

The Brazilian State as an agent of the reproductive process in a village in the Baixo-Sul of Bahia

I¹ Patrícia Souza Rezende, ² Cecilia McCallum I

Abstract: This article explores reproduction as a broad phenomenon that is integrated to social life and marked by power relations, in an analysis of the processes and structures that integrate subjects' lives and bind them with the State. Reproductive processes, which are more than physiological, connect subjects, health services and other sectors that represent the State. This ethnographic study, carried out between 2011 and 2015, focused on reproduction as a biosocial process among mostly black, low-income shellfish gatherers and fishermen living in Riachão – a village located on an island in the 'baixo sul' region of Bahia. Through ethnographic analysis, we explore the experiences of the reproductive process of the 18 women we followed during the research to conclude that the State plays a central role in the network of relationalities that constitute reproduction, establishing an oscillating and ambiguous relationship of care and violence with women at each stage: a fragile and discontinued care relationship during pregnancy; an intense, exclusive relationship marked by violence during childbirth; and a lack of care for the health of women in the puerperium, combined with high surveillance in the care of babies.

► **Keywords:** stratified reproduction; state; inequality; maternal healthcare; relationality.

¹ Universidade de Brasília. Brasília-DF, Brazil (psrezende@gmail.com).
ORCID: 0000-0001-7146-6711

² Universidade Federal da Bahia. Salvador-BA, Brazil (cecilia.mccallum@uol.com.br).
ORCID: 0000-0003-1927-7774

Received: 12/09/2019
Approved: 03/03/2020
Revised: 19/07/2021

DOI: <http://dx.doi.org/10.1590/S0103-73312021310317>

Introduction

By considering human reproduction as a social phenomenon embedded in both public and private spheres, anthropologists Ginsburg & Reiter (1995) reposition perspectives on the phenomenon, to contemplate the impacts of global processes of power on everyday reproductive experiences. They argue that the reproductive process is marked by external forces, but local practices express cultural logics that incorporate, revise or resist the influence and effects of these forces. Thus pregnancy, childbirth and the postpartum occur in contexts of social inequality, emerge within relations of power, and this - rather than so-called 'biological facts' - should be central to analysis (GINSBURG; REITER, 1995).

Anthropological studies of “relatedness” also go beyond the field of biology and highlight the everyday in the constitution of kinship and affinal relations (CARSTEN, 2000; MURILLO, 2016; YANAGISAKO; COLLIER, 1987). Ethnographies in Bahia have documented other elements fundamental to creating connections between people, such as 'consideration' and 'the house', which organize social ties (MARCELIN, 1999; MCCALLUM; BUSTAMANTE, 2012; PINA-CABRAL, 2007; PINA-CABRAL; SILVA, 2013).

Inspired by these approaches, we broadened our view of the reproductive process, considering it as a phenomenon constituted by/in social relations. We show that reproduction is constituted by a multiplicity of actors. The State emerges as a subject in this relational world and plays a powerful and ambiguous role of control and care of women, and violence against them, at different levels of interaction.

The study was carried out in a village on an island in the lower south of Bahia during early 2013¹ after approval by the Research Ethics Committee of the Public Health Institute of the Federal University of Bahia (CEP-ISC/UFBA) (Decision 252 510 of 02/04/2013). It complies with the ethical standards of Resolution 466 of 12/2012. The principal researcher, Patricia Resende, lived in the village for eight months in 2013 and visited it periodically between 11/2011 to 12/2014. During this time, she mapped state institutions, community organizations, churches and work and leisure spaces. When resident of the village, she had help from the villagers who welcomed her and also from local health service workers, to locate women experiencing reproduction who agreed to participate in the research (the

only inclusion criteria). The researcher met the participants frequently, in their homes or workplaces. She identified the people closest to these women who became key interlocutors: partners, family members and those who would be their main caregivers, such as mothers, sisters, sisters-in-law, neighbors. She conducted semi-structured interviews and talked informally with the women, as their pregnant-puerperal state evolved. Immersed in local daily life, the researcher carried out observations, semi-structured interviews and informal conversations with people from 18 women's relational networks. For ethical purposes, we use fictitious names to refer to the village, region and people.

Of the 18 participants, nine were shellfish gatherers and two students. Three were housewives. Daniela worked at Maria Helena's house and Rosa helped in the family shop. Only two had completed higher education: Dália, who was a nursery school teacher, and Maria Helena, who was the director of the local school. Seven received *Bolsa Família* (conditional cash transfer program from the federal government) and five did not have their own income. Only Iara (18 years old, married, 1 child) declared herself white. Of the eleven self-declared black participants, four were between 15 and 18 years old and were primiparous: Barbara (15), Isabela (17), Jussara (17) and Thalia (18). Of these, only Barbara was single. Four were between 24 and 26 years old, all married and mothers when they became pregnant: Dália (25) and Lílian (26) had two children, Daniela (24) had one child and Nina (25) three children. The others were between 31 and 36 years old: Rosa (31) was single and primiparous; Angela (36), married, four children and Bianca (34), married, one child. Among those who declared themselves brown, only Eduarda (17) was a minor, single and primipara, when she became pregnant. The others were between 25 and 30 years old: Flávia (25), Flaviane (26) and Maria Helena (27) had a child; Naiara (30), had 3 children and Caroline (30) was primipara.

We analyzed the data throughout the field work and afterwards, looking at the material produced, such as recordings, images, transcripts, diaries and Field Notes (FN). The relationship of affection built with the people of Riachão promoted continuous contact and, as a feedback, we held a workshop with the participants, where we discussed and exchanged information about the right to health and care for humanized childbirth.

The State in local social life

Riachão is an island village in the lower south of Bahia, part of the municipality of Visconde. It has about 1200 inhabitants. Close to an area of intense tourist flow, it integrates the Environmental Protection Area (APA - for *Área de Proteção Ambiental*) that extends across the region. Recognized as a maroon (*quilombola*) community in 1999, its inhabitants are predominantly low-income and black. Riachão developed at the edge of the tidal estuary and the mangrove. Although the adjective "rural" evokes the central role of the economic, social and political relations that the population establishes with nature and with the land (VEIGA, 2002), the transformations that the island has seen makes this classification inadequate.

To characterize Riachão as "traditional" also has limitations. It has been considered a "traditional community" and its people are artisanal fishermen and shellfish gatherers. In geography, ecology, biology, agronomy, it is usual to so qualify people in similar contexts. However, Castro et. al. (2006) warn of the risk that this concept ignores the internal political dynamics of communities and their historicity. The uses of the term "traditional" contrast with the idea of "modern" and carry distinctions between supposed "backwardness" as opposed to "advance". Such dichotomies support the attitude that these peoples are at fault, resulting in discrimination and the maintenance of social hierarchies (CASTRO et al., 2006).

By symbolically evoking a "primitive" way of life, the notion of "traditional population" strengthens attitudes that support the modernization of behaviors. We remember the manager of the local health post saying that it is difficult to educate such a "*little enlightened*" population. The island was experiencing changes such as social and geographical mobility, access to new technologies and the concomitant expansion of knowledge, real estate speculation, an increase in infrastructure and improvements in housing conditions, evidence of ways that the State, through implementing measures for socioeconomic development, emerges as subject.

We understand the modern, capitalist state as an organized form of class relations, consisting of socio-political forces, institutions and individuals that represent it as employees of state agencies. It is also a field of power, where power relations are in dispute, guiding the meaning of a given measure, action, program, or policy (BOURDIEU, 2014; FLEURY, 1994). We do not see it as an abstract and separate entity from society (ABRAMS, 1988), but we align ourselves with

the anthropological approach that thinks of the State as produced in actions and discourses, considering the materiality of the effects of its practices in local life, that is, as produced and reproduced in power relations (ASAD, 2004; DAS; POOLE, 2004; MALUF; DE ANDRADE, 2017; STEVENSON, 2007).

Through institutions, measures and public policies, the State is present on the island. This extends from the requirement that IBAMA (the Federal Environmental Protection Agency) imposed on the oil company Petrobras to implement an social and environmental compensation program, to the financial aid offered by the *Bolsa Família* Program (PBF) in the form of conditional cash transfer. In addition, Riachão has a health post of the Family Health Program (PSF for *Programa da Saúde da Família*) of the Unified Health System (SUS for Sistema Único de Saúde), a school, a day care center, the Social Assistance Reference Center (CRAS for Centro de Referência de Assistência Social) and the headquarters of the Child Labor Eradication Program (PETI for Programa de Erradicação do Trabalho Infantil). Workers receive state financial support twice a year, equivalent to a minimum monthly wage, during the periods when fishing is prohibited. Women receive maternity pay, via the social security system, once they have been registered as professionals in the area for more than ten months. Between 2006 and 2008, the federal government replaced the adobe houses of the native families with others made of masonry (SANTOS; SCHOMMER; ACCIOLY, 2009).

State power operates through biopolitics, a technology of power that acts on the collective body through disciplining individual bodies, according to Foucault (2005). In the case of Riachão, we argue that biopower also extends its controls in private domains and, as it spreads, intervenes not just to make people live, also affecting how they live (FOUCAULT, 2005). Thus, state sectors and the services they offer are important instruments for the execution of biopolitics.

The inhabitants of Riachão identified the *Bolsa Família*, conditional cash transfer Program (PBF for Programa Bolsa Família), as the main measure for transforming local life. The program aims to overcome poverty, with income transfer, strengthening access to education, health and social assistance and integration with complementary actions (LAVERGNE, 2012). Its conditionalities guarantee the connection of people with the education and health services, and are examples of the State's intersectoral articulation. Improvements in the health of the beneficiary

population have already been demonstrated; under-five mortality rates reduced as program coverage increased (RASELLA et al., 2013).

On the other hand, social policies and the PBF also produce contradictory effects through affording the State access to information and control of behaviors, which is inked to rationalization measures such as the Single Register (*Cadastro Único*) (which brings together all information pertaining to families for all the programs), (COHN, 2012).

In Mexico, Smith-Oka (2013) observed the normalizing effect of the reproductive experiences of indigenous peoples, based on the Oportunidades program, analogous to the Brazilian PBF. The program had a positive impact on living conditions and simultaneously adapted women's behavior to “modern practices”, depriving them of autonomy over their bodies, knowledge and decisions in reproductive life (SMITH-OKA, 2013). There is no similarity in the way in which the medicalization of experiences in Riachão is processed. Although there are impositions on women such as attendance at health services, prenatal care and child vaccination, the durability of practical skills reveals a dynamic interaction between distinct bodies of knowledge about health care.

The importance of expanding health facilities on the island was evident. The PSF expanded after 2004 and the population gained bigger facilities and a larger team of health professionals. The program was implemented in the country as the Ministry of Health (MS)'s reorientation strategy for Primary Care (AB), initiated in 1994, aiming to modify the hospital- centered care model (ESCOREL et al., 2007). The acquisition of a speedboat and the Visconde Support House in the city of Valiosa, where the nearest regional hospital is located – were also crucial. As a result, all births to Riachão's women began to take place in hospital.

In 2012, the Municipal Health Department of Visconde tried to register the active midwives, but found that the profession was extinct in the region. In fact, women who were midwives in Riachão no longer acted as midwives during the period studied. The centrality of the state in the reproductive process was already established; it was now a major healthcare agent, especially for childbirth.

When identifying the State as a subject, ethnography observes differences in forms and levels of action. It acts (1) as an agent in promoting public policies and measures, providing changes to and improvements in living conditions; and (2) as a subject in the relationships between the population of ‘users’ and the health

services – which we explore here. In the latter role, two levels may be distinguished: (2a.) of bureaucratic/institutional organization – the health sector with users of this system; and (2b.) of interpersonal interaction – service workers with users. The second (2b.) refers to people who interact and manage all the complexity of which they are constituted, operating concepts and values that they carry with them. The experiences of women at each stage of the process confirm this, our understanding.

Gestation

Until they disclose their pregnancy, women in Riachão face acceptance processes. Motherhood is seen as important in the construction of family ties, and is ever associated with the struggle to raise children, to sustain and care for them. Women look first to relatives and partners in their search for support: the partner must take responsibility, and parents/relatives must approve. Male participation is central, as recognition on the part of the partner is the main factor for family approval.

There follows an arrangement between subjects in order to guarantee the “*conditions for having a kid*”, referring to economic and affective issues where the house gains centrality, a dynamic that we detail in another text (forthcoming). The State is central to the economic support of families. However, it is only after the pregnancy is confirmed that this person – personified in the health service – will reveal itself as a subject in this network of relationships. From this moment on, reproduction is the main link between women and the State.

Women go to the health post mainly to take their children. Prenatal checkups are considered an important means of monitoring the development of their babies. But the first consultations were not always immediately at the beginning of the pregnancy. Of the 18 women, one started her checkups in the 1st month of pregnancy; four started in the 2nd month; five in the 3rd month; three in the 4th month; one in the 5th month and four in the 6th. Isabela expressed her thoughts thus...

One must go, but sometimes I think it's unnecessary... Because each person has to take care of themselves at home! You go because the person gives you guidance, how it will be during the birth, what you have to do, but you know you can't keep lifting weight at home. (FN).

Despite praise for the health service, it was difficult to get care. The professionals worked at different posts in the region, once a week in each. The work overload, alongside the nurse's absences, made it difficult to carry out consultations. Thus,

the date of the first prenatal checkup did not always reflect the date of the woman's search. Three pregnant women - Nina, Bianca and Flaviane - accompanied by the researcher, did not get the checkups sought because the health professional did not come to work. When they did take place, consultations were standardized, as the nurse explained:

In the first checkup, they register, I request exams, ultrasound, hand over the pregnancy card. Consultations are once a month. Measure the belly, the uterine height, give them supplements [...]. (FN)

Pregnant women also noted the standardization and impersonality of consultations. For Maria Helena *"Ask if you're taking vaccine, ferrous sulfate. Focuses a lot on vitamins to avoid anemia. Weigh, measure, check your weight, these basic things..."* (FN). According to Duarte and Andrade (2008), prenatal checkups should include health education, from the perspective of Integral Healthcare for Women, considering each woman's pregnancy process in its specificities. Women should be respected and understood within their own contexts (DUARTE; ANDRADE, 2008).

Standardized care and absent carers are a correlation of the limited time health professionals have available to do prenatal checkups, which prevents involvement with the population served. Follow-ups were mostly carried out within the SUS services. Only Rosa and Flávia consulted with private doctors. During pregnancy, the most common exams were urine and blood tests – most performed by SUS laboratories, the limitations of which were mentioned as a serious problem. The highly valued ultrasounds were almost always paid for.

The Community Health Agents (ACS for Agentes Comunitários de Saúde) monitored the pregnancy, sought out unregistered pregnant women, performed registrations, notified them when the nurse was present, or about the health post's activities and requirements of the women. Island natives, they participated actively in the lives of those closest to them. Osvaldo (ACS) was Barbara's father. Tereza (ACS) was close to Bianca and Nina. The relational networks of pregnant women also involved other health workers, who participated in these relationships in a double sense – as State agents and as local agents - enunciating the interaction of two knowledge domains – that of biomedical science and that of everyday life, to create hybrid discourses. However, knowledge of a biomedical nature extends widely into the different dimensions of all subjects' lives, as evinced in their high valuation of health equipment, access to prenatal checkups and laboratory tests, and ultrasonography.

Beyond involvement with the health services, pregnant women are connected in a network. As a “*belly*” grows, it strengthens the social relationships it creates around it: As the baby moves, people's interactions with the belly are intensified, infusing these transformations with meaning for the women. With the help of those closest to them, they organize baby showers, prepare the baby's things and room, and get ready for the birth.

Childbirth

The hospitalization of births was the reason why women considered healthcare to have improved “one hundred percent”. Before the introduction of free rapid transport, they accessed hospital by slow boats or canoes and deliveries sometimes took place on the way. Despite being valued, hospital births expressed a serious contradiction – the experiences were marked by suffering.

The State was the only agent of care, the hospital being the exclusive birth space. In 2013, birth companions were not allowed, though a right guaranteed since 2005 (Law 11.108/2005). Unlike pregnancy, when women could count on relatives and the like, during childbirth they only interacted with the institution and its health professionals.

First, they went back and forth between the hospital and their homes or the support home, as “*it was not time*”, a sign of the lack of adequate counseling during the prenatal checkups and the gap between professionals and parturients. The State, despite the guarantee of access to hospital care, omitted to offer qualified assistance from the moment these women were admitted. This highlights the ambiguity in its role as a subject and agent of care.

Once admitted, the women stayed in the pre-delivery room together with pregnant women with complications, women in the process of abortion and other parturients. Most reported an increase in pain after the unexplained use of intravenous serum and that the carers, when asked for help, neglected them. For Jussara, they could improve:

Attention to patients... Get closer, explain things more. Talk more about our body. They don't talk at all. They don't know anything, just tell you to push hard. (FN)

At this point, tension builds and indifference appears as a first step in denying help. Eduarda reported the suffering:

The nurse who was there was bad... all they did at night was sleep, she didn't want to know anything and there was a woman there who was in a lot of pain, more pain than me, she was moaning and they said: “Shut up! When it you made it, you didn't moan”².

They don't care, they turn over and sleep. When a woman comes there to have her baby, they make and raise the bed and the person lies down, but then they go to sleep and don't care at all. (FN)

Many studies in Brazil show experiences of violence in childbirth, name calling, refusal to help with pain relief and other ill-treatment in Brazilian hospitals, demonstrating an ideology of "*naturalizing childbirth pain as a price for sexual pleasure or as a biological fate*" (AGUIAR; D'OLIVEIRA, 2011, p. 89), trivializing the suffering of women (AGUIAR; D'OLIVEIRA, 2011; CARNEIRO, 2011; SALGADO; NIY; DINIZ, 2013). The moment of transfer to the delivery room, the Obstetric Center, as related by Flávia follows:

[...] We lie there, then, when the child is about to be delivered, we have to hunker down, lock our legs, as they say, and go to the delivery room. What I think is wrong is like this, they put us in that room, with pain, then when they see that the child is crowning, then she wants us to lower our legs [...] then we are made to go down and close our legs tightly so that the child does not come out. And we go to the delivery room, and on arrival they bind our legs and put them in the stirrups. (FN).

The destitution of the women's power is completed: left alone, locked in the room, tied up and totally subjugated through the orders of the carers. This is the case with normal births. Ten women had this type of delivery, six underwent episiotomy – an incision made in the perineum region to expand the baby's passage – without prior explanation. The procedure is questioned by organizations and studies that reveal its inadequacy, due to the lack of scientific evidence regarding its effectiveness (DINIZ, 2001).

On the other hand, nearly 50% of the 18 women had caesarean sections – most without negotiation. This data is consistent with other studies in Brazil and points to a high occurrence of unnecessary cesarean sections, which can be associated with severe maternal outcomes (LEAL et al., 2014; MASCARELLO et al., 2017). The numbers exceed the 15% limit established by the World Health Organization (WHO) (PATAH; MALIK, 2011; TORRES et al., 2014).

At birth, the baby is shown to the mother and taken to be cleaned, weighed, checked to "*see if everything is all right*". The women receive their children when they are in the maternity ward, where they are taken on a gurney after being stitched and cleaned up and left to wait for the gurney alone in the hallway.

[...] they took my son and I was scared. Then the nurse told me: Calm down, you'll see him in a little while, I thought it was absurd because how is it that a mother is going to

have a baby and not eat anything, with the child in her belly? I started to say desperately: I'm hungry, my son is hungry, you have to give milk to my son. And she: "Wait, Mum, wait a little!" Then I know they carried me out of the delivery room. They put me beside the operating room, I was on the stretcher for a long time, more than an hour on the clock they told me to wait, then I went to the ward [...] After I waited some time, about three hours, then they brought Dinho... (Eduarda - FN).

The experiences diverge from those envisaged in State normative directives with respect to care during delivery and birth. Since 2000, under Ordinance n. 569/2000, the Ministry of Health (MH) has encouraged the incorporation of welcoming and non-interventionist behaviors in healthcare, and that institutions adopt measures promoting humanization. Federal Law 11,108/2005 assured women in childbirth the right to have a companion of her choice. The MH pamphlet (2001) encouraged good practices, based on evidence, as well as MS Ordinance n. 1459/2011, which instituted and regulated the program known as 'Rede Cegonha' (BRASIL, 2000, 2001, 2011, 2005). Nevertheless, studies observe excessive and unnecessary medical interventions as routine institutional practice in the Brazilian context, confirming what the participants reported to us (LEAL et al., 2014).

State agency is strengthened, manifesting itself as violence. Obstetric violence, or violence in childbirth care, includes violence against women during pregnancy, childbirth, the postpartum period, miscarriage and abortion (SALGADO; NIY; DINIZ, 2013). It refers to human rights violations and practices that are based on traditional notions of gender. It encompasses the appropriation of the body and of women's parturition process, excessive use of technologies and unnecessary medications; aggressions; professional action or omission; inhumane treatment, pathologization of natural processes (WHO, 2014; PARTO DO PRINCÍPIO, 2012). An institutional violence, promoted and sustained under the umbrella of a biomedical rationality that enshrines the authority of medical power (AGUIAR; D'OLIVEIRA; SCHRAIBER, 2013; AGUIAR, 2010).

Institutional violence combines discrimination engendered in structural violence, the result of social inequality, maintained by the State, which makes people vulnerable based on gender, race and social class inequalities (FARMER, 2005). It is worth highlighting the importance of these markers, underlining the role of the intersection of race, class and gender in the context studied, given that we are dealing with mostly black women, with low income, coming from a "traditional

community”. Thus, the maintenance and intensification of structural violence subjects these women to institutional violence and, in this, to obstetric violence.

Despite this scenario, the preference for hospitalized delivery is surprising, possibly explained by the sense of security it conveys regarding the risk of death. Stories about tragic outcomes in the past confirm the importance of institutionalization, as in other studies in the region (MCCALLUM, et al, 2015). The phenomenon can express the strength of biopolitics and medicalization on the female body (FOUCAULT, 2005; VIEIRA, 2008), in addition to the positive value ascribed to that which symbolizes modernity, seen to permit the condition of “backwardness” associated with “traditional” ways of life to be overcome. It is worth remembering the history of marginalization and social exclusion from which these people come and their recent insertion in the consumer market. The hospitalization of births associates local and global issues, as pointed out by Ginsburg & Rapp (1995).

Puerperium

Once in the maternity ward, the women are visited by those who will take them back to the island, where they will be under their care, during a period of postpartum reclusion, the “*resguardo*”. During this period, the state is not very active as a caregiver for women, focusing mainly on babies. Medicine divides the puerperium, the period after childbirth, into three phases: the immediate (until the 10th day), the late (until the 42nd day) and the remote (from the 43rd day) (BRASIL, 2001). In Riachão, three months is the ideal for the “*resguardo*”, but there are restrictions that last for six months. In practice, the “*resguardo*” usually lasts a month, with the first fifteen days being the most restrictive. In other contexts, the period also varies: from 40 to 45 days among the Mundukuru (DIAS-SCOPEL, 2014) and for midwives in Pará (FLEISCHER, 2007); a week to several months, among Wapichana and Macuxi in Roraima (TEMPESTA, 2010).

In Riachão, restrictions include: contact with cold water, bending down, walking too much, lifting weights, washing clothes, sweeping, having sex, getting nervous, moving repeatedly or eating foods classified as “*remoso*,” said to contain inflammatory properties (“*resguardo of the mouth*”). And studies in other regions of Brazil identified similar restrictions for women during the postpartum period (DIAS-SCOPEL; SCOPEL; LANGDON, 2017; Fleischer, 2007; MACÊDO; Belaunde, 2007; Motta-Maues, 1977; PEIRANO, 1975; TEMPESTA, 2004).

Women in Riachão also mentioned the "*owner of the body*" - an entity that is located in the abdomen, as Vivian (Jussara's mother) and Bianca detailed:

Vivian: It protects the child and when (the child) is born, she (the owner of the body) remains there looking for the baby. If the person bends down during the "*resguardo*", she (the owner of the body) leaves and with time stays outside. Then the woman has to have an operation, people call it a rupture. Then the people (surgeons) remake the perineum. There are some that don't come out, there are some that cause pain in the legs, depression, things like that (FN)

Bianca: She (the owner of the body) keeps calling death. You have to be very careful [...] only after 41 days may one live a normal life, and also (it is necessary to) separate food, because there is food that you can't eat when we're on "*resguardo*" - the body is open (FN).

The "*owner of the body*" is not widely alluded to in Riachão, but most agree that the "*open body*" requires care so that the "*birth doesn't go to the head*". Similar to the Tupinambás from Olivença, Bahia state (MACÊDO; BELAUNDE, 2007) the postpartum period is the most important period for women's health, as Roberta explained to us:

Because it stays open. After childbirth, after the child comes out, the body is open and it is easier to get sick, one is more susceptible. That's why you have to be very careful. Here during the "*resguardo*" there are women who cannot put their feet on the ground, nor touch cold water. Sweeping is very dangerous, because one moves a lot, it takes a lot of effort. One cannot wash clothes nor take a cold shower (FN).

When they "break the *resguardo*", women get severe headaches and can "lose their minds". As among the Tupinambás (MACÊDO; BELAUNDE, 2007), these notions circulate in older women's discourse. In Riachão, they happily explained care during the "*resguardo*", underlining their concerns with younger women who lean more on medicalized notions to care for themselves.

Maria Helena, for example, had her "*resguardo* of the mouth", but a week after the last birth she was already working. Her mother-in-law was worried because Maria Helena did not follow the *resguardo* restrictions, claiming not to believe in what was not scientifically proven. Despite the variability, all women experienced some restrictions and some practices were recurrent. First, it is necessary to have a support network, as the mother and the newborn will be cared for by someone from this network – usually women: mothers or relatives. If they do not have family nearby, recently delivered mothers rely on the help of neighbors and friends – like Caroline – or, if they have adequate income, they pay for help – like Maria Helena. Naiara planned to go to her mother's house, but her teenage daughters took care of her.

Whoever “supports the *resguardo*” (the main carer) bathes the baby until the umbilical stump comes away and prepare the mother’s bath; cooks for her; washes her clothes and those of the baby. Care is also shared, as in the case of Barbara - her baby received cared from its paternal grandmother; and her mother Bela took care of her.

Breastfeeding was also an important postpartum phenomenon. Part of women's dietary restrictions are explained by the effect they can have on babies, through breastfeeding. However, few women adhered to exclusive breastfeeding. Food supplementation was seen as a form of care, as Eduarda explains:

[...] they said that for six months the child only had to breastfeed and not to give him anything else [...] I didn't do that because I don't think it's right. It's not correct! How does a small child do without herbal tea, without medicine? [...] I gave him gruel because I saw that it wasn't really enough for him. He asked for milk! My breasts were wounded [...]. At the health post no one said anything. She (the nurse) asked if I was breastfeeding, and I said I was. Because I know they were going to keep saying it was wrong and stuff, so I didn't say anything to them (FN).

Medical knowledge and practice legitimize the power of the State and make female bodies priority targets for birth and population control policies (VIEIRA, 2008). The effects of these dispositives reconfigure gender attributions, assigning to women not only giving birth, but also making children grow, raising and caring for new citizens – matters of the State (ROHDEN, 2000; VIEIRA, 2008). Even so, Eduarda fled from the control exercised by the agent of the State.

Women are aware of the divergences between what they do and the guidelines they receive, but they do not make them explicit in front of the health professionals. The concern with the feeding of newborn children, both in the study by Bustamante (2009) and in this one, reveals care with children's health and growth. But when there is a disjunction between what is prescribed and what is practiced, the widespread idea that the good mother is the one who follows the guidelines results in conflicting relationships, in addition to distancing in decision-making, as in the case of Eduarda. The vertically imposed biomedical guidelines for breastfeeding and care of babies do not reverberate homogeneously in local practices because behaviors influenced by biomedical prescriptions coexist to a greater or lesser degree, during the postpartum period.

The biosocial character of reproduction, then, is confirmed. The State deprives itself of the place of agentive subject – a role it intended to play with respect to women during pregnancy and which it does play during childbirth. The body that carried

another body is no longer the focus of biopolitics. The health service rarely offered any healthcare to postpartum mothers. According to the local nurse, health care actions for women in the puerperium were not necessary, as “*all the recommendations for the care of the babies were given in the prenatal consultations*” (FN).

This piece of information and the descriptions of care during the prenatal checkups show that the focus of state action during the reproductive process is not the women’s health, but rather it is the monitoring / following- up of the new being that is generated, as Wetterberg (2004) noted. The lack of care for women’s health in the postpartum period confirms that the concern is almost exclusively for the baby – the body that was inside the other.

Conclusion

The reproductive process in Riachão is a connective hub for a network of relationships. Within this hub, the State stands out as a powerful subject, helping to guarantee “*the conditions for having a child*” and to improve the living conditions of these people, in addition to being present in institutions. On the other hand, represented by the institutions of the formal health system, at both the organizational /bureaucratic and interpersonal level, the State manifests itself in an ambiguous relationship of care, control and violence towards women. If, on the one hand, it has made gestures towards the regulation of healthcare for women’s reproductive health in the broader systemic domain (laws, ordinances, etc.), on the other, its institutions are not organized in this sense.

Although valued, the State’s role as an agent of care during pregnancy is incipient. It moves in the direction of reproductive life but lacks connection. The focus of care for women in prenatal consultations is premised on a biomedical perspective, reducing them to a body that carries another, the same notion that underlies women’s understanding of this care.

In childbirth, this relationship intensifies and reaches the height of contradiction. As an exclusive subject in healthcare, the State’s performance is characterized by a form of care imbued with violent acts. In the immediate interaction of professionals with parturients, a sequence of discriminatory and improper practices can be observed, practices based on preconceptions about gender, race and social class. However, the State also presents itself, paradoxically, as an agent of care, given the importance

attributed to hospital care in preventing health problems and poor outcomes. Despite the abusive treatment, women insist on their preference for hospital birth and the legitimization of medical knowledge/power. The hegemony of the State's biopolitics gains centrality, reflecting the value attributed to techniques and science.

In the puerperium, on the other hand, the State is absent from women's health care, despite placing itself as an agent in the health care of babies. At this stage, the strength of the relationships between the subjects and the diversity of knowledge in interaction is highlighted.

Finally, we affirm that fomenting birth and growth can only be accomplished through subjects' engagements in the reproductive process, and that this is not just produced locally, without the effects upon these relationships of the State's biopolitics, in its oscillating and ambiguous role.³

References

- ABRAMS, P. Notes on difficulty of studying the state. *Journal of Historical Sociology*, v. 1, n. 1, p. 58-89, 1988.
- AGUIAR, J. M. DE; D'OLIVEIRA, A. F. P. L. Violência institucional em maternidades públicas sob a ótica das usuárias. *Interface - Comunicação, Saúde, Educação*, v. 15, n. 36, p. 79-92, mar. 2011.
- AGUIAR, J. M. DE; D'OLIVEIRA, A. F. P. L.; SCHRAIBER, L. B. Violência institucional, autoridade médica e poder nas maternidades sob a ótica dos profissionais de saúde. *Cadernos de Saúde Pública*, v. 29, n. 11, p. 2287--2296, nov. 2013.
- AGUIAR, J. M. *Violência institucional em maternidades públicas: hostilidade ao invés de acolhimento como uma questão de gênero*. Tese (Doutorado) - Universidade de São Paulo, São Paulo, 2010.
- ASAD, T. Where are the margins of this State? In: DAS, V.; POOLE, D. (Eds.). *Anthropology in the margins of the State*. New Delhi: Oxford University Press, 2004. p. 279-288.
- BOURDIEU, P. *Sobre o Estado: Cursos no Collège de France (1989-1992)*. São Paulo: Companhia das Letras, 2014.
- BRASIL. Ministério da Saúde. Área técnica de Saúde da Mulher. *Parto, aborto e puerpério. Assistência humanizada à mulher*. Brasília: Ministério da Saúde, 2001.
- _____. Ministério da Saúde. *Portaria nº 569, de 1º de junho de 2000*. Disponível em: <http://bvsms.saude.gov.br/bvs/saudelegis/gm/2000/prt0569_01_06_2000_rep.html>. Acesso em: 31 dez. 2019.

- _____. Ministério da Saúde. *Portaria nº 1.459, de junho de 2011*. Disponível em: <http://bvsmms.saude.gov.br/bvs/saudelegis/gm/2011/prt1459_24_06_2011.html>. Acesso em: 31 dez. 2019.
- _____. Presidência da República. *Lei nº 11.108, de 7 de abril de 2005*. Disponível em: <http://www.planalto.gov.br/ccivil_03/_Ato2004-2006/2005/Lei/L11108.htm>. Acesso em: 31 dez. 2019.
- BUSTAMANTE, V. *Cuidado infantil e construção social da pessoa: Uma etnografia em um bairro popular de Salvador*. Tese (Doutorado) - Instituto de Saúde Coletiva, Universidade Federal da Bahia, Salvador, 2009.
- CARNEIRO, R. G. *Cenas de parto e políticas do corpo : uma etnografia de práticas femininas de parto humanizado*. Tese (Doutorado) - IFCH, UNICAMP, Campinas, 2011.
- CARSTEN, J. *Cultures of relatedness*. 1. ed. Cambridge: Cambridge University Press, 2000.
- CASTRO, F. et al. Use and misuse of the concepts of tradition and property rights in the conservation of natural resources in the Atlantic forest (Brazil). *Ambient. soc*, v. 9, n. 1, 2006.
- COHN, A. *Cartas ao presidente Lula: Bolsa Família e direitos sociais*. Rio de Janeiro: Pensamento Brasileiro, 2012.
- DAS, V.; POOLE, D. *Anthropology in the Margins of the State*. 1. ed. New Delhi: Oxford University Press, 2004.
- DIAS-SCOPEL, R. *A cosmopolítica da gestação, parto e pós-parto: práticas de autoatenção e processo de medicalização entre os índios Munduruku*. Tese (Doutorado) – Centro de Filosofia e Ciências Humanas, Universidade Federal de Santa Catarina, Florianópolis, 2014.
- DIAS-SCOPEL, R. P.; SCOPEL, D.; LANGDON, E. J. Gestação, parto e pós-parto entre os Munduruku do Amazonas: confrontos e articulações entre o modelo médico hegemônico e práticas indígenas de autoatenção. *Ilha Revista de Antropologia*, v. 19, n. 1, p. 183-216, jun. 2017.
- DINIZ, C. S. G. *Entre a técnica e os direitos humanos: possibilidades e limites da humanização da assistência ao parto*. Tese (Doutorado) - Departamento de Medicina Preventiva, Universidade de São Paulo. São Paulo, 2001.
- DUARTE, S. J. H.; ANDRADE, S. M. O. de. O significado do pré-natal para mulheres grávidas: uma experiência no município de Campo Grande, Brasil. *Saúde e Sociedade*, v. 17, n. 2, p. 132-139, jun. 2008.
- SCOREL, S. et al. O Programa de Saúde da Família e a construção de um novo modelo para a atenção básica no Brasil. *Revista Panamericana de Salud Pública*, v. 21, n. 2-3, p. 164-176, mar. 2007.
- FARMER, P. *Pathologies of power: health, human rights, and the new war on the poor*. Berkeley: University of California Press, 2005.

- FLEISCHER, S. *Parteiras, buchudas e aperreios - uma etnografia do atendimento obstétrico não oficial a cidade de Melgaço, Pará*. Tese (Doutorado) - Universidade Federal do Rio Grande do Sul, Porto Alegre, 2007.
- FLEURY, S. *Estado sem Cidadãos: seguridade social na América Latina*. Rio de Janeiro: Editora Fiocruz, 1994. 252 p.
- FOUCAULT, M. *Em defesa da sociedade*. São Paulo: Martins Fontes, 2005.
- GINSBURG, F. D.; REITER, R. R. *Conceiving the new world order : the global politics of reproduction*. Berkeley, University of California Press, 1995.
- LAVERGNE, R. F. Programa Bolsa Família: uma nova modalidade de biopolítica. *Serviço Social & Sociedade*, n. 110, p. 323–344, jun. 2012.
- LEAL, M. DO C. et al. Intervenções obstétricas durante o trabalho de parto e parto em mulheres brasileiras de risco habitual. *Cadernos de Saúde Pública*, v. 30, n. supl 1, p. S17–S32, ago. 2014.
- MACÊDO, U.; BELAUNDE, L. E. “Resguardo” e tecnologias culturais Tupinambá de prevenção da morte materna. In: MCCALLUM, C.; BELAUNDE, L. E. (Coord.). *Relatório final: Projeto Mainba - Saúde Reprodutiva e Morte Materna entre os Tupinambá de Olivença-BA*. MUSA/ISC/UFBA, Salvador, 2007.
- MALUF, S. W.; DE ANDRADE, A. P. M. Entre políticas públicas e experiências sociais: Impactos da pesquisa etnográfica no campo da saúde mental e suas múltiplas devoluções. *Saude e Sociedade*, v. 26, n. 1, pp. 171-182, 2017.
- MARCELIN, L. H. A linguagem da casa entre os negros no recôncavo baiano. *Revista de Estudos em Antropologia Social*. Rio de Janeiro, v. 5, p. 31-60, 1999.
- MASCARELLO, K. C. et al. Complicações maternas e cesárea sem indicação: revisão sistemática e meta-análise. *Rev. Saúde Pública*. São Paulo, v. 51, 105, 2017.
- MCCALLUM, C. A. et al. Experiência e conhecimento no cuidado dos corpos femininos: A “Dona do Corpo” e o “Resguardo Quebrado” Tupinambá. In: ROHDEN, F.; MCCALLUM, C. (Orgs.). *Corpo & Saúde na Mira da Antropologia: Ontologias, Práticas, Traduções Brasileiras*. Salvador: EDUFBA & ABA, 2015.
- McCALLUM, C.; BUSTAMANTE, V. N. D. Parentesco, gênero e individuação no cotidiano da casa em um bairro popular de Salvador da Bahia. *Etnográfica*, v. 16, n. 2, 2012.
- MOTTA-MAUÉS, M. A. *“Trabalhadeiras” & “Camarados”: Um Estudo sobre o Status das Mulheres numa Comunidade de Pescadores*. Dissertação (Mestrado) - Universidade de Brasília. Brasília, 1977.
- MURILLO, A. L. *Culture of Relatedness*. Depto. Antropologia, Universidade de São Paulo, 2016.

- ORGANIZAÇÃO MUNDIAL DA SAÚDE. *Prevenção e eliminação de abusos, desrespeito e maus-tratos durante o parto em instituições de saúde*. Genebra: WHO, 2014.
- PARTO DO PRINCÍPIO. Mulheres em Rede pela Maternidade Ativa. *Dossiê da Violência Obstétrica: Parirás com dor*. Entregue à CPMI da Violência Contra as Mulheres, 2012.
- PATAH, L. E. M.; MALIK, A. M. Modelos de assistência ao parto e taxa de cesárea em diferentes países. *Revista de Saúde Pública*. São Paulo, v. 45, n.1, p. 185-194, fev. 2011.
- PEIRANO, M. *Proibições alimentares numa comunidade de pescadores (Icarai, Ceará)*. Dissertação (Mestrado) - Universidade de Brasília. Brasília, 1975.
- PINA-CABRAL, J. Mães, pais e nomes no Baixo sul (Bahia, Brasil). In: PINA CABRAL, J.; VIEGAS, S. de M. (Eds.) *Nomes: gênero, etnicidade e família*. Lisboa: Edições Almedina, 2007. p. 63-89.
- PINA-CABRAL, J.; SILVA, V. A. da S. *Gente Livre: Consideração e Pessoa no Baixo-Sul da Bahia*. São Paulo: Terceiro Nome, 2013.
- RASELLA, D. et al. Effect of a conditional cash transfer programme on childhood mortality: a nationwide analysis of Brazilian municipalities. *The Lancet*, v. 382, n. 9886, p. 57-64, jul. 2013.
- ROHDEN, F. *Uma ciência da diferença: sexo, contracepção e natalidade na medicina da mulher*. Tese (Doutorado) – Programa de Pós-Graduação em Antropologia Social, Museu Nacional, Universidade Federal do Rio de Janeiro, Rio de Janeiro, 2000.
- SALGADO, H. de O.; NIY, D. Y.; DINIZ, C. S. G. Meio grogue e com as mãos amarradas: o primeiro contato com o recém-nascido segundo mulheres que passaram por uma cesárea indesejada. *Rev. bras. crescimento desenvolv. hum.*, v. 23, n. 2, p. 190-197, 2013.
- SANTOS, Í. G.; SCHOMMER, P. C.; ACCIOLY, M. da C. (Orgs.). *Aprendendo com Identidades e Diversidades de Comunidades Tradicionais de Pesca e Mariscagem do Baixo Sul Baiano*. Salvador: CIAGS/UFBA; FAPESB; SECTI; CNPq, 2009.
- SMITH-OKA, V. *Shaping the motherhood of indigenous Mexico*. Nashville, Tennessee: Vanderbilt University Press, 2013.
- STEVENSON, L. Anthropology in the Margins of the State, ed. by Veena Das and Deborah Poole (Review). *PoLAR*, v. 30, n. 1, p. 140-144, 2007.
- TEMPESTA, G. *A produção continuada dos corpos. Práticas de resguardo entre os Wapichana e Macuxi em Roraima*. Dissertação (Mestrado) – Instituto de Filosofia e Ciências Humanas, Unicamp, Campinas, 2004.
- TEMPESTA, G. A. Os fluidos limites do corpo. Reflexões sobre saúde indígena no leste de Roraima. *Anuário Antropológico*, n. I, p. 129-148, 1 jun. 2010.

TORRES, J. A. et al. Cesariana e resultados neonatais em hospitais privados no Brasil: estudo comparativo de dois diferentes modelos de atenção perinatal. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 30, supl. 1, p. S220-S231, 2014.

VEIGA, J. E. *Cidades imaginárias: o Brasil é menos urbano do que se calcula*. São Paulo: Autores Associados, 2002.

VIEIRA, E. M. *A medicalização do corpo feminino*. Rio de Janeiro: Fiocruz, 2008.

WETTERBERG, A. My Body, My Choice... My Responsibility:: The Pregnant Woman as Caretaker of the Fetal Person. *Berkeley Journal of Sociology: a critical review*, 2004.

YANAGISAKO, S. J.; COLLIER, J. F. Toward a Unified Analysis of Gender and Kinship. In: COLLIER, J. F.; YANAGISAKO, S. J. (Eds.). *Gender and Kinship: Essays Toward a Unified Analysis*. California: Stanford Press, 1987.

Notes

¹ Doctoral Research in Public Health, completed and defended in April 2015.

² Translator's note: "When you had sex and got pregnant"

³ P.S. Rezende: text elaboration, main investigation, field research, data production and systematization, raw data analysis. C. McCallum: supervision of the research work, guidance on analysis, revision and editing of the final text, and translation into English. We are grateful for the critical and attentive reading of the researcher Romina Margarita Hamui. This work was carried out with the support and funding of CNPq, to which we also underline our thanks.

Resumo

O Estado brasileiro como agente no processo reprodutivo em uma vila do Baixo-Sul Baiano

Este artigo explora a reprodução como fenômeno amplo, integrado à vida social e marcado por relações de poder, analisando os processos e estruturas que integram a vida dos sujeitos e destes com o Estado. Os processos reprodutivos, para além do fisiológico, conectam sujeitos, serviços de saúde e outros setores representantes do Estado. Trata-se de um estudo etnográfico realizado entre 2011 e 2015, sobre reprodução enquanto processo biossocial, com marisqueiras e pescadores, majoritariamente negros e de baixa renda, moradores de Riachão – uma vila, localizada em uma ilha, no baixo-sul da Bahia. A partir de uma análise etnográfica, demonstramos as formas de vivência do processo reprodutivo das 18 mulheres que acompanhamos ao longo da pesquisa e concluímos que o Estado exerce papel central na rede de relacionamentos que constituem a reprodução, estabelecendo uma relação oscilante e ambígua de cuidado e violência com as mulheres a cada fase: uma relação de cuidado, frágil e descontinuada, na gestação; uma relação intensa, exclusiva e marcada por violências no parto; e a ausência de cuidado para com a saúde das mulheres no puerpério, conjugada à alta vigilância nos cuidados dos bebês.

► **Palavras-chave:** reprodução estratificada; Estado; desigualdade; atenção à saúde materna; relacionabilidade.

