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Strategies in primary health care in prenatal and postpartum care: the role of community health agents

Estratégias na atenção primária à saúde no pré-natal e puerpério: o papel dos agentes comunitários de saúde

Estrategias en la atención primaria de la salud en el prenatal y puerperio: la función de los agentes comunitarios de salud

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ABSTRACT

Objective: Understand how community health agents identify primary health care strategies to capture recommendations for prenatal and postpartum services. **Method:** A multisite, qualitative research approach with a critical ethnography design to examine issues of culture, knowledge, and actions was conducted in the municipalities of the states of Rio de Janeiro, Minas Gerais, and Paraíba, from July 2019 to March 2020, conducted through in-person focus groups. The recognition of existing conditions that promote and maintain obstetric violence, and the indefinite process of referral-counter-referral of these cases guided the thematic analysis. **Results:** In the 5 focus groups, the accounts of 48 participants, predominantly women, perceptions of the practice emerged in identifying, monitoring, referring and counter-referring cases of obstetric violence. Participants also reported the effectiveness and feasibility of supportive actions, as well difficulties or gaps in these processes. Therefore, an undefined

1 Exceptionally, this article has 12 authors since it reports a multisite study. .

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interprofessional practice was evidenced, whose effectiveness tends to be related to the personal success of individual agents in establishing excellent interprofessional relationships. Although on the frontline, agents deal with an absence of an identifiable network for referral and counter-referral of such cases in the community. **Conclusion:** Difficulties and ambiguities associated with the identification of obstetric violence, compounded by a lack of knowledge of the participants and precarious organization of the action network, causes gaps in care and discontinuance of follow-ups. Increasing the professional development and profile of such agents is a condition for promoting women's empowerment based on their rights.

Descriptors: Primary Health Care; Community Health Workers; Health Promotion; Obstetric Violence; Women's Health.

RESUMO

Objetivo: *Compreender como agentes comunitários de saúde identificam as estratégias na atenção primária à saúde, com intuito de captar as recomendações para a assistência nos serviços de pré-natal e puerpério.* ***Método:*** *Pesquisa multicêntrica, qualitativa, com abordagem da etnografia crítica, visando à análise de questões culturais, de saberes e ações. A pesquisa foi realizada em municípios dos estados do Rio de Janeiro, de Minas Gerais e da Paraíba, no período de julho de 2019 a março de 2020, por meio de grupos focais presenciais. O reconhecimento da existência de condições promotoras e mantenedoras da violência obstétrica, e o processo indefinido de referência-contrarreferência desses casos guiaram a análise temática.* ***Resultados:*** *Durante os cinco grupos focais dos discursos dos 48 participantes, predominantemente do sexo feminino, emergiram percepções da prática na identificação, monitoramento, referência e contrarreferência dos casos de violência obstétrica. Os participantes fizeram relatos sobre a efetividade e viabilidade das ações de suporte ao trabalho, bem como sobre as dificuldades ou lacunas nesses processos. Desse modo, foi evidenciada a indefinição da prática interprofissional, a qual ocorre somente nas situações em que os agentes estabelecem excelentes relações interprofissionais. Porém, embora estejam na linha de frente, não há um canal facilmente identificável pelos agentes para comunicar tais ocorrências.* ***Conclusão:*** *A identificação dessa violência, somada à falta de informação dos agentes, junta-se à precária organização da rede de ação, descontinuando o acompanhamento dos casos. A capacitação dos agentes é condição para a promoção do empoderamento das mulheres, pautado em seus direitos.*

Descritores: *Atenção Primária à Saúde; Agentes Comunitários de Saúde; Promoção da Saúde; Saúde da Mulher; Violência Obstétrica.*

RESUMEN

Objetivo: *Comprender como agentes comunitarios de salud identifican las estrategias en la atención primaria de la salud, con la intención de captar las recomendaciones para la asistencia en los servicios de prenatal y puerperio.* ***Método:*** *Investigación multicéntrica, cualitativa, con enfoque de la etnografía crítica, visando el análisis de cuestiones culturales, de saberes y acciones. La investigación fue realizada en municipios de los estados de Rio de Janeiro, Minas Gerais y de Paraíba, en el período de julio de 2019 hasta marzo de 2020, por medio de grupos focales presenciales. El reconocimiento de la existencia de condiciones promotoras y mantenedoras de la violencia obstétrica, y el proceso indefinido de referencia-contrarreferencia de estos casos guiaron el análisis temático.* ***Resultados:*** *Durante los cinco grupos focales de los discursos de los 48 participantes, predominantemente del sexo femenino, emergieron percepciones de la práctica en la identificación, monitoreo, referencia y contrarreferencia de los casos de violencia obstétrica. Los participantes hicieron informes sobre la efectividad y viabilidad de las acciones de soporte al trabajo, como también sobre las dificultades o huecos en estos procesos. De este modo, fue evidenciada la indefinición de la práctica interprofesional, la cual ocurre solamente en las situaciones en que los agentes establecen excelentes relaciones interprofesionales. Sin embargo, aunque estén en la primera línea, no hay un canal fácilmente identificable por los agentes para comunicar tales ocurrencias.* ***Conclusión:*** *La identificación de esta violencia, agregada a la falta de información de los agentes, se junta a la precaria organización de la red de acción, descontinuando el acompañamiento de los casos. La capacitación de los agentes es condición para la promoción del empoderamiento de las mujeres, pautado en sus derechos.*

Descriptores: *Atención Primaria de Salud; Agentes Comunitarios de Salud; Promoción de Salud; Salud de la Mujer; Violencia Obstétrica.*

INTRODUCTION

The pioneering definition issued by the United Nations[1] that violence against women encompasses any act of violence that causes physical, sexual, and mental harm, including actions that may restrict all forms of women's freedom, includes the social responsibility of health systems health, which must be responsive[2] to the multiple expressions of such violence. Accepting and tolerating such violence represent forms of trivialization, including within health services[3], with disrespectful, abusive, or negligent situations during the pregnancy-puerperal cycle, when women are in a more vulnerable condition[4]. Added to this, there is limited empathy on the part of some professionals who have inadequate clinical and humanistic skills[5].

Obstetric violence (OV) manifests at various levels of health care provision, and includes disrespect, abuse, mistreatment, and violence at the time of birth, such as gender violence[3], which potentially impacts the health of

both women and child[4]. To improve the quality of women's health care, respectful care is recommended in the pregnancy-puerperal cycle, requiring informed consent and continuous support during labor and birth[6].

Violence against women has existed in Brazil for a long time, being recognized as a serious public health problem rooted in social inequalities and gender inequities[7]. Despite the implementation of relevant policies and programs, from the pioneering National Program for the Humanization of Labour and Childbirth (PNHPN)[8] to the recent National Guideline for Care for Pregnant Women[9], these legal instruments have been unsuccessful in curbing OV.

As an international research team operating in a multisite context, our primary curiosity focused on the possible multidimensional manifestations of OV within the scope of Primary Health Care (PHC), examining the particular role of the community health agent (CHA) as a social actor participating in a Family Health Strategy (ESF)[10], which contributes to the promotion of health and the encouragement of healthy self-care. This is part of an ongoing search for insights into compromised social determinants of health – such as access to health services, health literacy, health practices – and the development of actions to guide and promote social well-being[10, 12]. Furthermore, the CHA carry out relevant political education actions for women users of Brazil's Unified Health System (SUS), regarding their rights during the pregnancy-puerperal cycle.

CHAs can contribute to improving maternal and child indicators, especially in socially vulnerable and disadvantaged communities, as well as to reducing maternal mortality and increasing access to family planning[11-12]. When carrying out home visits, CHAs promote the improvement of prenatal care and, when properly trained[13], assist during the postpartum period, encouraging longer breastfeeding times, and increasing maternal knowledge about hygiene and care for the newborn, among others[12]. Despite the above, the state of knowledge on this topic indicates gaps in the scientific evidence pertinent to the Brazilian context, regarding the CHA's role in preventing and identifying OV, as well as in relation to CHAs' support for women who have suffered OV.

This research is based on Brazilian philosopher Paolo Freire's conceptual framework on critical education for liberation and social change[14]. In this awareness process, individuals, by critically inserting themselves in social and political contexts, transform apathy into denouncing injustice[15] in the context of combating OV. In turn, such awareness can lead to an improvement in obstetric care to combat OV[16]. This research was guided by the following question: how do CHAs perceive the role and effectiveness of ESF team practices in identifying, monitoring, referring, and counter-referring OV cases? We aimed to understand how CHAs identify strategies possible within primary health care that best counteract and ameliorate OV to highlight recommendations to deepen and strengthen assistance in prenatal and postpartum services.

METHOD

This article reports partial data from a national, multisite survey, which used mixed and sequential methods[17]. For the qualitative component, critical ethnography was used[18]. This approach allowed the examination of cultural issues, knowledge, and actions. These questions allow for the deepening and refinement of value-based ethical commitments, both in the context of political agendas and power dynamics between individuals. From this general primary research, we extracted qualitative findings derived through data collection conducted exclusively with CHA focus groups. We sought to identify consensual aspects among CHAs regarding the phenomenon of OV they encounter in their practices[19]. The research explored the strategies implemented by ESF teams to capture recommendations from the PNHPN[8] from the CHAs' perspective.

The research sites were services within the SUS PHC network, located in the cities of Belo Horizonte and Juiz de Fora (Minas Gerais), Cachoeiras de Macacu and São Gonçalo (Rio de Janeiro), and João Pessoa (Paraíba). The choice of these municipalities is justified by the greater ease in conducting face-to-face interactions with CHA focus groups. The data collection sessions took place within a multisite research framework, implemented in an international partnership between a Canadian university and eight Brazilian universities and their nursing graduate programs.

The population and sample were composed of CHAs who were members of the ESF teams and met the following eligibility criteria: experience delivering PHC services to women receiving prenatal care and postpartum follow-up. Recruitment took place over a three-month period. During this time, at each research site, posters were displayed on bulletin boards in the nursing team rooms and in the health unit common areas (corridors, technical procedure rooms, general reception) – places where nursing students' supervised internships take place under the academic supervision of Brazilian researchers. CHAs interested in participating in the research contacted the local researcher by telephone.

The sampling considered two exploratory variables (prenatal and postpartum follow-up) with the participation of three CHAs participants per variable level[20]. Thus, the number of participating CHAs should be at least six per

research site. It should be noted that only in São Gonçalo was this number was not reached. The sample's empirical saturation criterion was not applied because the CHAs expressed interest in obtaining general information, in sharing experiences, criticisms and recommendations about the phenomenon investigated.

Data collection through in-person focus groups was carried out between July 2019 and March 2020 by nurse researchers with professional experience in the areas of health promotion, women's health, and obstetric nursing. After obtaining participants' signed consents a sociodemographic identification form was filled out containing closed questions about city, age, biological sex, ethnic-racial identity (optional), profession, years of professional experience with obstetric clientele, and education level. Four structured questions guided the focus groups in the search for consensus[21] among the CHAs on the phenomenon of OV. These same questions guided data collection with other PHC professionals, in accordance with the general objectives of the research, for greater exploration of multidimensional evidence.

Focus groups were guided by original questions addressing: (a) description of ESF team practices in identifying and monitoring OV cases; (b) criticism of the effectiveness and viability of ESF procedures and community resources to monitor the physical and mental health of OV victims; (c) narratives about the main difficulties or gaps in the referral and counter-referral process for these women; and (d) recommendations and suggestions to improve the effectiveness of implementing home monitoring in the postpartum period for this clientele. The sessions were digitally recorded as audio files.

The organization and analysis of the findings were guided by the thematic analysis method[21]. The digital audio files were transcribed manually, with the transcription being read critically. Next, the texts were subjected to manual coding, guided by a list of 217 preliminary codes, created and applied individually by the first two authors. Following these procedures, these authors discussed the consensual evidence to describe the findings. Next, procedures recommended by the thematic analysis method[21] were applied: identification of emerging ideas, after repeated readings of the compilation of written responses; reflection on such ideas organized into groups; and the attempt to identify categories and create possible themes to answer the research question. The thematic analysis procedures presented above were conducted by the first two authors.

It should be noted that carrying out this work involved predefined themes and, depending on the method used[21], offers the researcher the freedom to employ the predefined themes to guide the analysis. To this end, the researcher chose findings considered empirically relevant, whose content is potentially capable of responding, objectively, to what the researcher was looking for. The themes that guided the thematic analysis were: (a) recognition of the existence of conditions that promote and maintain OV; and (b) indefinite reference-counter-reference process characteristic of OV cases. Verification of the final interpretation of the results was carried out by two CHAs who acted as natural experts due to their experiences with OV cases[22], as a strategy to confirm the scientific validity of the research[19].

The research protocol was approved by the Research Ethics Committee of the Toronto Metropolitan University (Canada), protocol no. 063 on 4/24/2019, and by the National Research Ethics Committee (CONEP), protocol nº 3461.935 (Brazil), on 7/19/2019, in accordance with Resolution 466/12. All participants signed a *Free and Informed Consent Form* after reading it and clarifying any doubts, in a collective session led by one of the researchers. To preserve the anonymization of participants' personal and sensitive data, the CHAs' statements are uniquely identified by the name of the city where data collection was carried out.

The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist was partially applied to the writing of this report of qualitative findings, with only those items applicable to the contents reported here being considered.

RESULTS AND DISCUSSION

Five focus groups were held averaging 60 minutes duration, with an average of nine CHAs per focus group, amounting to a final sample of 48 CHAs. Many participants were women (n = 35), aged between 30–50 years, and with professional experience ranging from five to 27 years. Furthermore, 14 CHAs reported professional experience of more than five years, with a maximum of 26 years with obstetric clients. The distribution of CHAs in the focus groups across cities was as follows: Juiz de Fora (n = 15), Cachoeiras de Macacu (n = 11), João Pessoa (n = 9), Belo Horizonte (n = 8), and São Gonçalo (n = 5). As the research explored the level of CHAs' critical understanding of the PNHPN, testimony exhibiting a lack of knowledge of the PNHPN as well as its non-incorporation into the CHAs' health promotion practices was a surprising and recurrent finding.

The following paragraphs present the results gathered from the focus groups in five dimensions: (a) the contexts of CHA reports, as a scenario from which the findings emanate and their sociocultural meanings are expressed; (b) the perception of CHAs regarding ESF practices in the processes of identification, monitoring, referral, and counter-

referral of OV cases; (c) the perception of CHAs regarding the effectiveness and viability of identification, monitoring, referral, and counter-referral practices for OV cases; (d) the difficulties or gaps identified by CHAs related to referral and counter-referral processes of women victims of OV; and (e) the recommendations presented by the CHAs to improve the effectiveness of implementing home monitoring in the postpartum period for this population.

The context of CHA reporting

The scientific evidence identified by this research is characterized by two preponderant contextual elements in the CHAs' reports. First, the experiences of OV commonly identified (regardless of the CHAs' biological sex) in the community (n = 35 reports), in the family (n = 8 reports), and lived by one CHA herself (n = 5 reports). Second, there was an almost unanimous lack of knowledge about the existence of the PNHNP (n = 21 reports) by CHAs in Juiz de Fora, while in João Pessoa and São Gonçalo there was little knowledge about women's rights, whether obstetric, reproductive or human (n = 5 reports).

The reports reveal a significant lack of knowledge about pregnancy, childbirth, what would be considered "normal" and "abnormal" among many CHAs. Reports indicate a trend towards discontinued prenatal care, with limitations in the provision of follow-up and laboratory and imaging tests. A heightened sensitivity towards the stories that women experience during pregnancy characterizes some reports interspersed with an explicit acknowledgment of a lack of knowledge, all of which added to insecurity when guiding OV victims about a helpful course of action. At the same time, the CHAs emphasized knowing both the risks and the responsibility indirectly attributed to them. Given this, they expressed the need to receive formal training, with an emphasis on ongoing in-service education. Furthermore, they emphasized that they were unaware of the existence of a ministerial policy on the subject and reported inaccuracies in the information they received.

> *(…) having no type of training in obstetric violence (…). Health agents, in fact, are very, very poor in knowledge to bring to patients on a daily basis. (city of São Gonçalo)*
> *(...) I went to a course and they said we were supposed to guide women to learn about motherhood, which will be different... that women have the right to anesthesia (...). And it serves as an experience for me to pass on to other women. (city of São Gonçalo)*

Reports also revealed the concern about a greater need of knowledge of women's rights, as reflected in the following statement: *"(…) it is necessary to learn about pregnancy to understand what OV is".* (city of Cachoeiras de Macacu)

> *(...) If there is a pregnant woman in our area, with the knowledge we have now, we should already say, 'when you get there, you will demand more, or you will look for the director or someone at the hospital'. If you don't want this to happen to you, complain (...). Saying that there you have the right to this, this, this. (city of Belo Horizonte)*

Also in João Pessoa, CHAs were unaware of the PNHPN, women's rights, and the practice of monitoring cases of OV. They reported that OV victims tended to talk about their experiences with third parties rather than with themselves. Thus, there is a lack of consultation and feedback from the ESF team. In Juiz de Fora, the PNHNP and rudiments of women's rights are also unknown, and, despite reports of OV, there was no evidence of monitoring, reporting, or referral actions. In Belo Horizonte, the situation was different, due to the presence of a national reference hospital that educates a critical mass of professionals on the subject. However, several cases of pregnant women improperly evaluated for high blood pressure were revealed in São Gonçalo, with recommendations to return home and consequent loss of the fetus hours later:

> *She went to the hospital, the doctor said it wasn't time to have a baby, she came back with the baby dying and she knew the baby was dead and the doctor didn't want to take the baby away. So, after it was taken away, she received a lot of support from her family, yes, that I remember, but she was very psychologically shaken. (city of São Gonçalo)*
> *She was very humiliated. Very humiliated indeed. She told me crying, and I cried too. And I cried too because I felt like she was my daughter. That ended me, it ended me (...) (city of São Gonçalo)*

Perception of identification, monitoring, referral, and counter-referral practices of OV cases by ESF teams

In the focus groups, even before the CHAs talked about processes related to continuity of care in OV cases, numerous reports emerged about discontinuity and negligence in prenatal care by members of the health team, as well

as critical cases of negligence in hospital care extended to pre-delivery. In general, the lack of support and community exposure to situations of violence seem to be components of the women's social life scenario, as commented:

> *I think there is no [support], sometimes, not even at home. Not even her husband, sometimes. I think they don't speak, they are afraid, ashamed. (city of Belo Horizonte)*
> *I think there is a difference in poorer communities, it happens more. Why? When it is a violent community, it already experiences violence. (city of João Pessoa)*

At another point, the lack of institutional support that CHAs often face when responding to women's needs was reported:

> *(…) most of the times we request support, it is never completed until the end. They stop halfway, it seems that the service, the work we did to help that situation has no comeback, they stop the support. (city of São Gonçalo)*
> *(…) we don't know about integrated services yet, right (…). Because we don't have social services, but we have psychology classes (…). Now integrated service, no. (city of Juiz de Fora)*

This perception is due to the identification of community services for monitoring OV cases and newborn safety. Among formal community resources, the following were mentioned: the ESF (n = 7 reports), psychology services (n = 7 reports), and legal assistance services for women, such as the ombudsman's office at health institutions (n = 5 reports). As for informal community resources, they highlighted the neighborhood (n = 6 reports), despite these being superficial relationships with less involvement, as highlighted by CHAs in João Pessoa. Furthermore, these CHAs emphasized the difficulty in identifying resources for the referral process and the fear of reporting:

> *So, first of all, our hands were tied. Why? Then you are in doubt whether to contact the guardianship council, whether to seek the authorities, whether it is legal. Because, in reality, she is also afraid of seeking help. (city of João Pessoa)*
> *In my area [of coverage] mothers often report that they go to the hospital countless times and leave there (...) in addition to being sent back home, they leave without any information. And many times, the information that is passed on (...) it's not complete and it's in very ignorant ways, you know? They feel very humiliated. (city of São Gonçalo)*

The CHAs also identified a fear of reporting, among possible victims of OV, due to the comments they hear from the clientele in general during home visits:

> *People say that it makes them want to sue the hospital and the doctor, but they always say that 'the rope breaks for the weaker side', and they say: 'They are rich, and nothing will happen to them'. A lot of people say: 'If you complain, if you shout a lot, then they'll do worse to you'. (city of Belo Horizonte)*
> *When she came to receive the baby, she told of horrible things. That she didn't know she had to shave (...) (city of Cachoeiras de Macacu)*

Furthermore, ESF team practices related to OV cases, highlight the perceived dichotomy in the quality of services provided in public and private health systems:

> *Of course, in the private [health service], the top, he [the health professional] will do it right, because there he will receive [money], right? Mistreated, you won't get paid, and you're fired, right? Now, in public, he will do it and nothing will happen. There's no point in going to the ombudsman's office. (city of Belo Horizonte)*
> *I wanted to report about my daughter (...) when she had [the baby], she was a minor, and they didn't let me stay with her in the [delivery] room. I didn't insist much because I thought that, suddenly, if I did that, they might want to treat her badly inside (...). They didn't allow her a companion to be with her, like, during breastfeeding, at the beginning (...) she was alone, sometimes she was there, she needed help, and the nurse was far away. (city of Cachoeiras de Macacu)*

Monitoring OV cases in the community was also identified, such as for example in São Gonçalo where CHAs recognized the interest of neighbors in participating, especially in situations involving suffering, which was corroborated by the CHAs:

> *In the community, most of the time, neighbors get more involved in helping than in other communities (...) in needy communities it is easier for them to open up about the treatment they received in the hospital, as everyone depends on the SUS (...). (city of João Pessoa)*

She didn't want to share her situation in an open group so that everyone would know about her suffering, so she started undergoing treatment in another city and, some time later, more or less a year later, she got pregnant again, but then she didn't give any credit to our municipality, the health unit, our work. (city of São Gonçalo)

Perceived effectiveness and viability of identification, monitoring, referral, and counter-referral practices for OV cases

The effectiveness and viability of existing procedures among ESF teams and community resources for monitoring the physical and mental health of women OV victims were described according to the type of practice. In other words, the effectiveness of interprofessional practice between CHAs and nurses (n = 3), doctors (n = 3), social workers (n = 2) and other CHAs (n = 2) was reported, in addition to the effectiveness of direct monitoring of women's emotional conditions by CHAs (n = 2).

Feasibility was perceived as being related to the resolution of emotional problems by CHAs (n = 2). Mediation in making referrals, scheduling appointments, and psychological supports at the Primary Healthcare Unity to promote women's mental health care, were carried out by CHAs, based on the identification of emotional problems and traumas resulting from negative experiences related to motherhood.

I think emotional support comes first, right? Go to her and try, in a way, to comfort her and also bring her to the nurse, in this case, from the unit. In practice, it would be like this, knowing the fact and taking it to the nurse, right? Seek support from the appropriate professional. (city of São Gonçalo)
In the first few days she was very traumatized, she couldn't even go to the bathroom. So I started talking, I booked a psychologist for her. Now, she is even being assisted by the psychologist at the health center. She's fine nowadays, understand? (city of São Gonçalo)

The need for psychological support was highlighted by the CHWs, due to the emotional trauma resulting from OV, which can affect the well-being of women and children, disrupting family dynamics:

(...) I usually went alone. She [the doctor] said to my face: 'your daughter will be born with a foot like this, like this, like this (...) we will have to do several surgeries because your daughter will be born with a clubfoot'. I left the office; I didn't see anything in front of me. I sat on the sidewalk and started crying (...) I couldn't walk. When I went to have my daughter, I freaked out in the operating room. (city of São Gonçalo)
(...) because I was 24 years old and I also came from a very difficult birth, my daughter was 16 years old at the time, she arrived in a position with a lot of difficulty, and came in after 19 hours to give birth to the child, okay. (...) And the interesting thing is that the only person who supported me throughout this moment in the maternity ward was a nursing technician, in whom he tried some things to humanize the birth (...). (city of Juiz de Fora)

The CHA commented that the integration of work between doctors and psychologists is a preventive action and not a curative one. Furthermore, their narratives exemplify the case referral and counter-referral system through the integrated work of an ESF team, which can generally be extended to the participation of other PHC units:

Normally we bring it to the attention of the team, the nurse, the doctor, to see what their stance will be. When there is a NASF [Family Health Support Center] group in the unit, they refer them to a psychologist to talk. (city of Cachoeiras de Macacu)
What could be done, I think is humanization. It's a beautiful word, people like to say, 'ah, let's humanize health', but I think that's exactly what's missing. Humanize. Listening comes from having this general, humanized perspective, seeing this whole context. (city of São Gonçalo)

Difficulties or gaps in the referral and counter-referral process for victims of OV

The greatest difficulties in identifying reference services concern the records of OV cases at police stations (n = 4 reports), as well as psychology professionals (n = 3 reports). CHAs criticized the post-OV actions adopted by several social actors:

And, in the case of these girls, I don't know how they lost their babies, but I know they complain, right? But, so, they complained, they even filed a police report, but then nothing came of it (…). (city of Belo Horizonte)
(...) if she asks us for anything, and we refer her somewhere (...) So (...) we had a very good doctor, she listened to us a lot, so I had freedom with the doctor here, to say: 'I think this baby is too still, don't you think so?' She said: 'Yeah (...) I noticed it too, so let's send it to the service'. (city of Juiz de Fora)

Similar gaps in the quality control processes of obstetric services were highlighted:

> *(…) if there was a report that investigated where she went, there, in the maternity wards (…) all the maternity wards that have a specific maternal death committee. Or at least it should have (…). At [hospital x] there is a maternal and neonatal death committee, which is the first to investigate. (city of João Pessoa)*
> *She was a drug user (...). Now that the baby was born, she is no longer in my area (...) I had to be more present. Insist on consultations, prenatal care, with the nurse here. I took the requisition, and she didn't show up, so I went back there. They took her child because she was a user. I found out about it through the social assistance staff who came to talk to me, even to see how I was doing. (city of Juiz de Fora)*

Recommendations to improve effectiveness of home monitoring of OV victims during postpartum period

The CHAs' reports highlighted the need for in-service training for the multidisciplinary team in all research sites. The CHAs in Belo Horizonte revealed that participating in the focus group allowed them to become aware that the supposed naturalness (with no pain control) was not natural, it was violence. It is also worth highlighting that CHAs in Belo Horizonte work close to a national reference hospital, which allows them to offer frequent training opportunities. In Cachoeiras de Macacu, CHAs also emphasized the importance of psychological supports, as a way of adequately preparing them to deal with the consequences arising from cases identified among the clientele. To deal with the impact of OV in the community, CHAs commonly take advantage of moments of conversation among themselves to vent difficult emotions. As they recognize the need for more and better education about pregnancy and childbirth, and are aware of the lack of training, they use, as an alternative, self-directed learning on the internet on an intuitive basis:

> *(…) training, women's issues, pregnant women's issues, newborns' issues, this whole field that involves women, pregnant women, newborns, the postpartum period. Anyone who has a technical degree has already studied a little. (city of São Gonçalo)*
> *Starting with the basics, what guidance will you give to that person who has just become pregnant? Because she's a young woman, she doesn't have [knowledge], she doesn't know what she does. It's a despair that we go through together. (city of São Gonçalo)*

The focus groups also allowed CHAs to voice their original recommendations, aiming at greater effectiveness in the implementation of prenatal and postpartum home monitoring in identified cases of OV. This would allow them to carry out educational work in the area of pregnant clients' rights:

> *About the rights they have, pregnant women, children, because some are not respected. We also don't know, I don't know, how many, normally, all the rights she has for me (...) to pass on to her. (city of São Gonçalo)*
> *The pregnant woman recognizes her rights, she must know (...). So she is unaware of the issue of humanized birth, the issue of having (...) the right to have a companion who can be there fighting for her rights. And work on the head issue, right? And the issue of the right to choose and questioning during prenatal consultations. (city of Juiz de Fora)*

On the other hand, the CHAs emphasized that knowledge about the PNHPN could equip them, in general, to adopt a more active role in guiding users and family members, in defending the rights already guaranteed by the current legislation.

> *(…) we, CHAs, if there is a pregnant woman in our area, with the knowledge we have now, we should already say, 'when you get there, you will demand more, or you will look for the director or someone at the hospital'. Because there was even one time when she said: 'I called the police, and they helped me'. I think there needs to be more strength, you know? And we are training them. (city of Belo Horizonte)*

In reality, some CHAs are already starting to actively promote political awareness among their clients:

> *What happens is that, during the visit, we can guide some things that we know the mother is entitled to. Example: you have the right to a companion. (city of Cachoeiras de Macacu).*
> *(...) just when this prenatal care started, we started chatting, then I paid attention to the information the nurse was giving (...). No, I didn't have that information, and there, at that moment, there, I understood the importance of that information being given by the nurse, understand? So, I think I was at the right time and place to hear something very important, because I think it was the only professional thing, and it was by chance. (city of São Gonçalo)*

Therefore, based on the narratives reported, the CHAs presented 20 recommendations related to specific topics regarding their training, including pregnancy and childbirth (n = 6), improving the quality of services (n = 5), and women's rights (n = 3). The agents also made four other recommendations regarding in-service education about human rights training for doctors (n = 2) and nurses (n= 2); and, also, recommendations for OV cases to be the subject of monthly discussion in the ESF, and home actions to be implemented (n = 2).

The results indicate that the CHAs perceive it to be the ESF teams' responsibility to identify, monitor, refer, and counter-refer OV cases. Likewise, they understand that the effectiveness and viability of such practices is an unconsummated interprofessional duty, whose effectiveness tends to be related to the CHA's personal success in establishing excellent interprofessional relationships. This perception can be analyzed and understood from two distinct perspectives: (a) recognition of the existence of conditions that produce and maintain OV; and (b) the recognition of the indefinite reference-counter-reference process common in OV cases.

Having a clear perception regarding the issues underlying OV requires CHAs to have a certain level of knowledge, which is currently insufficient. Although there remains a persisting knowledge gap, CHAs' cumulative professional experience provides them with empirical knowledge to identify that current provision of assistance and monitoring of their users are inadequate. The evidence also reveals gaps in critical in-service education, which should be offered to CHAs, aiming to facilitate their comprehensive interventions on client issues, in the community context, and to support autonomy and social change[14].

Recognition of the existence of conditions that promote and maintain OV

The CHAs' complaint regarding the dichotomy between the quality of services offered in the public and private systems, which impacts the extent to which OV is recognized and curbed, requires the recognition of conditions that create opportunities for disrespect for the PNHPN.

The narratives gleaned from the focus groups indicate that, due to precarious working conditions and the overload of professionals in public institutions, women are more susceptible to suffering OV[24]. Among the clientele assisted by the CHA, the largest number of OV cases occurs in young women, with a lower educational level and low family income, black women, residents of urban areas, and with limited access to health services[23,24]. Addressing these systemic inequities and promoting respectful maternal care for all women are essential for improving health equity and quality of care throughout Brazil[24]. These objectives can be achieved with the help of CHAs, as their proximity to the most vulnerable members of their communities allows them to break down barriers and connect these populations to health services.

The desired professional role to be played by CHAs – once properly trained[13] to face the multidimensionality of OV, from the prenatal trajectory through the postpartum period – requires comprehensive education, including an extensive knowledge about the physiology of pregnancy and the lives of newborns, in addition to familiarity with social contexts, humanistic, and communication factors. Training CHAs to develop best health practices in a community context can help them overcome limitations in professional training, as suggested in a systematic review of multicenter international studies carried out in countries in Africa, North America, Asia, and Europe[25]. It should be noted that PHC in these countries operates with the assistance of volunteers or trained people providing functions similar to those performed by Brazilian CHAs. However, the role played by CHAs in an integrated health system, such as the Brazil's SUS, appears to be inadequate if we compare the actions and knowledge of these professionals with those conducting the same services abroad, given the significant differences in context, profile, and scope of the activities carried out.

The CHAs' narratives confirmed that in addition to the acceptance and tolerance of violence against women in Brazilian society, in certain cultures, these acts are trivialized and even unquestioned in health services[3], even when there is social and interpersonal interaction. Evidence also confirms the persistence of disrespectful and abusive care practices throughout all stages of the pregnancy and puerperal cycle, especially when female users are in a context of social vulnerability[4]. The actions of inept professionals contribute to this scenario, both in the technical and relational, and social and humanistic domains[5]. Therefore, it is necessary to raise awareness among health professionals and other health service workers about the importance of their attitudes: their behavior, tone of voice, choice of words, and the way they provide care to women[8].

These factors are crucial considering the routine situations of imposition, authoritarian conduct, and inequality of power between health professionals and women, SUS clients. There are power relations between the user and the health professional, based on an asymmetric interaction modulated by knowledge and power, in which formal and technical knowledge confers authority, establishing a hierarchy of knowledge[23].

The experience of OV, dehumanized treatment, and the distance between the professional and the woman can lead to a lack of trust in health services, causing separation, disconnection, and compromised monitoring of women in the pregnancy-puerperal cycle, as well as of the newborn by health services[3]. This can cause serious harm to the mothers and their babies. In fact, recognizing pregnant women's expectations as distinct individuals, with personal feelings and doubts, as well as satisfaction, about childbirth is a helpful general strategy for reducing OV[16]. Furthermore, making women aware of their rights and autonomy is another simple way to reduce OV[3]. This understanding is present in CHA narratives, highlighting the roots of a basic awareness of the conditions that promote and maintain OV underlying the practice of the ESF teams.

Undefined reference-counter-reference processes in OV cases

Regarding the identification of strategies in the reference-counter-referral process in OV cases, as well as the CHAs perception of them, it was evident that, without clear guidance on the process of interprofessional actions, it becomes impossible for CHAs to understand the course of actions necessary during maternal care and to advise accordingly, on the basis that this care is organized and offered to women to maintain dignity, privacy, and confidentiality[5].

Although the PNHPN ensures the improvement of access, coverage, and quality of care during prenatal care, childbirth, and the postpartum period, from the perspective of rights and citizenship[8], there is an aggravating factor related to the lack of definition in this process: the lack of clarity on referral and counter-referral flows in OV cases. Understanding the dynamics of referral and counter-referral processes in PHC would help CHAs advocate for improving the quality of services, and overcoming the trivialization of OV[3] in the context of their professional practice.

In light of the PNHPN, the debate on OV can contribute to better understanding and awareness about the changes necessary to promote dignified, respectful, and quality care for the pregnancy-puerperal cycle and abortion situations[23]. This awareness leads to a clear and effective approach to OV cases, so that interdisciplinary and complementary interventions ensure completeness, complementarity, and continuity of care. Contact with OV's consequences, which can take an emotional toll on CHAs, results in the mental suffering of these professionals, due to the lack of clearly defined protocols integrated in the referral-counter-referral process. The focus on resolving priority issues leads them to as sort of emergency management cycle of mediating referrals, scheduling appointments, and providing psychological support at the PHC unit to promote women's mental health.

Despite the structural uncertainty, the establishment of a work routine for monitoring OV cases identified in the community would be the responsibility of the ESF multidisciplinary team. These should establish guidelines for the educational work of the CHAs in the community, bringing together people who can form a network of social and emotional support for pregnant and postpartum women, so that they can overcome the traumas resulting from OV. Therefore, the ESF team itself could ensure continuity, comprehensiveness, and responsive care whatever the social reality and clinical vulnerabilities of individual women.

The evidence corroborates the view that the promotion of health rights in Brazilian PHC and the expansion of safe and respectful maternal care practices in the community have a fundamental role in eliminating OV[26]. To this end, intense advocacy and mobilization of the CHAs' potential for community action are necessary, combined with growing women's awareness of their rights and autonomy[24]. Evidence also suggests that such confrontation requires multisectoral collaboration, civil society organization, cross-sectoral partnerships, and advocacy groups for women's rights[24,26]. Future public policies, and the strengthening and implementation of existing ones, with a greater scope for social inclusion, must be based on interpersonal communication, informed consent, good practices in labor and birth, and, fundamentally, on the creation of bonds and strengthening of respect and trust between the professional and every woman requiring such care[23].

The novelty brought by this research focuses on the manifestations of OV in a community context, within the scope of health promotion practices of CHAs; while social actors on the frontline deal with an absence of an identifiable network for referral and counter-referral for OV cases. The discontinuity in community assistance to women in the pregnancy-puerperal cycle is repeatedly revealed, which can be worsened by a CHAs' ignorance of the PHPNP and the pregnancy-puerperal cycle, preventing them from developing a plan of action to protect women's health in PHC. This research confirms the need to design multidimensional strategies for identifying-recognizing-coping with OV in communities, its repercussions, as well as the need to better leverage the CHA role to implement such strategies.

The evidence confirms that although there is still a large gap between Brazilian PHC's goal of improving maternal health and existing realities, the path forward can be ensured through the work of CHAs, with an emphasis on family-centered educational care, prenatal monitoring, and maternal and child care[11,12]. In systematic reviews of multicenter international studies, conducted in South America, Africa, and Asia[25,28], it was recommended that ongoing in-service

education for PHC professionals, especially community health promoters, should prioritize events during visits pre- and postnatal care, for identifying early signs of risk, preparing for childbirth, essential care for newborns, reference procedures, and promotion of groups of pregnant women.

The first and main methodological limitation of this research relates to technical problems with audio files and loss of typed documents, which compromised the specific sociodemographic identification of the CHAs. Although it was possible to identify two CHAs working in the southeast region (only one of whom participated in the research), in the general verification of the final interpretation of the findings, they do not reflect practices in other Brazilian regions. What exists, therefore, is a relevant methodological limitation capable of compromising the transfer of evidence to other practice contexts in Brazil.

CONCLUSION

This research made it possible to understand how CHAs identify strategies in primary health care to assist particularly women experiencing or who previously experienced OV. Once the perception of these professionals is understood, we seek to design recommendations for assistance in prenatal and postpartum services, mainly through the analysis of daily reports, which can often reveal OV in the more general context of PHC.

In such everyday life, OV is present, recognized, and silenced. The CHAs corroborated the fact that OV remains systematically intertwined with a lack of information and the precarious organization of a referral and counter-referral networks. Therefore, combating OV in Brazil represents a challenge that requires sharing of power and knowledge within ESF teams. Expanding the base of theoretical, conceptual, and political-philosophical knowledge of CHAs and other ESF professionals implies substantiating the expected social change through awareness and systematized training of the countless social actors responsible for limiting and offsetting OV in the face of obsolete hegemonic, abusive, and dehumanizing practices.

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CONFLICT OF INTEREST

Nothing to declare

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