





# Vulnerabilities among homeless women experiencing pregnancy, childbirth and puerperium

*Vulnerabilidades entre mulheres em situação de rua vivenciando a gestação, parto e puerpério*

*Vulnerabilidades entre mujeres sin hogar viviendo el embarazo, parto y puerperio*

Cristina Elisa Nobre Schiavi<sup>1</sup>   
Vania Celina Dezoti Micheletti<sup>2</sup>   
Rosana Maffaccioli<sup>1</sup>   
Stela Maris de Mello Padoin<sup>3</sup>   
Adriana Roese Ramos<sup>1</sup>   
Letícia Becker Vieira<sup>1</sup> 

1. Universidade Federal do Rio Grande do Sul.  
Porto Alegre, RS, Brasil.

2. Universidade do Vale do Rio dos Sinos.  
São Leopoldo, RS, Brasil.

3. Universidade Federal de Santa Maria.  
Santa Maria, RS, Brasil.

## ABSTRACT

**Objective:** to understand the aspects that confer vulnerabilities to the women who experience pregnancy, childbirth, and puerperium on the streets. **Method:** qualitative research developed with twelve women in a southern city of Brazil, through a thematic analysis with in-depth interviews, in light of the Vulnerability and Human Rights framework. **Results:** three thematic categories describe situations of discrimination and violence that have repercussions on vulnerabilities during pregnancy and prenatal care, when (invisible) women become (visible) mothers, and at the time of childbirth, in which (the lack of) care and assistance is evident, and also in the puerperium, marked by the breaking of bonds with the babies. **Conclusions and implications for practice:** successive interventions of control, carelessness, misinformation and negligence, as well as the lack of acceptance and support made explicit the lack of actions and public policies that value the singularities of these women. From the findings, it is understood the urgency of raising the awareness of health professionals to act respecting the autonomy of these women for the full exercise of their sexual and reproductive rights, as well as the implementation of strategies for the construction of a health care committed to justice and social protection, mitigating vulnerabilities and promoting rights.

**Keywords:** Human Rights; Women; Mothers; Homeless people; Health vulnerability.

## RESUMO

**Objetivo:** compreender os aspectos que conferem vulnerabilidades às mulheres que vivenciam a gestação, o parto e o puerpério nas ruas. **Método:** pesquisa qualitativa desenvolvida com doze mulheres em um município do sul do Brasil, mediante análise temática de entrevistas em profundidade, sob a luz dos referenciais da Vulnerabilidade e dos Direitos Humanos. **Resultados:** três categorias temáticas descrevem situações de discriminações e violências que repercutem em vulnerabilidades tanto durante a gestação e o pré-natal, quando as mulheres (invisíveis) se tornam mães (visíveis), quanto no momento do parto, em que se evidencia o (des)cuidado e a (des)assistência, e também no puerpério, marcado pelo rompimento dos vínculos com os bebês. **Conclusões e implicações para a prática:** sucessivas intervenções de controle, descaso, desinformação e negligência, bem como a falta de acolhimento e suporte, deixaram explícitas a carência de ações e políticas públicas que valorizem as singularidades dessas mulheres. A partir dos achados, entende-se a urgência da sensibilização dos profissionais de saúde para atuar respeitando a autonomia dessas mulheres para o exercício pleno de seus direitos sexuais e reprodutivos, bem como da efetivação de estratégias para a construção de um cuidado em saúde comprometido com a justiça e proteção social, mitigando vulnerabilidades e promovendo direitos.

**Palavras-chave:** Direitos Humanos; Mulheres; Mães; Pessoas em situação de rua; Vulnerabilidade em saúde.

## RESUMEN

**Objetivo:** comprender las vulnerabilidades de mujeres sin hogar que viven el embarazo, parto y puerperio. **Método:** investigación cualitativa realizada con doce mujeres de un municipio del sur de Brasil, a través del análisis temático de entrevistas en profundidad, a la luz de los marcos Vulnerabilidad y Derechos Humanos. **Resultados:** tres categorías temáticas describen situaciones de discriminación y violencia que inciden en vulnerabilidades durante el embarazo y prenatal, cuando las mujeres (invisibles) se convierten en madres (visibles), así como en el parto, cuando se evidencia la falta de cuidados y asistencia, como también en el puerperio, marcado por la ruptura de vínculos con los bebês. **Conclusiones e implicaciones para la práctica:** sucesivas intervenciones de control, descuido, desinformación y negligencia, así como la falta de acogida y apoyo explicitaron la falta de acciones y políticas públicas que valoren las singularidades de estas mujeres. A partir de los hallazgos, se comprende la urgencia de sensibilizar profesionales de salud para actuaren respetando la autonomía de estas mujeres para el ejercicio pleno de sus derechos sexuales y reproductivos, así como la implementación de estrategias para la construcción de un cuidado en salud comprometido con la justicia y la protección social, mitigando vulnerabilidades y promoviendo derechos.

**Palabras-clave:** Derechos Humanos; Mujeres; Madres; Personas sin hogar; Vulnerabilidad en salud.

### Corresponding author:

Cristina Elisa Nobre Schiavi.  
E-mail: cris\_schiavi@hotmail.com

Submitted on 12/07/2022.  
Accepted on 09/08/2023.

DOI: <https://doi.org/10.1590/2177-9465-EAN-2022-0384en>

## INTRODUCTION

Recent research shows that the number of homeless people has grown in several countries around the world. It should be noted, however, that the number of women is significantly lower than that of men in a variety of scenarios.<sup>1-5</sup> In the USA, women account for around 28% of homeless people, while in Europe, they represent between 15% and 25% of this social segment.<sup>4</sup>

In Brazil, from 2012 to 2020, there was a significant increase (140%) in the number of homeless people (HP). It is estimated that the number of this population in 2020 was 221,869 people, with a strong concentration in the capitals and larger municipalities.<sup>6</sup> In Porto Alegre, a capital located in the southern region of Brazil, there was a drop in the percentage of women from 18.2% in 2008 to 13.8% in 2016.<sup>5</sup>

These disparate figures are no coincidence. There are huge differences in the impact of life on the streets for men and women, revealing singularities that tattoo on woman's bodies the expressions of subalternity and subjugation.<sup>7-9</sup> Although fewer in number, they are more vulnerable to the discrimination, inequalities, violence and oppression that mark the street scenery.<sup>2,3,9-11</sup> Furthermore, there is a lack of health actions and services that consider their specificities and rights as women, especially when they experience motherhood in this context.<sup>1,7,11</sup>

Homeless women are twice as likely to become pregnant, have a higher risk of obstetric complications and receive less health care than those with access to housing.<sup>1,12</sup> Their babies spend more time in hospital after birth, undergo fewer tests and are less likely to be breastfed.<sup>2</sup> Furthermore, more barriers than facilitators have been identified in the access to and use of health services among homeless women during the antenatal and postnatal periods,<sup>2,12</sup> making them more susceptible to worse health outcomes for themselves and their children.<sup>13</sup>

This situation reveals that the experience of pregnancy, childbirth and puerperium in street situations is a public health problem that impacts different countries around the world and is due to a series of conditions of vulnerability.<sup>1,7,14</sup> This is a topic that requires research to identify obstacles and difficulties experienced in health care, helping to implement actions that respect and meet the needs and rights of these women and their children.<sup>2,7,14</sup>

In this sense, this study uses the theoretical framework of Vulnerability and Human Rights (V&HR) as its analytical lens, as it seeks to identify potential situations of vulnerability in order to provide evidence-based support for democratic and effective public policies. It is based on the assumption that where there is a greater violation of human rights, there is a greater degree of vulnerability and less impact from health actions. In this way, health intervention is not just a solution, but also part of the problem, depending on how it is implemented. Thus, how much and how well governments promote the right to health are also determinants of vulnerability.<sup>15</sup>

Considering these points, a study was proposed based on the following question: how do homeless women experience

pregnancy, childbirth and the puerperium in terms of the processes of vulnerability in this scenario? The aim was to understand the aspects that make women who experience pregnancy, childbirth and the puerperium on the streets vulnerable.

## METHOD

This is a qualitative, exploratory-descriptive study based on the theoretical framework of V&HR.<sup>15</sup> The fields of this study were a Street Clinic and an independent Collective called "Troque a Fome por Flor" (Exchange Hunger for Flower, in free translation), both recognized as powerful spaces for care and resistance for the HP in the municipality of Porto Alegre, located in the metropolitan region of Rio Grande do Sul, Brazil. The choice of spaces involved fundamental criteria for the feasibility of the research, as it enabled the researcher to get closer to possible participants in both formal services and informal spaces within the care network for this population.

The research participants were twelve women over the age of eighteen who had experienced pregnancy, childbirth and the puerperium in a homeless situation. Women who had any impediment that made it impossible to conduct the interview, such as being under the influence of alcohol and/or other drugs, were excluded from the study. All the participants were selected and invited intentionally, with the help of workers and supporters from the respective fields. The number of participants was limited to the extent that the researchers found the internal logic of the object of study, even if only provisionally, considering the depth, breadth and diversity of the phenomenon, as Minayo points out.<sup>16</sup>

The information was collected from May to November 2021 through in-depth interviews carried out by the main researcher, a graduate student with experience in this collection technique with this audience. In order to test the sensitivity of the Interview Script, the "sensitization study" proposed by Moré was carried out, the purpose of which is to assess whether the questions that make up the Script have the potential to stimulate and provide narratives around the objective of the study.<sup>17</sup> During this process, which took place with the first interviews, small modifications were made to the Script as the researchers recognized the need to reformulate the questions, in order to facilitate the participants' understanding and qualify the continuity of the dialogue around the object of investigation.

The interviews lasted approximately 40 minutes. The time and place were chosen according to each case and situation, taking into account the availability of the researcher and of the participants. Seven interviews took place in the women's homes, where they now have access to housing; two took place in the health service that was the field of research and three took place near their places of living on the streets. Two of the participants were interviewed twice, at different times and on different days, so that we could complete the interview in full, mainly because of the demands of their daily lives on the streets, which involve looking for the means and resources to survive on a daily basis.

All the interviews were recorded and transcribed verbatim in their entirety. To analyze the information obtained, Minayo's thematic analysis was used,<sup>18</sup> which unfolds in three stages: in the pre-analysis, a floating reading of the interviews was carried out, making it possible to apprehend structures of relevance; in the exploration of the material, it was possible to identify and group the units of meaning, making it possible to define the thematic categories; in the treatment of the results obtained and interpretation, the findings were analyzed and discussed, providing a basis in current literature for a better understanding of them, articulating with the analytical framework of V&HR.

The research was approved by the UFRGS Research Ethics Committee in May 2021 under opinion no. 4.722.878. After clarifying about the research, the participants gave their consent in writing, in accordance with the Informed Consent Form. To preserve the anonymity of the women, they were all identified by flower names.

## RESULTS

The profile of the participants showed that the twelve women were aged between 21 and 56. With regard to affective relationships, eleven declared themselves "single", five of whom lived with their partners, and only one mentioned being widowed. As for race/color, nine declared themselves as black. All of them had incomplete primary education and none of them had a formal employment contract, so their income came from selling various items at the traffic lights/streets or from social benefits. The number of children varied from one to ten, and the length of time they had been on the streets ranged from a few months to more than twenty years.

Based on the analysis of the interviews, it was possible to create three thematic categories, presented below, which allowed us to understand the aspects that make women who experience pregnancy, childbirth and the puerperium on the streets vulnerable.

### **Pregnancy and prenatal care: when (invisible) women become (visible) mothers**

Women who experience pregnancy on the streets carry out prenatal care according to their possibilities, and there are many aspects that indicate the difficulties of daily life on the streets. These adversities prevent them from using services, since they have to prioritize their basic daily survival needs over specific health care. Situations of violence or substance abuse are recurrent in these women's lives, embarrassing them to the point of not seeking services, especially for fear of judgment from professionals, which implies their individual and social vulnerability.

*Sometimes I would go, sometimes the guys had to go after me, it was very complicated. [...] I drank a lot, so I couldn't go... Sometimes people beat me up, so I was ashamed to go because I was hurt (Petunia).*

Thus, the women interviewed indicate that they start prenatal care late, in general, when they are approached by the services through an active search. When institutions identify homeless pregnant women, they turn their efforts to caring for these women and babies, seeing their follow-up as a priority. Therefore, the pregnant woman's condition causes changes in the health care she receives. It is made clear that homeless women become more visible when they are pregnant and are thus assisted in terms of access to health care.

*I started having prenatal care when I met the social approach service, when I was four to five months pregnant [...]. Every day they would refer me, so either I went or they gave me a lift. [...] And ever since the people from the street clinic Consultório na Rua found out I was pregnant, they've been coming to see me [...]. When I couldn't go there, they would always go to the shack to listen to the baby, the whole thing (Kalanchoe).*

This context reinforces the profound social invisibility of women living on the streets, except when they get pregnant, when they become more visible. However, soon after giving birth, attention is focused on the child, and they return to the streets without their babies, again invisible to society, experiencing the puerperium without assistance, which implies social vulnerability. In other words, they live in the midst of absences and excesses of attention from the state, legitimizing dichotomies such as: visibility versus invisibility, attention versus lack of assistance.

### **At the time of childbirth: (the lack of) care and assistance**

Contradictory to the attention received on the streets while pregnant, several reports revealed discrimination and violence experienced by women during childbirth. That said, there were several difficulties in getting to the hospital, including the denial of aid and transportation. As a result, they experience this moment alone, insecure, without support or information, resulting in individual and social vulnerability. One participant said that she gave birth in an abandoned house, and another revealed that, after many difficulties, when she arrived at the maternity hospital, she was denied access.

*I gave birth inside an abandoned house. [...] I jumped over the gate and started calling everyone to try and get to the hospital, but no one would stop. So, I jumped over the gate again and went under the hot water of the shower. I started to push, and the next thing I knew, she was out. I picked her up, gave her a bath, wrapped her in a towel and put her to bed [...] Then I managed to call SAMU (Four O'Clock flower).*

*I walked from the shack to the hospital. There were contractions and contractions, and my husband threw himself in the middle of the cars, but none wanted to stop. Not even the police wanted to give me a lift [...] I got to the hospital and the security guard wouldn't let us in.*

*My husband made a fuss, and I was screaming in pain. I thought I was going to lose my son (Kalanchoe).*

Those who manage to cross the hospital gates realize that discrimination and violence persist and intensify. There were successive reports of moments of carelessness and lack of assistance reproduced by professionals in the institutions. Because of their street situation, they are treated with disregard, suspicion, and misinformation. Thus, the moment of childbirth is perceived as difficult and painful, which has repercussions on social and programmatic vulnerability.

*I still remember that horrible feeling. It took a long time and I didn't know what was happening. It was my first pregnancy. [...] I was hospitalized for a week with postpartum depression. I just wanted to look after him, but they wouldn't let me near him. I never knew why. I don't know if it was because they were afraid of me doing something to him, but I never had such intention. I never understood (Torenia).*

It is clear that homeless women are deprived of breastfeeding and establishing a bond with their children, and are separated from them in maternity wards on the basis of justifications founded on the vision and values of the professionals. Instead of guiding and helping these mothers with care at this time of their lives, the professionals treat them with disrespect, failing to provide explanations and not letting them stay close to their babies. This is a violation of their human rights, which is intertwined with the three dimensions of vulnerability.

*When I had him, I suffered like you can't imagine. I was treated like a bitch. They were so stupid. I spent very little time with him in the hospital, I couldn't even breastfeed him. [...] He was born at eight months. I found out later, at the clinic, because they didn't explain that he was born prematurely (Kalanchoe).*

It is worth pointing out that the moment of childbirth is often the only opportunity for these women to access the health system. However, in addition to not being adequately welcomed, cared for, and assisted in health services, they are still constantly challenged by countless human rights violations, which are based mainly on the moral judgment that they cannot and should not be mothers. On the one hand, not being able to access the services constitutes lack of care, but on the other hand, access can lead to situations that increase the vulnerabilities experienced in health.

### **The puerperium marked by the breaking of bonds**

It turns out that leaving hospitals is marked by what can be called the kidnapping (or attempted kidnapping) of the babies of homeless women. They tell us that their children are taken from their arms while still in the maternity wards, and are compulsorily taken to institutional care, by means of a discourse of child protection. And once they are in these institutions, any possibility

of bonding, caring for and even receiving information about their children is hindered or often denied.

*I haven't seen my son for three months. The last time was in the hospital. They were clever. They sent him away early. When I got to the hospital, he had already gone. I couldn't even kiss him. I still can't see him today. That's what hurts the most [...] It touches me a lot. It hurts [...]. Now he's in a shelter, but I don't know where it is. I haven't heard from him since. I miss him (Kalanchoe).*

The interviewees revealed that, when institutions become suspicious of their street situation, they invest in interventions and attempts to kidnap their babies. With a frequency that they denounce as the norm, they are questioned numerous times by professionals, who carry out detailed investigations to check if they are in condition to raise and care for their children. Chrysanthemum says that she has faced intimidation and embarrassment from professionals in the maternity ward:

*I almost lost my daughter because the hospital social worker didn't want to hand her over to me. They were arranging for a Council van to pick her up. The social worker from the shelter had to say that there was enough space for just a child. If she hadn't complained, my daughter wouldn't have been handed to me [...] When she was discharged, the nurses wouldn't even let me put her clothes on. They said, "You have to wait for the social worker to release her. Let's see if she really leaves with you" (Chrysanthemum).*

It is clear that the puerperium is marked by countless human rights violations, impacting on the three dimensions of vulnerability. Faced with this situation, these women are gripped by the fear that their babies will be brutally taken from their arms on the grounds that they are homeless, which curtails their possibilities of exercising motherhood. Because of this fear, it was observed that, as a line of escape, some women devise strategies to prevent their babies from being kidnapped, trying to escape the institutional constraints, like Perpetua:

*I was afraid of going to the hospital, of them seeing that I was on the street and taking my son. I got it into my head that I couldn't stay here anymore, that I had to go to a farm that takes in women [...] so I wouldn't lose custody. In fact, I was only able to keep him because when I went to check out at the hospital, there was an old address on the computer. They asked if I lived in the same street and I confirmed that I did. I kind of overlooked it, because I didn't live there anymore (Perpetua).*

It was also possible to identify that there are women who seek institutional protection in family shelters to stay with their children, as a way of exercising motherhood. However, they reveal that these are rigid places, where they are constantly threatened by professionals with having their children taken away by the public authorities if they fail to comply with institutional rules.

*I didn't want to go. I had to go because of her. I knew it wouldn't do any good to be away from my husband. It's horrible there, we're humiliated and mistreated. They say, "If you leave, you won't take your son. We'll ask the Council to take him away". They don't care if you suffer away from your child (Chrysanthemum).*

Even so, not all homeless women manage to be offered this alternative of sheltering their children together, especially due to the lack of investment in these spaces on the part of the public authorities, which reveals aspects of programmatic vulnerability. Perpetua tried to keep all her children together in a family shelter, but the response she got was disregard and delays in finding a place in these institutions.

It is clear that the institutions' efforts, instead of going in the direction of creating a network of care and protection to help women exercise motherhood, are going in the direction of removing their children and sending them to shelters. With this line of action, we can interpret that the health services support themselves as ideological apparatuses for maintaining a moral, blaming and controlling perspective, which judges women as incapable of being mothers. This scenario reminds us of the social and programmatic vulnerability that these women face.

Consequently, the puerperium is marked by the worsening of health vulnerability conditions for these women and their children, while other life and care options are not made possible. The state is ready to act forcefully at the borderline of these vulnerabilities, that is, when the situation is too complex and there is no alternative but to take the children away from their mothers.

## DISCUSSION

In general, public policies in Brazil are focused either on women's health as pregnant women or on children's health, following a tradition of prioritizing women in the pregnancy-puerperal context. It is no different with homeless women. Health policy for homeless women is linked almost exclusively to maternity.<sup>19</sup>

A study on the subject reveals that pregnancy was the aspect that linked homeless women to health services, due to prenatal care, demonstrating that the reproductive issue is more valued than the other needs involved in women's health.<sup>20</sup> Therefore, it is noticeable that state agents take extensive care of pregnant homeless women, which ceases at the end of the pregnancy and the removal of the children from their mothers in maternity hospitals.<sup>19</sup>

The literature shows that, in Brazil,<sup>7</sup> as well as in the UK<sup>1</sup> and the US,<sup>14</sup> homeless women have poor access to prenatal care, attending fewer appointments than recommended by health agencies. Barriers that hinder or prevent them from accessing health services include: bureaucratization of access;<sup>2,13</sup> network disarticulation;<sup>2,13</sup> shortage of specialized services for women;<sup>2</sup> lack of social support;<sup>2,12</sup> low socioeconomic status;<sup>1</sup> inadequate approach by professionals;<sup>2,12,21</sup> negative previous experiences;<sup>12,21</sup> lack of information and awareness;<sup>2,11,12</sup> as well as fear of stigma, prejudice and discrimination.<sup>1,2,11,12,22</sup> These factors have an impact on women's decision to seek (or not) institutional health care spaces.<sup>1,2</sup>

These issues bring us back to the Vulnerability and Human Rights framework,<sup>15</sup> which highlights the absence of government action and the effectiveness of programs aimed at organizing special support that takes into account a person's condition as a woman, in this case affected by gender inequalities intersected by racism, poverty and the stigmatization of life on the streets. We have learned, from this reference, that where governments fail to guarantee essential human rights, populations experience the worst profiles of health, suffering, illness, and death.

However, one of the main obstacles mentioned by the participants in this study to accessing and attending prenatal care was the fear of losing custody of their children, making health care during pregnancy even more complex. Similarly, other studies have shown that the fear of having their children taken away by the public authorities produces a feeling of distrust towards professionals, which encourages them to hide their pregnancy, negatively influencing these women's interaction with health services.<sup>1,12</sup> Because of the fear of being denounced and having their children taken away, they delay seeking health services, postponing prenatal care in order to remain unnoticed by institutional facilities.<sup>1,2</sup>

That said, faced with the fear of losing custody of their children, there has been a significant increase in the number of women who have withdrawn from health services. Evading hospitals, refusing to go to certain maternity hospitals and moving to other municipalities are seen as alternatives to having their children taken away. There are women who run away to give birth to their babies in areas far from urban centers, as well as those who leave hospitals with babies hidden in bags, with the prospect of exercising their desired motherhood.<sup>22-24</sup> There are also women who omit information from health services and declare old addresses or those of family members in order to prevent institutions from identifying their condition of living on the streets and, consequently, kidnapping their children.<sup>1,3,22</sup>

When it comes to childbirth itself, homeless women also encounter numerous barriers to accessing maternity hospitals, due to various absences, such as: information; documentation; transportation; and a conventional address.<sup>11,12</sup> A study carried out in Ethiopia indicates that they do not receive enough information about health services, revealing that they do not know where, when and how to look for them, and are unaware of their importance.<sup>12</sup> Given the lack of accessible guidance, it is complex for them to navigate the health system and make the right decisions in this regard.<sup>2</sup>

The discriminatory attitude of health professionals towards these women is pointed out, both in this study and in other studies, as an aspect that negatively impacts their search for help in institutional spaces. When they reveal the reasons for their negative experiences in accessing services during maternity, they often report that they are treated differently and have little control over their healthcare, feeling stigmatized, disrespected, and neglected by professionals.<sup>1,2,12</sup>

The reality that these women experience in maternity wards is that, as soon as their street situation is suspected or confirmed, their babies are deprived of their care, being taken away from them to await a court decision to deprive them of family power and to make available a place in institutional care. Thus, even though they can breastfeed and even though scientific evidence recommends skin-to-skin contact, breastfeeding, and early bonding, demonstrating the negative repercussions of the immediate separation of mothers from their babies, they are prevented from having these experiences with their children.<sup>22-25</sup>

Therefore, the argument that homelessness makes it impossible to exercise motherhood safely has been used as a technical justification to legitimize compulsory removal, disregarding other possibilities for these women and children to remain together. Furthermore, the quantitative and qualitative insufficiency of institutional facilities aimed at welcoming mothers and children together has been another argument commonly used in this context.<sup>24-26</sup>

It can be said that this insufficiency materializes the precariousness and dismantling of public policies aimed at homeless women. This does not happen by chance and ends up making them more vulnerable, sustaining the production of precautionary and eugenic measures, which assume that being on the streets alone would make them more likely to abuse or neglect their children. In this way, another perverse mark of sexism, racism and classicism is inscribed in history. From the perspective of Vulnerability and Human Rights,<sup>15</sup> care actions should be guided by awareness of this social condition, which requires specific actions to promote equity.<sup>22,24</sup>

In this sense, it should be stressed that in other scenarios, such as Belo Horizonte, São Paulo and Rio de Janeiro, institutional interventions to kidnap the children of homeless women are also recurrent, reflecting the interdiction of their sexual and reproductive rights, based on official regulations that authorize the compulsory removal of their babies. The class and race division behind these regulations is unmasked, making explicit the institutionalization of racism and poverty, given that private services, mostly accessed by white women from privileged social classes, are not called into action in relation to these determinations.<sup>22-25</sup>

This situation shows that the compulsory removal of the children of homeless women happens without subtlety, and is marked by pain and suffering. After the babies have been abducted, these mothers leave the maternity hospitals alone, return to the streets without knowing where they have been taken, and no longer receive any news about them, thus breaking their bonds. Authors call this process *dematernization*. These recurrent kidnappings correspond to situations of unjustifiable violence, which have left irreparable marks on the bodies of these women who, having also had their maternity kidnapped, return to the streets shaken and traumatized.<sup>22,27</sup>

Thus, their living conditions on the streets prevent them from exercising their right to motherhood as they idealize it, since the institutions, as a rule, kidnap and institutionalize their children.<sup>10,26</sup> The separation from mother, family and community

to which these children are being subjected is responsible for immeasurable damage and harm, which is reflected in the formation of institutionalized children, who are disconnected from their birth stories and end up growing up with a distorted narrative of abandonment and denial. It is therefore necessary to consider this early and compulsory separation as a potential violator of children's rights as well.<sup>22,25</sup>

It is worth pointing out that the daily violence perpetrated by the institutional apparatus is marked by moral judgments and the massacre of maternal desires. When mothers enter public maternity hospitals, they are seen by professionals as 'homeless', and this denomination is enough to eliminate all previous life production. In this sense, health facilities have reproduced countless human rights violations directed at them, perpetuating a generalized control over the bodies of black, poor, and homeless women,<sup>28</sup> thus constituting what is recognized as programmatic vulnerability.<sup>15</sup>

That said, institutional violence occurs within establishments through the imposition of rules and operating norms that reproduce social injustices. The way in which public services are (or are not) offered corresponds to this violence.<sup>10</sup> Thus, the health sector has generated a breakdown in trust and bonds between these women and professionals through moralistic, hygienist and exclusionary interventions. The naturalization of gender, race and social class inequalities drives these practices, so that this emptying of the care function ends up aggravating the context of health vulnerability to which they are subjected.<sup>23</sup>

The state's action of taking babies away from their mothers, in a context of extreme vulnerability and threat to the children's lives, appears to be an unquestionable alternative. Research shows that the women themselves may believe that living on the streets and in a context of drug use is not conducive to the care the child needs.<sup>25</sup>

The problem is complex and not easily circumvented in times of ideological extremism and the retraction of social protection policies. However, it is believed that these issues could be better addressed during prenatal care. For these women, this care could involve a major commitment to mitigating vulnerabilities by establishing a deeply humanized therapeutic relationship and mobilizing different sectors (social services, health, justice/public security, housing, etc.) committed to the lives and human rights of these families.<sup>25</sup>

## FINAL CONSIDERATIONS

The findings of this study have highlighted a series of situations of discrimination and violence that result in vulnerabilities among women who experience pregnancy, childbirth and the puerperium on the streets. These vulnerabilities are made explicit by the lack of actions and public policies that take into account the specificities of these women, especially in the experience of motherhood, as well as the lack of awareness and training of health professionals to act with commitment, ethics and responsibility, promoting human rights and respecting the autonomy of these women with regard to the full exercise of their sexual and reproductive rights.

It was possible to see the reproduction of a real machine for violating the rights of homeless women and their children. The experience of pregnancy, childbirth and the puerperium on the streets is traversed by actions that reproduce the vulnerability of these women through successive and constant interventions of control disguised as care, in which disregard, misinformation, mistrust, lack of assistance and negligence remain explicit, as well as a lack of support and reception.

We understand the need to create an effective institutional support network that is committed to justice and social protection for these women, especially when we recognize that health proposals must mitigate vulnerabilities and promote human rights. Strategies to put into practice the construction of health care that values singularities and desires must go towards guaranteeing the right to be a mother, without reproducing invisibilities, silences, stigmas, oppressions, kidnappings and guardianships.

The main limitation of this study is the difficulty in accessing homeless women, which complicates the feasibility of research with this public. Due to the specific characteristics of the places where the interviews were conducted, there were times when other people were present, such as family members and/or health professionals, which may have influenced the opinions expressed by the participants. We recommend other perspectives that could explore aspects that are still incipient in research on the subject, based on listening to professionals and managers, for example, serving as tools for the implementation of democratic and effective public actions and policies.

## AUTHOR'S CONTRIBUTIONS

Study design. Cristina Elisa Nobre Schiavi. Vania Celina Dezoti Micheletti. Rosana Maffaccioli. Stela Maris de Mello Padoin. Adriana Roese Ramos. Letícia Becker Vieira.

Data collection. Cristina Elisa Nobre Schiavi. Vania Celina Dezoti Micheletti. Adriana Roese Ramos. Letícia Becker Vieira.

Data analysis. Cristina Elisa Nobre Schiavi. Vania Celina Dezoti Micheletti. Rosana Maffaccioli. Stela Maris de Mello Padoin. Adriana Roese Ramos. Letícia Becker Vieira.

Interpretation of results. Cristina Elisa Nobre Schiavi. Vania Celina Dezoti Micheletti. Rosana Maffaccioli. Stela Maris de Mello Padoin. Adriana Roese Ramos. Letícia Becker Vieira.

Writing and critical revision of the manuscript. Cristina Elisa Nobre Schiavi. Vania Celina Dezoti Micheletti. Rosana Maffaccioli. Stela Maris de Mello Padoin. Adriana Roese Ramos. Letícia Becker Vieira.

Approval of the final version of the article. Cristina Elisa Nobre Schiavi. Vania Celina Dezoti Micheletti. Rosana Maffaccioli. Stela Maris de Mello Padoin. Adriana Roese Ramos. Letícia Becker Vieira.

Responsibility for all aspects of the content and integrity of the published article. Cristina Elisa Nobre Schiavi. Vania Celina Dezoti Micheletti. Rosana Maffaccioli. Stela Maris de Mello Padoin. Adriana Roese Ramos. Letícia Becker Vieira.

## ASSOCIATED EDITOR

Ana Luiza de Oliveira Carvalho 

## SCIENTIFIC EDITOR

Ivone Evangelista Cabral 

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