

# Nurses' representations regarding the care of women experiencing unsafe abortion\*

REPRESENTAÇÕES DE ENFERMEIRAS SOBRE O CUIDADO COM MULHERES EM SITUAÇÃO DE ABORTO INSEGURO

REPRESENTACIONES DE ENFERMERAS SOBRE EL CUIDADO DE MUJERES EN SITUACIÓN DE ABORTO INSEGURO

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## ABSTRACT

Abortion, a current reality in our society, is a complex challenge for healthcare professionals. The objective of this article is to report the representations that Primary Healthcare nurses from the city of Chapecó (SC) have regarding the care of women experiencing abortion/unsafe abortion. This is a qualitative, exploratory-descriptive study. Data were collected by means of focal groups comprised of eight nurses, and then analyzed using the method of Collective Subject Discourse Analysis. The discourses indicate that the care provided is permeated with conflicts between assuming an attitude against abortion, supporting the women or remaining impartial. The representation of the preservation of life, a principle taught by professional training and Christian tradition, triggers attempts to convince the women to avoid the abortion. When nurses are not successful in trying to help women find a safe alternative, they advise them to go home and think about the situation, making it clear to the women that she is not the professional who performs the abortion and abandoning the women...

## DESCRIPTORS

Abortion  
Abortion, criminal  
Primary Health Care  
Nursing care

## RESUMO

O aborto, realidade presente em nossa sociedade, é um desafio complexo para os profissionais da saúde. Este artigo objetiva relatar as representações de enfermeiras da Atenção Básica à Saúde do município de Chapecó (SC) sobre o cuidado com mulheres em situação de abortamento/aborto inseguro. Trata-se de estudo qualitativo, exploratório-descriptivo. Os dados foram coletados por meio de Grupo Focal, constituído por oito enfermeiras, e depois analisados com a utilização do método do Discurso do Sujeito Coletivo. Os discursos indicam que o cuidado vem permeado de conflitos entre posicionar-se contra o aborto, apoiar as mulheres ou manter-se na imparcialidade. A representação da preservação da vida, princípio almejado pela formação profissional e tradição cristã, desencadeia tentativas de se evitar o aborto. Quando não há sucesso, mesmo desejando-se ajudar a mulher a encontrar uma saída segura, as enfermeiras apenas a orientam a ir para casa pensar, deixando claro que não é com ela a prática do aborto. Ficando a mulher abandonada...

## DESCRITORES

Aborto  
Aborto criminoso  
Atenção Primária à Saúde  
Cuidados de enfermagem

## RESUMEN

El aborto, realidad social presente, es un complejo desafío para el profesional de salud. Se objetiva relatar las representaciones de enfermeras de Atención Primaria de Salud del municipio de Chapecó (SC) sobre cuidado a mujeres en situación de aborto inseguro. Estudio cualitativo, exploratorio, descriptivo. Datos recolectados mediante Grupo Focal, constituido por ocho enfermeras, analizados luego utilizando el método del Discurso del Sujeto Colectivo. Los discursos indican que la atención se ve impregnada por conflictos para posicionarse en contra del aborto, apoyar a las mujeres o mantenerse imparcial. La representación de la *preservación de la vida, principio deseado por la formación profesional y tradición cristiana*, da lugar a intentos de evitar el aborto. Cuando no hay éxito, aún con voluntad de ayudar a la mujer a encontrar una salida segura, apenas se la orienta para *ir a casa a pensar, dejando claro que el aborto no es para ella, dejándola abandonada...*

## DESCRIPTORES

Aborto  
Aborto criminal  
Atención Primaria de Salud  
Atención de enfermería

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## INTRODUCTION

Abortion is a reality in our society. It is also a taboo subject, a complex challenge for health professionals, and an extreme situation that involves matters of life or death:

*Biological life or death of a future human being; existential life and death of dreams, projects and aspirations; life and death in every way, of millions of women, as a result of the sequelae caused by illegal abortion<sup>(1)</sup>.*

This theme allows for multiple interpretations and represents diverse interests of social institutions, and there is no consensus on the issue. It is a forbidden subject whispered about in corridors and almost never discussed in society, lying at the heart of the family, school and among health professionals.

Globally, 25% of pregnancies end in induced abortion, which corresponds to approximately 50 million abortions annually. Of this total, 20 million are performed under unsafe conditions, the underlying cause of approximately 13% of maternal mortality. Adolescents and women under the age of 24 comprise 46% of this epidemiological scenario<sup>(2)</sup>. It should be pointed out that this unsafe practice happens mainly in countries where abortion is restricted or illegal, where many women, as a result of unplanned or unwanted pregnancies, resort to the practice of illegal abortion<sup>(3)</sup>.

This reality shows that, despite the criminalization of abortion in many countries, women who undergo abortion feel trapped and distressed to the point of ignoring the legal consequences of their actions and disregarding the risk to their own life in order to remedy what seems to them an untenable situation. This is because the laws are doomed to minimal success and the woman must solve what, to her, represents a significant, life-altering problem<sup>(4)</sup>.

In Brazil, where abortion is a crime (except in cases of rape or life-threatening situations to the health of women), the rates of maternal mortality due to abortion have not decreased and persist with alarming incidence, a scenario worthy of *a more serious treatment than the one that has been so far given in our society*<sup>(3)</sup>.

Nationally, women's movements in the first and second Conferences on Public Policies for Women have demanded the decriminalization of abortion, supported by the platforms of action signed by the Brazilian government in the UN-sponsored conferences in recent decades<sup>(5)</sup>.

The issues surrounding abortion gain political relevance when they exceed the boundaries of the private universe, of individual life, and become part of the agenda of the country's political life, as well fodder for discussion

forums on national and international sexual and reproductive rights.

The issue is being discussed in the current Brazilian health scenario, because, according to the declaration of the Minister of Health during the first half of 2007, *abortion is a public health issue and needs to be faced by society and by the National Congress*<sup>(6)</sup>. This leads the speech beyond morality and legality, releasing the debate into the spectrum of health services, among managers and professionals, not only within the hospital scope, but also within Primary Healthcare.

Based on this understanding, on September 18, 2007, the Ministry of Health, aiming at expanding knowledge on the subject of Women's Health on issues relating to teenage pregnancy and abortion, released an announcement promoting research on these issues<sup>(7)</sup>.

**In the professional approach, the issue of abortion raises moral, religious and ethical questions, and assisting with abortions has been permeated with the concept of committing a crime, without reference to the reproductive rights and issues of the underground and social movement**

The current National Plan for Women policies includes in women's healthcare *the understanding of biological, epidemiological, social, cultural, ethical and anthropological articulated aspects in a context of performance within a multidisciplinary team*<sup>(3)</sup>. It is the theme of discussions involving population groups which present morbimortality indicators related to the major public health problems in the world and especially in Brazil<sup>(3)</sup>.

In the professional approach, the issue of abortion raises moral, religious and ethical questions, and assisting with abortions has been permeated with the concept of committing a crime, without reference to the reproductive rights and issues of the underground and social movement<sup>(1)</sup>.

The relationship between Primary Health Care and the abortion theme occurs because this is usually the gateway for women within the Single Health System (SUS). Those women who, for various reasons, are assisted in the promotion, prevention and/or recovery of health significantly expand their social life in this service, generating confidence and the freedom to express feelings and desires to the professionals who assist them.

The professional experience lived by the author of this study, in the course of working as a welfare nurse and coordinator of a Polyclinic of the Municipal Health Department of Chapecó (SC), led to the desire to investigate the theme related to nursing care in Primary Health Care. During this professional period, during the registration of a pregnant client in the Prenatal Program, the women expressed a desire to have an abortion. Faced with this comment, it took me a few seconds to think about what to say. The only thought that occurred to me at that time was: - This is not up to me and not up to the health service. After a few days, the client returned, reporting that she

had used the drug misoprostol, but that it was not having the desired effect (abortion). This situation allowed the perception of trust by the client, because she could have omitted her desire to abort.

The drug misoprostol, used by women in the practice of abortion, is responsible for reducing the number of hospitalizations due to the popularity of its use in the early 1990's, which resulted in reduced complications from induced abortion, since women using such a drug abort at home with no need to make use of health services, either those of Primary Health Services or hospital services<sup>(8)</sup>.

This fact prompted some questions: how should the issue of abortion/induced abortion be dealt with as a personal matter and as a professional caregiver? What professional training does one have for referral of issues related to abortion/unsafe abortion?

In seeking answers to these questions, it was determined that in 2005 the Ministry of Health developed technical standards regarding the humanization of abortion, taking into account the definition of sexual and reproductive rights defined in the International Conference on Population and Development (CIPD) held in Cairo in 1994 and in the 4th World Conference on Woman, held in Beijing in 1995<sup>(9)</sup>. These conferences confirmed that sexual and reproductive rights must be envisaged in human rights, and they recommended quality attention to all people, so that they could exercise such rights<sup>(10)</sup>.

The technical standard *Humanized Attention to Abortion*, created with the objective of ensuring women's human rights (included in these the sexual and reproductive rights), provides guidance to support practitioners and health services, introducing new approaches to care and attention to women in matters relating specifically to abortion. The standard proposes to shelter and provide humanized assistance to women seeking to establish trust, setting aside judgment, discrimination, religious and moral precepts, respecting ethics, autonomy and decision-making capacity<sup>(9)</sup>.

When examining issues relating to abortion discussed in the literature, there arises concerns and anxieties related to personal and ethical dimensions in relation to this practice, especially since, according to the Brazilian Penal Code, this is a crime. In the ethical dimension, several questions come up: Is a complaint to a Court of Law or another institution worth it since it is a crime? What are the limits of ethics when the woman's life is at stake, as well as a potential life? What ethical criteria and human rights apply in abortion care? What can we offer as a health service? When obtaining a diagnosis of pregnancy, should we question the woman if the pregnancy was a result of rape or not? If the answer is yes, should we tell her legal rights? Regarding access to services in legal cases - voluntary interruption of the pregnancy in cases of pregnancy

resulting from rape or involving risk to the mother's life – should we tell the mother where they are performed?

Criminalizing induced abortion would not be the most appropriate way to overcome the problems described previously. Central issues are still set aside, such as the moral precepts, religious values and beliefs in judging and discriminating against these women. How do we deal with the meanings that are mobilized and reassessed at heart?

Seeking other literature on the topic, articles were found in the databases that cover many of these issues, including systematic reviews on abortion, issues related to epidemiology, treatment and the points of view of women in relation to assistance provided by professionals in situations of abortion within the hospital scope, enabling elements for the study object context. In this process, it was important to find the study entitled "Profissionais de saúde frente ao aborto legal no Brasil: desafios, conflitos e significados"<sup>(11)</sup> (Health professionals before legal abortion in Brazil: challenges, conflicts, and meanings), published in 2003 in the *Cadernos de Saúde Pública*, which addresses the issue from the perspective of the challenges, conflicts, and meanings for professionals who provide assistance to women in cases of legal abortion.

This study aimed at seeking the representations of the different professional categories of services that have implemented assistance programs for women victims of sexual violence in Paraíba and the Federal District. The results ranged from the concept of pregnancy interruption as a right to addressing religious values, with abortion seen as a sin<sup>(11)</sup>.

With respect to religious restrictions, the professionals were unanimous in stating that they must maintain a neutral and impartial stance regarding the women's decision and should not judge them by the practice of abortion. "*The professional should not persuade anyone to have or not to have an abortion*" (physician). Paradoxically, one professional said, "*I decided to stay in the program to help women not to interrupt the pregnancy*" (physician)<sup>(11)</sup>.

There is, on the part of some professionals, the concern of being judged by society, being labeled as "abortionists" and legally prosecuted for participating in the interruption of pregnancy<sup>(11)</sup>.

It is emphasized that the main difference of the study mentioned refers to the representations of professionals in cases of legal abortion, while this research focuses on the problem of unsafe abortion, according to the following objective.

## OBJECTIVE

Identify Primary Healthcare nurses' representations regarding the practice of care provided to women undergoing abortion/unsafe abortion in the city of Chapeco (SC).

## METHOD

This is a qualitative research, of the descriptive exploratory type, based on the Theory of Social Representations<sup>(12)</sup>.

This type of research aims at assisting future studies, overcoming *the empirical approaches of social issues*, exploring and describing a problem or situation that is insufficiently known, showing a lack of organized knowledge regarding the existing problem for individuals, for relations and for services<sup>(13-14)</sup>.

In the delimitation of the participants in the study, we observed the following criteria: being a nurse (called *female nurse (s)* because most nursing professionals are women); working in Primary Healthcare; having experienced in their working practice situations related to abortion/unsafe abortion, and having agreed to take part in the study as a free and informed subject.

Data were collected using the *Focal Group* technique, which constitutes a specifically qualitative approach to obtain information about the object of study, by means of (...) *conversation in small and homogeneous groups (...) coordinated by a moderator capable of gaining the participation and the perspective of each and every one*<sup>(15)</sup>.

The Focal Group was composed of eight nurses, and the meetings for the collection and validation of data occurred in three stages, from July to September 2009. In the first and second meetings, data were collected and in the third meeting, the participants validated the data presented. The meetings were videotaped and the lines were recorded.

The data were discussed and analyzed in accordance with the methodological strategy of the Collective Subject Discourse Analysis (CSD), because the speech brings more clarity to social representations of the studied object while *the set of representations that conforms to an imaginary datum* are collected.<sup>(16)</sup> It is the rebuilt representation,

(...) with pieces of individual speech, as in a puzzle, many synthetic discourses as deemed necessary to express a given *figure*, i.e. a given thought or social representation of a phenomenon.

The set of verbal discourses issued by members of a group or a population, when asked questions of a qualitative nature, corresponds to a triggered and manifested discursive thought by means of thoughts of the group or the population people asked about the theme. Therefore, it is through collective discourse that a population seeks to express, as faithfully as possible, their thoughts on the theme<sup>(16)</sup>.

Following the theoretical, philosophical and methodological precepts of the qualitative research approach, data analysis began simultaneously with the first meeting of the Focal Group and concluded at the end of data collection. The analysis was performed according to the four tools proposed in the strategy of the Collective Subject

Discourse Analysis: analysis, selection and grouping of key expressions (ECH); analysis and grouping of central ideas (CI)/categories; analysis of the anchorage present in key expressions; and construction of the Collective Subject Discourse Analysis - CSD<sup>(16)</sup>.

During data analysis, we observed that presenting the position of the investigator in relation to the issue is essential, considering that it is in the relationship between the investigator and his object of study that one builds the interpretation and analysis of empirical material and all methodological process. The moment the investigator identifies his/her personal position, he/she is able to respect and understand the different and complex attitudes that permeate the studied problem. Speaking, therefore, about the personal position of the author of this study, it takes into account the voluntary interruption of pregnancy as an act relative to the empowerment of women, who can make ethical and responsible decisions and responsibility for their own reproductive lives. In short, the investigator stands in favor of freedom of decision for women facing an unwanted pregnancy.

The ethical aspects of the research were observed throughout the development of the study: approval of the research project by the Ethics in Human Research Committee with Human Beings (CEPSH) of the Federal University of Santa Catarina (Certificate No. 159, Case 163/09, FR 261 928); and agreement to participate and maintain the anonymity of the subjects involved according to the Terms of Consent.

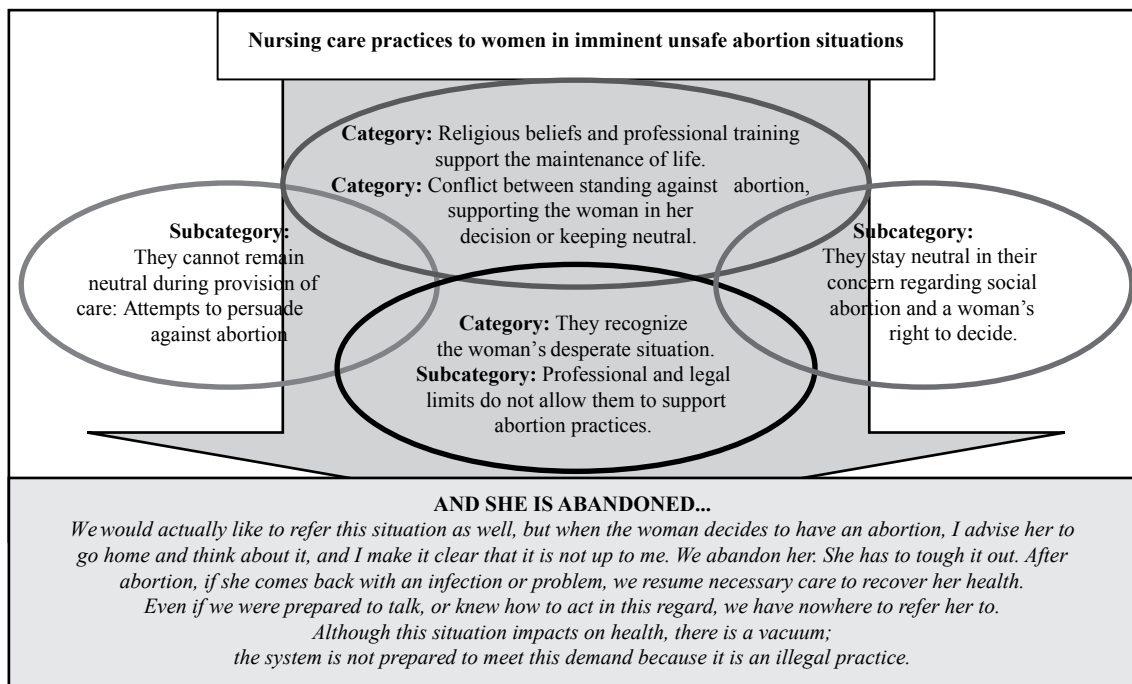
## RESULTS

The representations of nurses working in Primary Healthcare in the city of Chapecó (SC) regarding the care provided to women experiencing a situation of abortion/unsafe abortion are presented below in the form of Collective Subject Discourse Analysis, constituted by categories and subcategories of representations.

The category *Concerns and feelings triggered in the practice of this service* is represented by the following speech:

It is a very difficult situation. It stirs our feelings: it concerns the psychological side of the woman and the fact that the child is not alive; there is sadness and trauma for not having contributed to a safe abortion in cases of maternal death or not having persuaded the woman not to abort; outrage, anger, prejudice and criticism because she had unprotected sex, with so much information and contraceptive methods available at the health unit; unrest, despair, anxiety and impotence when there is willingness to help.

Permeated by this category 'Concerns and feelings triggered in the practice of this service' and by other categories and subcategories of representations, the development of the service practice can be represented by the following diagram:



**Figure 1** - Representative diagram of the nursing care provided in Primary Health Care to women undergoing situations of abortion/unsafe abortion – city of Chapecó, SC – 2009

The conceptions rooted in religious, cultural, family and vocational training often view abortion as a *crime*, realizing that this practice of care should strive for maintenance of life

personal, cultural and, especially, religious values tell us: Let us populate the world! There is always room for one more! There is a life and abortion is a crime.

Professional training prepared us for the ethics and legality in the maintenance and preservation of life, a principle to be pursued in professional practice.

These concepts are shaken by conflicts between positioning against abortion, supporting women in their decision or remaining impartial in the situation.

In general, there are attempts to provide care maintaining impartiality.

The aim is being impartial in care, but being impartial is difficult. Our values, culture, religion and the principle of the profession ultimately reflect in our speech in an attempt to prevent what we see as a crime.

In this sense, we may subtly, by verbal and/or nonverbal expressions, attempt to reverse a decision made regarding an abortion

One cannot be impartial. We try to convince the woman not to abort, expressing the positive side of having the child: it was God who sent it to you! He will take care of you in the future.

I requested that the health worker drop the little box in the mail box at the pregnant women's home (folders about breastfeeding) I knew she was going to open it. After two weeks, she came in bringing the package with her, saying she had talked with her father about the pregnancy and that everything would be okay and that she no longer wanted to abort.

Unlike this practice of care, based on the concept of the human right to a decent life, there is an impartial positioning and referral based on the concern for the future of the child that is not aborted and the woman who, from her life experience, recognizes that she will have no way to provide a decent life for this child.

Telling the woman not to have an abortion because there is a life is useless. We do not know how this child was conceived, whether it will have a decent life or not. We do not know the economic and social resources of the woman who, if she does not have the abortion, might let the child die afterwards, or the child may suffer throughout its life: an abortion that was not abortion, it simply did not have the mechanism.

The woman who, from her experience, knows she will not cope with another child and thinks of the child's future suffering in a situation of extreme misery, knows what she's doing and should not be treated as a criminal.

Thinking about having a child entails also thinking of the existence of a favorable structure for one's life. In order for a human being to have a life, it does not mean only to be in a corporeal body, breathing; it means also having access to human rights.

Based on concern for the future of the child that was not aborted, there is a category called Social Abortion in this study: death can be in life, abortion in life:

Abortion involves a whole social question, and this matter weighs heavily.

For this child who was not aborted, there may be a lack of everything: family, food, warmth, tenderness and lap. This is life.

Sometimes not having an abortion is letting the child die later, because death can be in life.

In this category, there is the following subcategory: When we stand against abortion, social responsibility in regards to the child is also ours.

Our position opposed to abortion generates responsibility for the social situation experienced by the child. What will become of the child tomorrow whom we have positioned ourselves against aborting today? Today this child suffers sequelae and tomorrow this child will be a drug addict, and will steal to support its needs.

This subcategory is founded on the understanding that we all share and are actors in our society - the events and facts present in a society reflect the actions and referrals given by the various actors that make up society.

For professionals, beyond the conflicts discussed previously, there is the conflict generated by the recognition of the desperate situation of women and the legal and professional limits in the desired referral of the situation:

For the woman it is a desperate situation. It is very easy for us to say to that person who is desperate: you did it; now you will have to assume responsibility for it; you did not take care of yourself.

Today the responsibility falls on the women. Surely men get out of it too easily.

There is concern regarding the psychological effects on the woman due to the trauma of having an abortion.

Professionals perceive in this situation the woman in her existential context

She does not need criticism, but rather someone who backs her up. One has to pay attention to the situation the person is going through. Being a professional means not forgetting that there is human being with 'n' problems and 'n' experiences.

Anchored to the criminalization of abortion practice, such as the position of the State, there is, among the professionals, the category of interpretation regarding the notion that the system does not take into account their responsibility in meeting the demand generated by this positioning

*While this situation impacts on health, there is a void. The system is not prepared to meet this demand because it is an illegal practice. For being willing to refer the woman to a reflective support service, other professionals also suffer the limits of the law - It is not just the nursing staff that has*

*no support from referrals; even if we refer the expectant mother to the doctor's, he/she will not know what to do. Depending on the availability of time, he will only talk to her.*

They understand that there should be an immediate avenue for psychological support for these women without having to wait two weeks or a month.

Even so, if she still decides to have an abortion, there is the sense of abandonment in the assistance provided to women

We would really like to refer this situation as well, but when the woman is determined to have an abortion, she is forced to go home to think, making it clear that it is not up to me. We abandon her and she goes underground. She will have to work it out for herself. After the abortion, if she comes back with an infection, a problem, we resume care to restore her health.

Regarding the ethics of the profession, speeches bring the lack of a clear and unanimous understanding regarding the issues, noting contradictions in speeches

I would not report it to the Guardian Council because it is not my role, not least because the Council fights for the rights of the child. I would trigger it, for example, if the mother were 16 years old and were a crack user placing the infant at risk. I would not betray the woman, regardless of the situation. If there is no way to prove that the abortion was induced, it is no use reporting it. I would report if the woman was being pressured to induce abortion, but I do not know if I would report it to the Guardian Council.

## DISCUSSION

Because this is a study that aimed at identifying representations, it adopted as reference the Theory of Social Representations (TSR) - *La Psychanalyse, son image som public*<sup>(12)</sup>.

According to the Social Sciences, the representations come from the real experiences of human interaction. Under this perspective, in recent years the Theory of Social Representations has been used extensively in qualitative research in nursing<sup>(12)</sup>.

The current practice of health care, inserted in Social Sciences, includes a new look at the health/disease process, situating and contextualizing the individual in his entirety, belonging to a social and cultural environment. Investigating the social representations in health/disease provides creative scientific studies involving subject care and caregivers, considering, respectively, the representations of the health/disease process and the care process, such as the individual or group caregiver<sup>(12)</sup>.

The speeches express the triggering of various conflicts in the practice of care, based on different representations of the subject.

Conflicts originate primarily from distinct views that do not mesh. On the contrary, each concept requires a differentiated position in the referral of professional care.

The concept of the maintenance of life, grounded on Christian tradition, professional training, and the concept of each individual's responsibility in assuming the consequences of their acts persuade the practice of care directed towards the attempt to discourage abortion. Since the intent is supporting the right to a worthy life, human rights and social responsibility in terms of non-aborted children resulting from professional interference originate care practices from the perspective of impartiality, where professionals do not try to reverse a woman's desire for the right to make her own decisions regarding reproductive choice.

These concepts are responsible for all kinds of feelings and concerns with respect to the child who may not exist, the risk to a woman undergoing an unsafe abortion and the non-aborted child living in the condition of *social abortion*.

These feelings and concerns are exacerbated mainly due to the professional ethics issue, seeking to maintain life and the position of the State in regards to induced abortion, because it is understood that two lives are at stake: the child's life and the woman who wants to have the abortion. This results in a justification of the subtle position of being between *the cross and the sword*; that is, between positioning themselves against abortion or remaining impartial, ignoring all risks relevant to women in the practice of unsafe abortion.

With regard to the feelings triggered by the fact that women do not take due care to avoid an unwanted pregnancy, we professionals must reflect on the effectiveness of health education related to family planning. This does not have to do only with access to contraceptive methods, but must also contemplate, as a process, the context and perspectives of women's lives, and who will be most likely to practice family planning based on their life experiences.

It is pertinent, upon concluding this discussion, to resume the discourse here on the so-called *Social Abortion: death can be in life, abortion in life*:

The State, by not allowing the right of women's autonomy and decision-making on issues concerning repro-

duction, despite their efforts towards providing assistance to children and adolescents, does not *accommodate delinquent children, caving the street, the sidewalk and the shelter below the bridge their home*.

## CONCLUSION

The professionals committed to healthcare seek to develop their role considering the various aspects and nuances that permeate the health of the population here in relation to women's health. However, the representations relating to induced abortion grounded on religious principles and cultural traditions will always be present in the collective imagination, even if subtly, because they are part of relationships and communication between caregivers and those needing care.

Impartiality regarding such care happens when there is, in particular, careful representation of the so-called *social abortion*, realizing the concern that the unwanted child *is aborted in life, calling the street, the sidewalk its home...*

This study allowed the identification of the representations of nurses regarding the practice of care provided to women undergoing or contemplating having an abortion/unsafe abortion in Primary Healthcare, as well as the need for the State to ensure women's sexual and reproductive rights, allowing women and men to decide *freely and consciously to have children or not*. Such positioning on the part of the State could interfere with the redefinition of views on abortion practice, beyond the psychological contribution to women regarding decision making, safety and health of women and reduction of *social abortion* experiences.

From the moment the practice of care begins in observing the woman's right to have control and decision-making ability on issues relating to her sexuality free of coercion and discrimination, and legitimized by the State, the ethical and professional criteria are overlapped by moral and religious positions, which, quite often, prevent a less biased healthcare service.

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