

# *Maternal health care from the perspective of Primary Care users and professionals: daily life and violence*

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**Abstract:** The aim of this article is to understand the senses and meanings attributed to the daily experiences of primary health care (PHC) users and practitioners in public maternal care services. This is a qualitative study based on these individuals' accounts of their interactions. Focus groups were held with 56 working class women, aged 17-35, mostly self-identified as black or brown, and 115 PHC practitioners, in two cities in a northeastern Brazilian state. The theme of "violence" emerged spontaneously in discussions about rights during pregnancy, childbirth and the puerperium. The women reported difficulties in access and problems with the quality of the services offered. The hierarchical and asymmetrical relations between practitioners and users are crossed by symbolic, naturalized and institutionally legitimized violence, which is reproduced in a game of (dis)accountability on the part of the practitioners. In response, users resort to controlling their emotions and resorting to violence. Depending on the context, violence is more or less explicit, acting as a common thread, a symbolic language, present in the relationship between users and health practitioners. Daily life is marked by violent practices that generate violence as a response and reveal the failure to recognize women as integral subjects with rights.

► **Keywords:** Violence. Maternal Health. Primary Health Care. Maternal Health Services.

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## Introduction

Starting with the proclamation of the 1988 Constitution and, subsequently, the implementation of the Unified Health System (SUS), there have been profound changes in Brazilian health policies and a significant expansion of Primary Health Care (PHC). A new concept of social security, as an expression of the social rights inherent to citizenship, integrating health, welfare and assistance, recognized the right to health as a duty of the state, guaranteed by a set of economic and social policies (Paim, 2013).

The Family Health Strategy (FHS), which reorganized the care model, aimed to expand access to the health system and strengthen disease prevention and health promotion actions (Andrade *et al.*, 2018). A greater number of programs to reduce maternal mortality aimed to improve the living conditions and health of women and, consequently, children (Leal *et al.*, 2018).

The creation of the National Prenatal and Birth Humanization Program (PNHPN in the Portuguese acronym), by Ordinance No. 569 of 1/6/2000, aimed to reduce the high rates of maternal, perinatal and neonatal morbidity and mortality in the country (Santos Neto *et al.*, 2008). Based on the right of pregnant women and newborns to access health care, the PNHPN aimed to ensure comprehensive care during pregnancy, both for normal and high-risk pregnancies, with the necessary investments and funding. However, the expansion of access and coverage occurred in different ways, reproducing existing inequalities in the different regions of the country (Mario *et al.*, 2019).

In the field of sexual and reproductive rights, the National Policy for Comprehensive Women's Health Care (PNAISM in the Portuguese acronym) aimed to improve obstetric care, tackle unsafe abortion, family planning and combat domestic and sexual violence against women (Brasil, 2004). The document makes reference to institutional violence against women in the health services, reflected in delayed care, a lack of interest on the part of the teams in listening to and guiding women, or even explicit discrimination with condemnatory words and attitudes.

There is an additional strategy for guaranteeing rights, the so-called Stork Network<sup>1</sup> prioritizes implementing care from prenatal care onwards, which includes assessing and classifying risk and vulnerability, among other actions. There is also a proposal to link pregnant women to a referral unit and safe transportation during this period, as well as safe delivery and birth and quality health care for children from zero to 24 months (Vilela *et al.*, 2021).

Despite the changes in the Brazilian health system and policies, as well as the effects caused by the expansion of health care, there are still expressions of violence against women in the most diverse services which, due to their constancy and high distribution, are characterized as institutional in nature (Azeredo; Schraiber, 2017). This situation is further aggravated by poverty, crystallizing in the high rates of maternal and infant morbidity and mortality, especially in the North and Northeast of the country. Diniz *et al.* (2016) state that policies aimed at changing childbirth care have had a limited effect, which is also illustrated by the increase in caesarean sections and prematurity. In light of this, social movements have been working with bodies such as the Public Prosecutor's Office to curb abuses and practices that affect women's rights, denouncing interventions and violence during childbirth across the country.

In the area of Collective Health, Minayo (1999), Deslandes (2002), Schraiber (2005), Sarti (2009), Villela (2000), Leite *et al.* (2022), among others, point out that the entry of the theme of violence is associated with the demand for "rights", characterizing a different approach to the "external causes" adopted in epidemiological studies and data.

Violence is considered to be a risk factor for various health problems for women, resulting in a high demand for health services and violating bioethical principles (Lévesque; Ferron-Parayre, 2021; Martín-Badia *et al.*, 2021; Martínez-Vásquez *et al.*, 2021). In the institutional sphere, the violence present in the health professional-user relationship has been described and analyzed based on the health practices themselves (Aguiar; D'Oliveira, 2011; Tobasía-Hege *et al.*, 2019).

Aggressive comments, cursing, threats, racial and socioeconomic discrimination, abusive touch examinations, physical and psychological aggression are reported by women who have given birth in various cities in Brazil (Aguiar; D'Oliveira, 2011; Andrade *et al.*, 2016; Diniz *et al.*, 2015; Guillén, 2015; Rodrigues *et al.*, 2017; Sena; Tesser, 2017; Torres; Santos; Vargens, 2008). Violence against women is expressed by the disrespectful treatment of practitioners, the perceived abusive use of medicalization and the pathologization of childbirth (Leite *et al.*, 2022; Tobasía-Hege *et al.*, 2019).

The study presented here seeks to describe and analyze the reports of PHC health practitioners and users about their daily lives during pregnancy, childbirth and the puerperium, as perspectives situated in dialogue. The users talk about their relationship with PHC and maternity practitioners. The practitioners report on their

relationship with the users during pregnancy(s) and the puerperium and what they know or have “heard” about what happened in the maternity ward. This analysis aims to problematize the tensions present in the broader debate on violence, health and rights, based on concrete situations.

## Methods

This is a qualitative, exploratory and analytical study, part of the project entitled “Involving Users to Improve the Quality of Services and Guarantee Rights: Strengthening the Maternal and Child Health Care System in the First 1000 Days in Brazil (in Portuguese EU QUERO - I WANT)”, a partnership between the Federal University of Maranhão (UFMA), the Federal University of Goiás (UFG) and the University of Southampton (Rodrigues *et al.*, 2023).

The field research was carried out between January and May 2019, in Primary Health Care Units (UAPS in the Portuguese acronym) located in two cities in a state in the Northeast of Brazil, in the capital (four) and in the interior of the state (nine).

The team was made up of three researchers (a doctor, a psychologist and an anthropologist) who are professors, PhDs in Collective Health, with experience in qualitative research, eight undergraduate students in the health area and four postgraduate students in Collective Health.

The fieldwork began by contacting health managers in the state, the municipalities and, later, the respective UAPS. Exploratory visits were made and, together with health practitioners, pregnant women and/or women with children up to two years of age, who were users of the units surveyed, were selected.

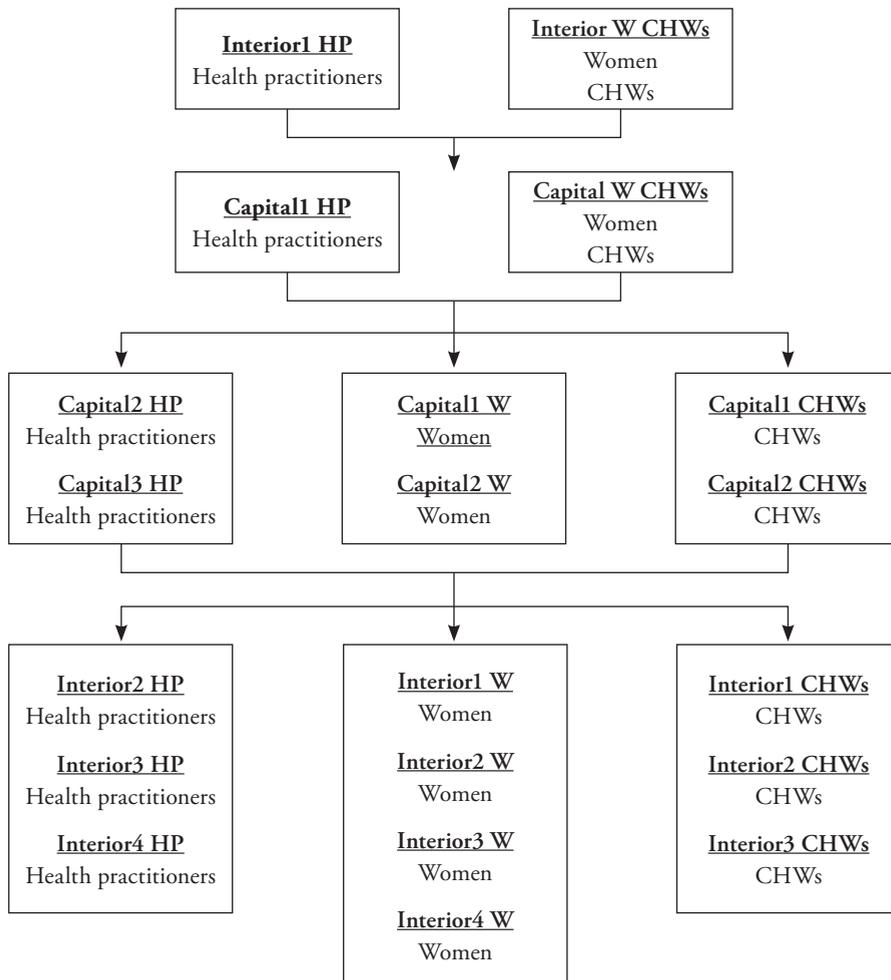
The sample was chosen on the basis of residence in the municipality, age differences, number of children and availability to take part in the research. All health practitioners were invited to take part, with the exception of those on leave, on vacation or who had recently worked at the unit (less than a month).

Eight Focus Groups (FG) were held in the capital and 12 in the interior (Figure 1). There were no refusals to take part in the study. Initially, the FGs brought together women and community health agents (CHWs) on the one hand, and other health practitioners (doctors, nurses, dentists and technicians) on the other.

The proposal to bring users and CHWs together was associated with the idea of belonging to the same territory, a community. However, after holding the first two meetings, both in the interior and in the capital, it was decided to change this

composition, separating groups of users and CHWs. This new organization allowed users to speak more openly, even criticizing the practitioners. In that context, the “us” and “them” was marked more by the health professional-user relationship than by a relationship between the “insiders” and the “outsiders” of the community”. Understanding this division made it possible to problematize intersubjectivity in the researcher-researched relationship and the production of research data. In order to guarantee a place for the CHWs to speak, they were separated from the users in both municipalities. The composition of the two spaces surveyed was strictly the same, which allowed these contexts to be compared.

**Figure 1** – Composition of Focus Groups. Brasil, 2019.



The FGs lasted an average of 90 minutes and were held in the UAPS themselves, with the exception of two FGs in the interior, which took place in a school. The change in social space, however, did not change the hierarchical relationship between higher education and technical practitioners. The activities were recorded and the excerpts presented correspond to the transcribed material.

In epistemological terms, the aim was to access the representation that the subjects make of the reality they experience, as well as the asymmetrical interaction with the “other”, as in the relationship between users and health practitioners. In order to interpret the data, the aim was to use sociological analysis to understand the practices, values and meanings attributed to the context and, above all, to the interactions between these actors (Victora; Knauth; Hassen, 2000; Goldenberg, 2013). It was considered that prenatal, childbirth and puerperium experiences are individual, but the senses and meanings are shared collectively by women with close social properties and discussed from the perspective of practitioners who share a different social context (Rezende, 2019).

Successive readings of the transcribed material were carried out, as well as analysis workshops with the group of researchers. Initially, the content was systematized based on the description of the services and care provided in the primary care units and maternity hospitals. The results were then organized into the following thematic axes: maternal health care and violence as a guiding thread; the dynamics of asymmetrical relations between practitioners and users; control of emotions and violence as language.

The study was cleared by the Research Ethics Committee of the University Hospital linked to the Federal University of Maranhão, under CAAE no. 92281818.9.1001.5086. In order to safeguard the secrecy and confidentiality of the information collected, the FGs were coded (capital or interior non-capital cities) and numbered; the identity of the participants was omitted: women were represented by M, health practitioners by P and ACS (CHW), with the numbering relating to the temporal sequence of the FGs carried out.

## Results and Discussion

Fifty-six women (Table 1) and 114 health workers (Table 2) took part in the study. In both municipalities, the users' FGs sometimes resembled conversation circles. In these, the participants collectively shared their individual experiences of

care and relationships with health practitioners. Women from the interior reported more obstacles to accessing health services when compared to those from the capital, especially with regard to geographical distance and the number of practitioners in the UAPS. The moment of childbirth in maternity hospitals was generally described as an event marked by violence, a situation that was also recognized by the other participants in the survey. In order to move around in these settings and ensure their rights, users seem to resort both to silencing, expressed by controlling their emotions, and to shouting and threats, configuring a language mediated by violence, practiced by practitioners, resisted and sometimes reacted to by parturients and their families.

**Table 1** - Sociodemographic characterization of health practitioners interviewed. Brazil, 2019

Practitioners	Age (median)	Sex		Self-referred race/color		Time of tenure (min/max)	Total
		F	M	Black/ Brown	White		
<b><i>Capital city</i></b>							
Physician	40,4	4	1	3	2	8 months - 11 years	5
Nurse	39,7	10	0	7	3	3 months - 10 years	10
Dentist	43,3	2	1	0	3	5 months - 5 years	3
Nurse Technician	43,1	5	1	5	1	11 months - 23 years	6
Oral Health technician	48	2	0	2	0	7 years - 14 years	2
Community Health Workers	49,1	13	2	14	1	7 years - 23 years	15
<b><i>Interior (non-capitals)</i></b>							
Physician	38,3	3	3	1	5	1 month - 2 years	6
Nurse	39,7	9	0	8	1	1 month - 3 years	9
Dentist	36,7	3	1	2	2	2 months - 3 years	4
Nurse Technician	38,8	9	1	9	1	3 months - 20 years	10
Oral Health technician	37,5	8	1	9	0	4 months - 13 years	9
Community Health Workers	40,6	21	14	32	3	6 months - 23 years	35
<b>Total</b>							<b>114</b>

Source: Authors.

**Table 2** - Sociodemographic characterization of women interviewed. Brazil, 2019

<b>Characteristics</b>	<b>Interior (non-capitals) n or (min/max)</b>	<b>Capital n or (min/max)</b>
Women	46	10
Self-referred race/color		
Black-brown	45	8
White	1	2
Age	(15/34)	(17/35)
Family income*		
Up to 1 minimum wage (MW)	41	6
2 - 3 MW	4	3
Does not know	0	2
Schooling		
Elementary/Junior High incomplete	10	0
Elementary/Junior High Complete	4	2
High School incomplete	12	2
High School complete	18	4
Higher Education incomplete	0	1
Higher Education complete	2	1

Note: \* 2019 Monthly minimum wage: R\$ 998,00.

Source: Authors.

The practitioners had to be told that our research was not evaluative. In the FGs with practitioners, we observed an attitude of accountability on the part of the users, who were described as uninterested in keeping to the schedule of appointments, especially prenatal and childcare appointments and other maternal care. In the FGs, the role of the CHW in monitoring the community, the difficulties encountered in professional practice and those relating to the care network and public management were discussed. In the interior, logistical issues that limit access to the UAPS were highlighted.

In the FG of practitioners, doctors led the way, followed by nurses and dentists, both in the capital and in the interior. CHWs and technicians

occupied a subordinate position in terms of social class, but the former took a stand, while the technicians had little to say. Although they didn't occupy a hegemonic position in biomedical knowledge, the CHWs had more stable employment relationships because they were public servants; they also lived in the area and had worked there longer than the others. They also had active institutions representing the professional category. In the inland municipality, the health secretary was a CHW at the time of the survey.

The hierarchy between senior and mid-level practitioners was present in the research scenario, pointing to the difference in the relative position of the social actors expressed literally in the discourse. The manifestation of symbolic conflicts reproduced in the research context leads us to think of the instruments used to legitimize the domination of one class over another, known as symbolic violence (BOURDIEU, 2011). Being able to speak and feeling authorized to speak on behalf of the group marked the distinction between eloquence and muteness.

### **Maternal health care and violence as a common thread**

It was possible to identify differences in the reports of the FGs carried out in the interior (non-capital cities) of the state and in the capital. Users in the interior of the state reported intense difficulties in moving around the territory due to the distance between their homes and the UAPS. In addition to the women, the practitioners and CHWs also recognized this aspect as a barrier to their professional practice, creating obstacles in prenatal and childcare consultations. The lack of transportation in some locations was seen as a factor that intensifies the obstacles to guaranteeing access and continuity in maternal health care.

We don't have fixed transportation. (Interior2 M9).

[prenatal consultations] [...] the more distant areas like mine, this sometimes makes it difficult both for us to travel and for the mother to travel (Interior2 ACS17).

The pilgrimage of users intensifies during labor, revealing a mismatch between the institutional logic of maternity hospitals (linkage and availability in the network) and the demand from women. The difficulty of transportation and the time it takes to get to the health services add to the distant relationship with the team, especially the doctor. The region had only one general hospital with five beds for obstetrics (Brasil, 2021) which, at the time of the research, was under renovation. Pregnant

women classified as high risk during prenatal care were followed up in maternity hospitals in neighboring towns or in the capital.

It is worth noting that advances in access to maternal health are recent and the organization of services in the care network has been strengthened in recent years in the context studied, especially since the Stork Network, with actions aimed at qualifying care for delivery and birth and based on the rights of women and children up to the age of two (Vilela *et al.*, 2021).

Professionals from the Interior were critical of users who demanded their mediation in accessing services, known as favors, criticizing them for not asserting their position as subjects of rights. The CHWs in the region recognized situations of discrimination experienced by women in health institutions when they tried to assert their rights. In the capital, the right to health was seen as an element that is subordinate to the municipality's insufficient resources.

[...] We see that people are still very much into the favor thing. "Because I don't know anyone there [at the hospital]. I need help for my son. (Interior1 P9).

[...] this issue of mothers when they need it, in labor, right? We see that in some offices they even suffer discrimination, they go through really difficult situations, right? (Interior2 ACS14)

[...] sometimes things happen that are beyond our control. So we offer, within the possibilities of what we have, what the municipality makes available to us (Capital2 P4).

The interviewed practitioners, in general, showed more solidarity with the users when the subject of maternal care was related to maternity hospitals, especially when mentioning the practices related to childbirth and how much discomfort this caused the patients.

A lack of basic hospitality materials, unsatisfactory hygiene conditions and a precarious hospital structure characterize the scenario, according to users from both the capital and the interior.

It's not enough for us to be inside the hospital, it has to be at least clean... everything organized, with the materials [...] (Capital1 M1).

It's something that's really lacking, this part about cloths and utensils. Not that we don't have to bring our own little sheets with our own little smell, but... in any area of the hospital, you already have to bring everything [referring to towels and sheets], because there aren't any (Interior5 M5).

[...] He arrives here at the hospital, [the professional asks]: "Didn't you bring a bedspread? Didn't you bring a towel? You didn't bring any clothes?". (Interior3 M5).

This situation can be seen as an additional health risk for women and, consequently, for children, as well as causing insecurity and intensifying suffering. So, to what extent do the difficulties experienced in seeking care pointed out by women and recognized by health practitioners and CHWs constitute a naturalized practice of violating rights? The barriers to accessing services and the scarcity of materials pointed to an institutional logic, whether in the UAPS or maternity hospitals, which has violence as a daily practice.

Health care during the pregnancy-puerperium cycle, constitutionally guaranteed as a right and recognized, at least in the discourse, by practitioners, is marked by discriminatory practices of gender, social class and race/ethnicity in public maternity hospitals. Such acts are called institutional violence by Aguiar and D'Oliveira (2011). The differences - being a woman, poor, black and with a low level of education - are transformed into inequalities, revealing a hierarchical relationship in which the patient is not treated as the subject of her own choices and decisions.

This is invisible violence, sometimes not named as such, because it is naturalized in care practices and routines. Institutional interests take precedence over the needs of parturient women. What women say they know and feel about their own bodies tends to be disregarded in a context where practitioners' knowledge is decisive and technology and medical knowledge are praised.

The provision of health services during pregnancy, childbirth and the puerperium reveals practices in which violence is not recognized, especially by health practitioners. Rather than criticizing the precarious structures and functioning of health services, it is in the relationship with practitioners that violence corroborates the devaluation of the protagonism of users (Kiss; Schraiber, 2011).

Institutional violence in healthcare has been discussed and denounced by academia and social movements for decades. The persistence of practices that prioritize procedures over subjects seems to indicate that they have long been rooted in the relationships between practitioners and users. In addition, other social markers of difference such as race/ethnicity, class and gender are superimposed.

### **Dynamics of asymmetrical relations between practitioners and users**

When talking about their experiences at the UAPS, the women from the capital related the notion of care to the expectation of being listened to by the practitioners, clarifying doubts and emphasizing the importance of dialogue. Both users in the

capital and in the interior reported acts perpetrated by practitioners in maternity wards, ranging from reprimands for screaming in pain during contractions to the feeling of abandonment as punishment for behavior considered scandalous. From the women's perspective, practitioners scold, ignore and abandon them. Their experiences of care revealed more embarrassment and mistreatment than welcome.

Because they [the nurses and technicians] like it... they left me locked in the room screaming (Capital2 M2).

[...] I was stitched up without anesthesia, **without anything!** I swear! It was the nurse who attended to me, the doctor was asleep, the doctor. She cut me wrong, it's crazy, a lot of blood! (Interior2 M11).

The FGs made it possible for women to share their experiences of pre-natal care and childbirth. They reported fears and disrespect, as well as outcry reactions to the violence practiced against them, both in the capital and in the interior of the state. A mismatch was identified between the expectations users had of care and what was provided at prenatal and childcare appointments and in maternity wards.

Users verbalized a lack of dialogue and welcome, while practitioners in the capital and in the interior spoke of a "cultural" lack of interest on the part of women in seeking information. For them, what was valued by users centered on prescriptive medical practice and medication. In the view of doctors, nurses and dentists, users attach little importance to the material and guidance they receive verbally during consultations and lectures.

It's a lack of interest! And it's, like, when we see that there's some encouragement, there's an appointment, then they come. You give them a layette kit, they come. So, when there's something to give in return, then they're more... (Capital2 P2).

It's... cultural. If you don't write anything down, [if she] doesn't bring any paper from the appointment, she'll say: "Oh, I went there just for her to look at it (Capital1 P4).

A doctor who doesn't give medicine is no good (Capital1 P15).

From the perspective of CHWs from the interior, geographical distance and lack of transportation are barriers to accessing prenatal care, as is the shortage of practitioners. The mismatch between the instructions given and the lack of doctors to provide care is seen as a situation that "puts their professional credibility in check". Mistreatment during childbirth and the lack of information are seen as violations of women's health rights. The essentialization of the notion of culture is not part of the repertoire of accusations of a supposed lack of interest on the part of users.

In the women users' view, the centrality of the doctor in relation to the other members of the team is perceived by practitioners as a devaluation of multidisciplinary and interprofessional knowledge and practices. This view reinforces the asymmetry in the relationship between the practitioners and between them and the users, corroborating the biomedical bias to the detriment of biopsychosocial care that values the integrality of the subject.

Camargo Júnior (2005) addresses biomedical rationality as a producer of discourses with universal validity, with models and laws of general application that do not relate to the subjective issues surrounding the subject. In this paradigm, birth is seen as just another technical procedure and childbirth is medicalized.

The hegemonic model of maternal health care, which is interventionist, uses medical procedures and technologies that are disconnected from good practice and sometimes from scientific evidence (Nicida *et al.*, 2020). This is compounded by relationships of authority and hierarchy between practitioners, centered on the figure of the doctor, which imply a loss of the woman's leading role, as pointed out in the research findings.

Rohden (2001) discusses the constitution of knowledge about the female body as the object of medical interventions and the medicalization of motherhood. Deslandes (2006, p. 34), when dealing with the debate on humanization in health, highlights the permanence of structures that underpin the production of care, reproducing and updating exclusionary relational dynamics. She refers to the "logic of professional training in the biomedical area, the organization of services, the structures of social hierarchy and the provision of care" as structural factors, as well as the relationships of conflict, cooperation and subordination between practitioners and patients that constitute practices in which violence is naturalized.

Thus, the non-recognition of the subject in a rationality in which people are seen as a set of standardized needs and attended to by equally standardized services can lead to accessory, dispensable or even absent interaction. This operating logic is related to the violation of health rights in these scenarios, as it does not consider meeting users' demands and expectations (Deslandes, 2006).

Bourdieu (2021, p. 64), when commenting on symbolic violence, points out that "it is instituted through the adherence that the dominated cannot but grant to the dominant", so that this unequal relationship is seen as natural, unrecognized and therefore invisible. It is a form incorporated into the relationship of domination that

can only be understood by observing the lasting effects that the social order has on women, female submission, the symbolic force over their bodies.

Users in the capital complained about the lack of communication and unmet demands during appointments, while practitioners pointed to women's lack of interest in seeking more information and following the recommendations of the health team, understood beyond the figure of the doctor. Inside, reports of reprimands intensify the hierarchical knowledge-power relationship. In this interaction, symbolic violence, observed as a form of accountability, present in the asymmetrical relationships between practitioners and users, is processed through the act of (un)knowledge that takes place below consciousness and will, as the aforementioned author points out. It exerts its "hypnotic power" with all its manifestations, threats, reproaches and orders for perpetuation (Bourdieu, 2011, p. 4).

The symbolic conflicts present in everyday life are constituted through power relations, whose effectiveness is exercised because it is ignored as arbitrary, because it is a transformed, transfigured and, so to speak, legitimized form of other forms of power. Actualized in the asymmetrical relationships between health practitioners and users, symbolic violence is ingrained in maternal health care.

### **Controlling emotions and violence as language**

After reporting on what users understood to be their rights, experiences in health institutions were recalled, revealing a way of proceeding and a language based on violence, in the face of the imperative that pain should not be expressed, but controlled, especially in maternity wards. Difficulties in accessing services intensified in the interior of the state, either because of limited material resources and few practitioners, or because of travel barriers.

Both in the interior and in the capital, PHC practitioners recognized situations of violence in maternal health care when they discussed practices in maternity hospitals. However, they did little to problematize the asymmetrical relationships built up in the health institutions where they work and the extent to which institutional logic naturalizes and makes violence invisible. The users showed that they were aware of their rights, but in order to access them, they resorted to the language of violence as a practice they needed to adopt in order to be respected by health practitioners.

I'm afraid of giving birth. I don't know what it's going to be like... I take my husband and he's immediately terrified... When he gets to the hospital, if he doesn't make a fuss right away, he won't be seen. That's how it is nowadays (Capital2 M3).

In this case, I had to look as if I was be crazy! I had to be rude, because otherwise: "Look, my child, I have the right, what do you want? You want me to report you? You know best! I'm here screaming 'aaah!' I'm in pain, but I'm going to the police station. (Interior3 M4).

The stories about the fear of giving birth and not being well attended to in the maternity ward are accompanied by the strategy adopted to assert their rights: scandal and threats. When faced with obstacles in the services, the response is to "strike terror", using the language of violence. According to Aguiar and d'Oliveira (2011), rude treatment accompanied by threats constitutes verbal abuse and is therefore considered a form of violence.

As well as fear, loneliness, pain, the silencing of suffering and other forms of mistreatment are part of the experience of users, especially in the interior of maternity hospitals:

[...] I suffered some, some, torture because it's that: "Oh, when you did it you didn't shout, now why shout"? I had that penance of being left alone in the room, they left me alone... they told me to shut up a lot... (Interior3 M2).

Shut up? Nobody shuts up at that time (Interior3 M4).

The PHC practitioners at the units surveyed confirm the perception that there is violence in maternal care services, describing situations in which women go on pilgrimages in labor, as well as negligence, invasive procedures considered unnecessary, and humiliation in maternity wards. This view was also highlighted by the CHWs.

There, those small hospitals. Like our cases. They don't have ultrasound scans [...] So you get there just by looking! 'It's not time'... Then you go home... You go home three or four times. Then, sometimes, when you come back, the baby is already in pain. So, I think there's a little bit of negligence going on there on the part of some practitioners, not all of them. But we know there is (Interior1 P9).

If I receive a patient here, and I know that this patient is going to get complicated, I have nowhere to run. If they close their doors to me there [maternity hospital], there's no point in opening them here [at the UBS]. That's the big problem. So I say: right, right to what? (Capital1 P15).

Because it's horrible. Horrible! There are practitioners who don't even... it's disrespectful, ignorant, I don't even have words for it (Interior3 ACS6).

[...] women shouldn't have to go through... let's say... so much humiliation. Because that's being humiliated, isn't it? Humiliated inside the hospital to have a child (Interior3 ACS6).

The FGs brought together women with different experiences of motherhood. Often, the “veterans” took center stage and told the “newbies” how to behave, especially during childbirth. It is possible to talk about rules, negotiated or not, that are imposed during childbirth: behaviors, ways and strategies to enforce rights, whether by threat or even denunciation, once again falling into forms of violence.

Tornquist (2003, p. 24) points out that middle-class and working-class women are very concerned about their performance in terms of controlling their emotions in maternity wards, so as not to express their pain and thus “not to scream, not to despair, to obey medical orders, to heed the advice of the staff”. Situations that go beyond the limits of expected behavior end up generating strong tension among practitioners and can lead to changes, such as speeding up labor, changing the type of delivery.

With regard to episiotomy, the women interviewed said they had “had that cut unnecessarily” (Capital2 M2). This practice appeared in the survey as part of the parturition routine. The surgical incision mentioned in the reports was used during vaginal delivery in order to achieve perineal expansion for the passage of the fetus, even though it was only indicated in selective and non-routine cases. Situations in which the procedure is not communicated and authorized constitute obstetric violence, as well as violence against women's autonomy and integrity (Freitas *et al.*, 2020). They are associated with potential risks and sequelae, and also constitute a practice of non-recognition of women's reproductive rights (Sena; Tesser, 2017).

The women's reports concern the experiences they have suffered and their responses to claim their care needs. Professionals recognize violent practices when they report what happens in maternity hospitals, but this is not the case when they describe their relationships with PHC users. From the obstetric violence discussed in the media, to the violence that is invisible, unnamed and naturalized by institutional logic, we see the reproduction of practices that are little (re)known and problematized, present in the routine of maternal care services. As pointed out in the research, these practices are even more intense in the reports of women and practitioners from the interior of the state.

## Final considerations

The reports highlight the dynamics of how the services work, which reveal unequal and asymmetrical power relations, impacting on the quality of what is offered and on the way in which users are held accountable by health practitioners in terms of outcomes. Unmet expectations, neglected demands and violent practices generated reactions in response.

These symbolic conflicts reproduced in the research context highlight the legitimizing instruments of domination of one class over another, as well as the intersectionality of gender and race issues. Threats, complaints and mishaps in services during pregnancy, childbirth and the puerperium show that violence is used as a resource to enforce what these users understood to be their rights, and is therefore a common thread in maternal health care.

The interaction with health practitioners is marked by the presence of naturalized violence, which is accentuated in the interior of the northeastern state by a context of difficulties expressed by the lack of transport, vaccines, medication, ultrasounds and inadequate accommodation in maternity hospitals. This intensifies the barriers to accessing health services, when compared to experiences in the capital.

Looking at the specificity of the accounts of everyday maternal health care in a context of poverty, including relationships mediated by a grammar of violence, can contribute to understanding the concrete difficulties and challenges to implementing reproductive rights.

Commitment to the notions of health, universal rights and social justice, among others, requires an understanding of the interplay of political forces which, despite efforts to reduce social inequality in recent decades, have recently been extinguishing social rights historically won in our country. It's not just a question of thinking about promoting equity in programmatic terms, but of facing up to the ways in which diversity (class, gender, race/ethnicity, among others) is culturally legitimized as social inequality. Concrete cases help us to problematize the complexity of social relations between collective subjects and also the challenges of democratizing health knowledge and practices.<sup>2</sup>

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## Notes

<sup>1</sup> Translation note: *Stork Network*: Maternal-child strategy that refers to the folk tradition of storks bringing babies to the world.

<sup>2</sup> R. R. M. Rebouças: writing the article, analyzing and interpreting the data, responsible for all aspects of the work to guarantee the accuracy and integrity of any part of the work. R. H. de S. B. F. de Carvalho: conception and design, analysis and interpretation of data, relevant critical review of the intellectual content, final approval of the version to be published. J. V. B. Sobreira: analysis and interpretation of data, relevant critical review of intellectual content. E. B. A. F. Thomaz and Z. C. Lamy: conception and project, relevant critical review of the intellectual content.

## Resumo

### *Assistência à saúde materna na perspectiva de usuárias e profissionais da Atenção Primária: cotidiano e violência*

Compreender os sentidos e significados atribuídos às vivências cotidianas de usuárias e profissionais da atenção primária à saúde (APS), em serviços públicos de assistência materna, é o objetivo deste artigo. Trata-se de estudo de abordagem qualitativa a partir do relato desses sujeitos sobre suas interações. Foram realizados grupos focais com 56 mulheres, de classes populares, de 17-35 anos, majoritariamente autoidentificadas como pretas ou pardas; e 115 profissionais da APS, em duas cidades de um estado do nordeste brasileiro. O tema “violência” emergiu espontaneamente em discussões sobre direitos na gestação, parto e puerpério. As mulheres relataram dificuldades no acesso e problemas na qualidade dos serviços ofertados. As relações hierárquicas e assimétricas entre profissionais e usuárias são atravessadas por uma violência simbólica, naturalizada, institucionalmente legitimada, que se reproduz em um jogo de (des)responsabilização dos profissionais. Como resposta, usuárias recorrem ao controle das emoções e à violência. A depender do contexto, a violência é mais ou menos explícita, atuando como um fio condutor, uma linguagem simbólica, presente na relação usuárias-profissionais de saúde. O cotidiano é marcado por práticas violentas que geram violência como resposta e revelam o não reconhecimento da mulher como sujeito integral e de direitos.

► **Palavras-chave:** Violência. Saúde Materna. Atenção Primária à Saúde. Serviços de Saúde Materna.

