal situations—the ones covered by regulations—we already have a hard time; these are everyday situations. A more specific situation like this, at this level, I don't think it's easy to handle, right? (C2).

Well, actually, I had very little—really very little—knowledge [about safe methods used for abortion]. The methods I'd come across... I'd heard that medication was only available on the black market, that it was clandestine. That you couldn't get it at commercial pharmacies; I didn't have any information about whether it was still available or even planned to be made available. But I even asked some colleagues if they knew anything about it, and some of them told me that in some private hospitals, they use methods other than dilation and curettage (C2).

The feeling of institutional abandonment was also mentioned by the professionals as one of the contributing factors to the invisibility that allows them to avoid taking responsibility for the care of unwanted pregnancies and providing qualified counseling.

As far as I understand, we don't have any guidance on this. I haven't come across any informational materials, protocols, etc. There's the issue of referral in cases of abuse of a vulnerable person to a specialty center, but at no point is the possibility of referral for abortion (C2) mentioned.

I believe this course should be taken by primary care managers so that it is truly [emphasis on "truly"] outlined in a care pathway and agreed upon with the hospitals in the network, because knowledge without the necessary resources will, in a way, cause suffering for the staff, who will be unable to implement it. Besides being a very sensitive topic, there needs to be an institutional policy to prevent a health issue from becoming a political one (C2).

DISCUSSION

Women do not openly express their desire to have an abortion, since, in Brazil, the topic is shrouded in taboos and treated as a criminal matter. There is widespread ignorance in Brazil, making the lack of information a major barrier to access to legal abortion⁽¹²⁾. Thus, women seek protection from criminalization and moral judgment through silence, which affects how they are received, resulting in clandestine abortions or forced pregnancies⁽¹³⁾.

Given this situation, the question arises: would the unplanned pregnancies mentioned earlier in the professionals' statements be "accepted" if these women were aware of other options? According to the provisions of medical and nursing codes of ethics and WHO manuals, free and informed consent is that which is obtained by explaining each available option, offering alternatives, and clarifying their respective implications, risks, and benefits^(14,15).

The literature confirms the perception that the time allocated for prenatal visits is insufficient for carrying out the actions recommended by health agencies^(16,17). Adherence to established protocols, focused on maintaining the pregnancy and fetal development, is prioritized by professionals at the expense of women's right to fully understand their rights.

Providing an appropriate welcome and maintaining a bond with patients strengthens the effectiveness and continuity of healthcare interventions⁽¹⁸⁾. The "welcoming" referred to in this study relates to the act of listening that provides guidance tailored to clients' needs, with a focus on resolution and accountability. This concept sometimes conflicts with the accounts provided by the professionals in this study regarding their practice.

In the professionals' statements, it is evident that there is a preference for continuing the pregnancy and that, to some extent, there is an implicit expectation that the professional will convince the pregnant woman to continue

it. This conduct does not appear to be viewed as an imposition or influence on the woman's decision; there is no indication in the workers' statements of any fear that they might be obstructing her access to a basic right⁽¹⁹⁾.

The statements revealed that the professionals feel more comfortable referring cases of pregnancies involving girls under 14 years of age, which can be explained by the fact that children are more readily viewed as innocent victims⁽⁷⁾. Qualified counseling in these cases is contingent upon a direct and prior expression by the girl or her guardians of the desire for termination.

The system of surveillance, isolation, and social punishment imposed by the teams themselves on professionals willing to accept abortion cases causes intentional disruption, whether conscious or unconscious⁽¹⁹⁾. Healthcare professionals, however, cannot be held entirely responsible, since they are merely reproducing the cultural and historical context of misogyny and religious conservatism that keeps Brazil at constant risk of regression⁽¹²⁾.

The Ministry of Health's (MS) Technical Standard for Humanized Abortion Care⁽²⁾ states that "Humanized care for women undergoing abortion is the right of every woman and the duty of every health professional" and that "Counseling entails providing the information necessary for the woman—as the subject of the health care process—to manage the process, make decisions, and practice self-care, in accordance with the Guidelines of the Unified Health System (SUS)." The WHO recommends not only counseling but also the provision of legal abortion in primary health care (PHC) as being safe, convenient, and capable of reducing costs through the accessibility and availability of outpatient services^(1,20). Qualified counseling is feasible and supported by current regulations. Simple adaptations in primary health care can expand effective measures to reduce maternal mortality from unsafe abor-

tions in Brazil⁽⁹⁾.

CONCLUSION

To understand the perceptions of professionals in the Primary Care Network following training on the care of women experiencing abortion. The results revealed that while women and girls are cared for, cases often remain unreported. Concerns about possible individual repercussions and the need to avoid conflicts take precedence over the greater concern of protecting the lives and health of service users.

The issue of abortion challenges established structures and involves deeply rooted personal and religious beliefs in a society that often neglects women's rights and health. This dynamic is permeated by elements of machismo and misogyny and by restrictions on women's decision-making power over their own bodies. The authors suggest using the term "qualified counseling" to denote intentional and care that is qualified to welcome, build rapport, identify, adequately inform, and refer or guide cases of unwanted pregnancies in primary health care (PHC).

A restructuring of public policies regarding abortion is needed so that qualified counseling is explicitly included in the manuals and protocols made available to health professionals.

A key limitation of this study is the difficulty in carrying it out. The study took more than two years from its initial planning to its completion, due to numerous institutional and subjective obstacles encountered along the way. Raising awareness among professionals to encourage their participation was challenging, requiring support from the management of the facility in question. Thus, the small number of participating professionals stands out, and especially the fact that only one woman agreed to participate in the extension and research project.

REFERENCES

1. IFF/Fiocruz Portal de Boas Práticas em Saúde da Mulher, da Criança e do Adolescente - Conteúdo para profissionais de saúde, voltado para prática clínica e baseado em evidências científicas [Internet]. Abortamento seguro: Orientação técnica e de políticas para...; [citado 29 jul 2024]. Disponível em: <https://portaldeboaspraticas.iff.fiocruz.br/biblioteca/abortamento-seguro-orientacao-tecnica-e-de-politicas-para/>.
2. BRASIL.Biblioteca Virtual em Saúde MS [Internet]. Atenção humanizada ao abortamento; [citado 2 fev 2023]. Disponível em: https://bvsm.sau.gov.br/bvs/publicacoes/atencao_humanizada_abortamento_norma_tecnica_2ed.pdf
3. Cardoso BB, Vieira FM, Saraceni V. Aborto no Brasil: o que dizem os dados oficiais? Cad Publica [Internet]. 2020 [citado 13 fev 2023];36(suppl 1). Disponível em: <https://doi.org/10.1590/01002-311x00188718>
4. Uliana MD, Marin DF, Silva MB, Giugliani C, Iser BP. Interações por aborto no Brasil, 2008-2018: estudo ecológico de série temporal. Epidemiol Serv [Internet]. 2022 [citado 28 jul 2023];31(1). Disponível em: <https://doi.org/10.1590/s1679-49742022000100017>
5. Sedgh G, Bearak J, Singh S, Bankole A, Popinchalk A, Ganatra B, Rossier C, Gerdts C, Tunçalp Ö, Johnson BR, Johnston HB, Alkema L. Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends. Lancet [Internet]. Jul 2016 [citado 19 fev 2025];388(10041):258-67. Disponível em: [https://doi.org/10.1016/s0140-6736\(16\)30380-4](https://doi.org/10.1016/s0140-6736(16)30380-4)
6. Observatório da Criança e do Adolescente [Internet]. Número de nascidos vivos de mães de até 19 anos de idade; [citado 23 fev 2023]. Disponível em: <https://observatoriocrianca.org.br/Indicador/Grupo/b8903ad7-8883-414b-a3be-919b248f587b?T=b7e23e85-b462-4251-a414-9cc9b5dfd614>
7. Diniz D, Dios VC, Mastrella M, Madeiro AP. A verdade do estupro nos serviços de aborto legal no Brasil. Rev Bioet [Internet]. Ago 2014 [citado 28 jul 2024];22(2):291-8. Disponível em: <https://doi.org/10.1590/1983-80422014222010>
8. Maia MN. Oferta de aborto legal na atenção primária à saúde. Rev Bras Med Fam Comunidade [Internet]. 26 jan 2021 [citado 14 fev 2023];16(43):2727. Disponível em: [https://doi.org/10.5712/rbmfc16\(43\)2727](https://doi.org/10.5712/rbmfc16(43)2727).
9. Giugliani C, Ruschel AE, Belomé da Silva MC, Maia MN, Pereira Salvador de Oliveira DO. O direito ao aborto no Brasil e a implicação da Atenção Primária à Saúde. Rev Bras Med Fam Comunidade [Internet]. 23 fev 2019 [citado 10 abr 2025];14(41):1791. Disponível em: [https://doi.org/10.5712/rbmfc14\(41\)1791](https://doi.org/10.5712/rbmfc14(41)1791)
10. BRASIL. Biblioteca Virtual em Saúde MS [Internet]. [citado 14 fev 2023]. Disponível em: https://bvsm.sau.gov.br/bvs/publicacoes/politica_nacional_saude_populacao_negra_3d.pdf
11. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Care [Internet]. 16 set 2007 [citado 11 mar 2023];19(6):349-57. Disponível em: <https://doi.org/10.1093/intqhc/mzm042>
12. Pereira C. Entre a Cruz e a espada: a (des)penalização do aborto na América Latina: Insular; 2021. 164 p.
13. Ruschel AE, Machado FV, Giugliani C, Knauth DR. Mulheres vítimas de violência sexual: rotas críticas na busca do direito ao aborto legal. Cad Saude Publica [Internet]. 2022 [citado 28 jul 2024];38(10). Disponível em: <https://doi.org/10.1590/0102-311xpt105022>
14. CONSELHO FEDERAL DE MEDICINA. Código de Ética Médica: Resolução CFM nº 2.217, de 27 de setembro de 2018, modificada pelas Resoluções CFM nº 2.222/2018 e 2.226/2019 / Conselho Federal de Medicina – Brasília: Conselho Federal de Medicina, 2019.
15. World Health Organization (WHO) [Internet]. Abortion care guideline; [citado 17 dez 2023]. Disponível em: <https://www.who.int/publications/i/item/9789240039483>
16. Livramento DD, Backes MT, Damiani PD, Castillo LD, Backes DS, Simão AM. Percepções de gestantes acerca do cuidado pré-natal na atenção primária à saúde. Rev Gauch Enferm [Internet]. 2019 [citado 28 set 2024];40. Disponível em: <https://doi.org/10.1590/1983-1447.2019.20180211>
17. Amorim TS, Backes MT, Carvalho KM, Santos EK, Dorosz PA, Backes DS. Gestão do cuidado de Enfermagem para a qualidade da assistência pré-natal na Atenção Primária à Saúde. Esc Anna Nery [Internet]. 2022 [citado 28 set 2024];26. Disponível em: <https://doi.org/10.1590/2177-9465-ean-2021-0300>
18. Rio Grande do Sul. Acolhimento na Atenção Primária do RS [Internet]. Nov 2022 [citado 28 set 2024]. Disponível em: <https://atencao primaria.rs.gov.br/upload/arquivos/202211/23095813-acolhimento-na-aps-3.pdf>
19. Branco JG, Brilhante AV, Vieira LJ, Manso AG. Objeção de consciência ou instrumentalização ideológica? Uma análise dos discursos de gestores e demais profissionais acerca do abortamento legal. Cad Saude Publica [Internet]. 2020 [citado 28 jul 2024];36(suppl 1). Disponível em: <https://doi.org/10.1590/0102-311x00038219>
20. Santos VC, Anjos KF, Souza R, Eugênio BG. Criminalização do aborto no Brasil e implicações à saúde pública. Rev Bioet [Internet]. Dez 2013 [citado 28 jul 2024];21(3):494-508. Disponível em: <https://doi.org/10.1590/s1983-80422013000300014>