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Healthcare during the pregnancy-puerperium cycle from the perspective of public service users[1]

O cuidado em saúde no ciclo gravídico-puerperal sob a perspectiva de usuárias de serviços públicos

El cuidado en salud en el ciclo gravídico puerperal bajo la perspectiva de usuarias de servicios públicos

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ABSTRACT

The aim of this paper was to apprehend the social representations of puerperal women about prenatal, childbirth and puerperal period health care, in a public health service regional context in São Paulo state. The qualitative research approach and Collective Subject Speech were used. Data collection was held by semi-structured interviews, led in 20 municipalities of XI Regional Health Administration Office of Botucatu/SP, in 2004. The humanization look under the social representations apprehended and analyzed makes evident the importance of new directions in politics and regional practices for the puerperal-pregnancy cycle, specially in

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interpersonal relationships; the essentiality of technical quality in service and the perception of woman as the subject of attention and, as so, must effectively take part in it.
Keywords: Prenatal Care, After-birth period, Health Evaluation, Qualitative Research

RESUMO

O objetivo do trabalho foi apreender as representações sociais de puérperas sobre o cuidado em saúde no período pré-natal, no parto e no puerpério, em um contexto regional de serviços públicos de saúde do interior paulista. Seguindo a abordagem de pesquisa qualitativa, os dados foram colhidos por meio de entrevistas semi-estruturadas, realizadas em 2004, e organizados segundo o método do Discurso do Sujeito Coletivo, tendo o Programa de Humanização do Pré-natal e Nascimento (PHPN) como referencial teórico para discussão dos resultados. A perspectiva das puérperas sobre o cuidado em saúde no ciclo gravídico-puerperal evidenciou a importância das relações interpessoais, a essencialidade da qualidade técnica do atendimento e a propriedade da percepção de que o sujeito da atenção é a mulher e, como tal, dela deve participar efetivamente. Conclui-se que as diretrizes do PHPN devem ser incorporadas de forma mais ampla nas práticas de saúde voltadas à mulher, recomendando-se a adoção de indicadores específicos para avaliação das dimensões do cuidado evidenciadas por este estudo.

Palavras-chave: Cuidado pré-natal. Parto. Período pós-parto. Avaliação em saúde. Pesquisa qualitativa. Parto humanizado.

RESUMEN

Este estudio tuvo por objetivo aprehender las representaciones sociales de puérperas sobre el cuidado en salud en el período prenatal, en el parto y en el puerperio, en un contexto regional de servicios públicos de salud del interior de São Paulo. Según el enfoque de investigación cualitativa, los datos fueron cosechados por medio de entrevistas semi-estructuradas realizadas en 2004 y organizados según el método del Discurso del Sujeto Colectivo. El programa de Humanización del Prenatal y Nacimiento (PHPN) se utilizó como referencial teórico para discusión de los resultados. La perspectiva de las puérperas sobre el cuidado en salud en el ciclo gravídico-puerperal evidenció la importancia de las relaciones interpersonales; la esencialidad de la calidad técnica de la atención y la propiedad de la percepción de que es la mujer el sujeto de la atención y, como tal, debe participar efectivamente en ella. Se concluye que las directrices del PHPN deben incorporarse de forma más amplia en las prácticas de salud dirigidas a la mujer y además se recomienda la adopción de indicadores específicos para evaluación de las dimensiones del cuidado evidenciadas en este estudio.

Palabras clave: Cuidado prenatal. Parto. Período pos-parto. Evaluación en salud. Investigación cualitativa. Parto humanizado.

INTRODUCTION

The health promotion paradigm encompasses, among its constituent elements: integrality of care and disease prevention, commitment to quality of life and the adoption of community participation as a fundamental component in services planning and assessment (Ayres, 2004).

In light of these issues, it is supposed that the contribution that healthcare service users can give to studies about the assistance process is very important, especially when the intention is to approach healthcare humanization, as is the case of the present investigation.

The term humanization has been used for more than forty years with different meanings, from a charitable perspective to the introduction of the discourse of citizens' right to high-quality care. In a recent study developed with managers of maternity hospitals in Rio de Janeiro, the main meanings attributed to the term regarded: the quality of the interpersonal relationship between professionals and users; the recognition of customers' rights and democratization of the power relations between them and the professionals; the demedicalization of delivery and birth care; the promotion of bonds between family members, mother and newborn; and the valorization of health professionals (Deslandes, 2005). In this study, we decided to adopt this multiplicity of meanings.

Specifically in the obstetric area, in Brazil, a broader discussion about autonomy and humanization of care has proved to be relatively recent and reflects the dissatisfaction with the excessively interventionist model of care developed in the country, especially when it comes to delivery care (Serruya, Lago, Cecatti, 2004a).

In terms of public health policies, this question was clearly approached, for the first time, in the *Programa de Humanização do Pré-natal e Nascimento* (PHPN - Prenatal and Birth Humanization Program), created by the Ministry of Health in the year 2000. One of the principles of this program is the right to humanized obstetric and neonatal assistance as the first condition for an adequate follow-up of women and newborns (Brasil, 2000).

This research study was proposed in view of maternal and child health promotion, the importance of humanized assistance in the pregnancy-puerperium cycle, and because we attribute importance to women's perspective about the care received in this period. Our objective is to

apprehend the social representations of puerperal women concerning healthcare in the prenatal, delivery and puerperal periods, within the regional context of public health services in the interior of the State of São Paulo.

We hope that this study provides subsidies for managers who are responsible for women's healthcare, in the formulation and implementation of public policies in this area. We also expect that, when the other involved subjects, workers and users, share this knowledge, they can have an active participation in this process.

MATERIAL AND METHOD

The study was carried out in 2004, in the region of the former IX Regional Health Direction – Botucatu, composed of 31 municipalities. Of these municipalities, 20 adhered to PHPN by 2003, and due to this, they were included in the investigation. Such municipalities have different sizes (less than five thousand to more than 110 thousand inhabitants), and, in the region, the services area is the one that most employs workers in the formal market (Fundação
Seade, 2006).

As for assistance in the obstetric area, the twenty studied municipalities have primary healthcare units for prenatal assistance and 11 have maternity hospitals for low risk delivery assistance. However, the number of beds varies: three in the hospitals with low monthly average of deliveries and 29 in the one with the highest average. In the region, there is only one service for tertiary care in obstetrics.

The qualitative approach was utilized, defined as the one that is concerned about a level of reality that cannot be quantified and works with the universe of meanings, motives, aspirations, beliefs, values and attitudes, which, in turn, correspond to a deeper space within relationships, processes and phenomena that cannot be reduced to the operationalization of variables (Minayo, 1994). The theoretical framework used to discuss the data was PHPN (Brasil, 2000).

To choose the subjects of this investigation, two basic criteria were employed: they should express diversities of origin and of experience. Regarding origin, the study included women living in municipalities of different sizes, with maternity hospitals of different dimensions and degrees of complexity and with distinct forms of primary care organization. Concerning experience, the study included women with varied obstetric histories, type of delivery and having experienced or not situations like: participation in groups of pregnant women, abnormalities in the pregnancy-

puerperium cycle and presence of a family member at the moment of delivery.

Thirty-four semi-structured interviews were conducted with puerperal women, based on guiding questions, in two encounters with each subject, which happened during home visits after the delivery. At the first one, we requested the participation of a family member that could actually contribute so that the puerperal woman could answer the interview, and at the second, the interview was complemented only with the puerpera. This strategy allowed us to return to questions that deserved to be further investigated or clarified. It is important to highlight that the conduction of the interviews outside the health service aimed to give more freedom to the women when the received care was approached.

The guiding questions mentioned above are related to the puerperal women's representations regarding the healthcare received in the prenatal assistance services and the care received during delivery, namely: *How was your prenatal assistance? What did you like and what did you not like during your prenatal assistance? How were you cared for during your hospitalization period for the delivery? What did you like and what did you not like during delivery? How was the assistance that you and your baby received after delivery?*

The organization of the collected data was performed according to the proposal of Lefèvre and Lefèvre (2003), and consisted of the determination of the central idea (statements that enable to translate the essential part of the discursive content expressed by the subjects in their testimonies); identification of key expressions (literal transcriptions of parts of the testimonies, which allow to recover what is essential in the discursive content and to construct the collective subject discourse - in Portuguese, DSC); and reconstruction, with parts of individual discourses, of as many synthesis discourses as are necessary to express a certain thought or social representation about a phenomenon. It is important to mention that the application of the DSC technique to a large number of empirical studies has showed its efficacy to the processing and expression of collective opinions (Lefèvre & Lefèvre, 2006).

The project of this investigation was analyzed and approved by the Research Ethics Committee of the School of Medicine of Botucatu, Universidade Estadual Paulista, and complied with all the norms concerning research with human beings.

RESULTS AND DISCUSSION

The interviews were numbered 1 to 34. When certain key expressions contributed to the development of a DSC, in its sequence, the number of the interview from which each expression was transcribed is marked. At the end

of each DSC, the central idea related to it is also displayed. The results are presented according to the social representations apprehended about healthcare in prenatal, delivery and puerperium assistance.

Prenatal assistance

The analysis of the puerperal women's representations concerning healthcare in prenatal assistance is presented below, based on two themes: interpersonal relationships: weaknesses and strengths, and technical quality as a humanization factor.

Theme 1 – Interpersonal relationships: weaknesses and strengths

The positive representations about healthcare during the prenatal period emerged from the puerperal women's discourses, relating it to the interaction between professionals and users, characterized by active listening, attention and cordiality, as can be observed in Discourse 1:

DSC 1 – I liked everything concerning assistance, it was great, I have nothing to complain about, they always treated me very well. I talked to everybody, all the nurses became my friends, the doctor was very attentive, polite, friendly… I liked the way she talked to us. I even asked her about stuff related to my home. (*IC 1- Friendship-proximity-bond.* Interviews n. 1-8, 10, 11, 13-23, 25-30, 32-34)

Satisfactory care is, therefore, represented as care developed with friendliness and politeness. As the correlated literature shows, the importance of interpersonal relationships and of receptiveness in the health services has been ascertained, understood as care that is open to listening (Deslandes, 2005). These relationships should promote a network of conversations that is essential to care, as it contributes to the establishment of negotiations between users' needs and the means to meet them (Teixeira, 2001).

On the other hand, some women, when they approached prenatal care, represented it in a negative way, referring, mainly, to lack of dialog with the doctor:

DSC 2 – I didn't like my prenatal assistance, the doctor was very rude, he didn't talk and I felt a little insecure. My, he made me cry out of nervousness, he didn't talk, he didn't say: when the day of the delivery comes, things will happen this way, you must be calm. He just kept calling me big bull, because I put on a lot of weight. (*IC 2 – I didn't get along well with the doctor and I didn't like my prenatal assistance*. Interviews n. 9, 12, 24, 31)

In a context in which the care provided during the pregnancy-puerperium cycle is centered on the process of medical work, as occurs in the

municipalities of the studied region, effective and humanized interaction between the pregnant women and these professionals is extremely important to the success of the provided care, and the testimonies above denounce that this goal is far from being achieved.

In fact, the preparation of the woman for the delivery should start early, still during prenatal assistance. This requires a viable effort, in order to raise the awareness and to motivate the health professionals of the primary network to prepare the pregnant women psychically and physically (Brasil, 2003). However, according to Discourse 2, the women expressed that they lacked this preparation; moreover, the minimum that should be expected of a health service is that it treats the pregnant woman respectfully. To the Ministry of Health, humanization requires, among other things, that the woman is called by her name, avoiding terms like “mother” or “madam” (Brasil, 2003). Thus, it seems inconceivable that a professional, no matter his education, calls a pregnant woman “big bull”.

In light of what has been exposed, it is possible to infer that the representations about healthcare in Prenatal Assistance are partly supported by the perspective of humanized assistance, which occurs through a good relationship between professionals and customers, giving security to the women and considering them the subjects of care.

Theme 2 – Technical quality as a humanization factor

In another perspective, positive representations about healthcare in the prenatal period were also apprehended, based on many testimonies, especially as deriving from the dispensed technical quality, related to the availability of tests, prompt assistance and development of basic actions, as exemplified by the discourse below:

DSC 3 – I attended all the prenatal visits and did all the tests. On pregnant woman’s day, he (the doctor) arrives on time, and very attentively, indicates how we should do everything to feel well during pregnancy, examines everything… and every time I needed, I received the best possible assistance. (*IC 3 – I received the best possible assistance*. Interviews n. 1, 5, 7, 8, 11, 12, 14-23, 25-30, 32,34)

On the other hand, Discourses 4 to 6 reflect negative representations about the healthcare provided during Prenatal Assistance, when the assistance lacks an adequate technical quality:

DSC 4 – I didn’t like it very much, the doctor didn’t register the things on my card, the size of my belly, a lot of things weren’t registered. (*IC 4 – The doctor didn’t register the things on my card*. Interviews n. 9, 24, 31, 33)

DSC 5 – I think they didn’t do one ultrasound, I thought they should have done it but they didn’t. The State’s equipment was broken and the

municipality one could only be used after I had the baby. (*IC 5 – I have a complaint about the ultrasound*. Interviews n. 1, 11, 18, 21, 25, 26)

DSC 6 – I didn't like the tests, they lost the first ones I did, then I repeated them and they told me they were altered, they referred me to Botucatu, but in Rubião (tertiary service), I did the test again and I didn't have the disease. (*IC 6 – I didn't like the tests.* Interviews n. 2, 4,10, 11)

The conception that guided the creation of PHPN presupposes that the humanization of prenatal assistance requires that a set of basic procedures is followed, in order to prevent problems during pregnancy and to ensure every woman's fundamental right to the experience of maternity in a safe way (Serruya, Lago, Cecatti, 2004a). Among such procedures, there is the performance of laboratory tests at the beginning and at the end of pregnancy. However, this program does not explicitly approach questions like: minimum clinical procedures, register instruments, or complementary tests like the ultrasound. These items emerged from the puerperal women's discourses, which indicates that, in some way, they are valued by them, and sometimes, they are not accessible.

DELIVERY ASSISTANCE

Next, we present the analysis of the puerperal women's representations regarding the healthcare provided during delivery, subdivided into four themes: receptiveness towards the parturient, supporting the women during delivery, the woman as the protagonist of the process of delivery assistance and the technical quality of the provided care.

Theme 1 – Receptiveness towards the parturient

Discourse 7 shows that it is important that the professionals and the parturients are in tune with each other, as the women represented positively the healthcare they received during delivery based on the experienced receptiveness:

DSC 7 – Everybody said bad things, they said the doctors were stupid, they left you alone, but I have nothing to complain about, they treated me very well. I was assisted at the moment I arrived, the doctor was nice, polite, patient, she told me not to be nervous, because this would affect the baby… Everybody was 100%, from the cleaning ladies to the nurses. (*IC 7 – They treated me very well*. Interviews n. 1, 6, 8, 12, 18, 20, 27, 29)

This discourse reveals the health professionals' receptiveness towards the parturient, translated by terms such as: politeness, goodness, patience and promptness. It is observed that these representations are supported by the idea that a calm assistance promotes a calm delivery. By means of Discourse 8, it is possible to verify, on the other hand, that the lack of receptiveness may generate serious distortions:

DSC 8 – My children are not born by normal delivery, I've already had two C-sections. My youngest girl died inside my belly and didn't come out. Then, when I started feeling bad, I talked to the doctor and he told me: come here on Wednesday, I'll do your C-section if I can. I thought: but I'll wait for the baby to die? Then, I went to another doctor and he said that the baby should have been born already. Then I paid 800 to the doctor and 400 to the hospital and he did the C-section very quickly. (*IC 8 – I paid and the C-section was performed quickly*. Interviews n. 11, 17)

Considering that the subjects of this investigation are women assisted by *Sistema Único de Saúde* (SUS – National Health System), Discourse 8 reveals an important ethical problem. The described situation reveals the representation according to which the right to healthcare, even in the public service, is related to payment: only when you pay for the assistance, is it performed satisfactorily. This is also mentioned in Discourse 9:

DSC 9 – I don't like it when we arrive at the hospital and we don't receive good assistance, like the one received by those who have (money). You're waiting there, a wealthy person who is paying arrives, they call that person first and we keep waiting. (*IC 9 – The person who has money has precedence*. Interviews n. 5, 7)

Discourses 10 and 11 indicate that some women in this study had to go to many services until they received assistance, a fact that is extremely serious, as it is in the period close to delivery that the majority of maternal deaths occur (Brasil, 2003). These discourses show that effective healthcare is represented by guarantee of assistance.

DSC 10 – In the eighth month the doctor said it was going to be a C-section, and I was sure of it, because in the other times, I waited until the last minute and the babies were not born by normal delivery. I arrived there and the nurse said that the baby was in the right position, ready to cut, but the doctor told me to wait and do the C-section on the following day. But on the following day he didn't do it, and told me to go home again. Then I looked for doctor "X" (prenatal doctor), I talked to him and he told me to go there during somebody else's shift. (*IC 10- They sent me away and I had to look for another assistance*. Interviews n. 7, 13, 14)

DSC 11 - The doctor was very stupid and rude. There was liquid coming out and he said that it wasn't time yet, that I should leave and come back on Friday. I had another consultation with him and he was even more impolite. He said: just a normal little pain and you are already here? (*IC 11- The doctor said that with any little pain I searched for assistance*. Interviews n. 16, 31).

In order to minimize the problem of searching for assistance at the moment of giving birth, PHPN recommends the connection of the services of

Prenatal Assistance and Delivery Assistance (Brasil, 2000a), but it seems that this is not being followed in the studied maternity hospitals. Many times, the difficulty emerges due to the lack of receptiveness and bond between the professional and the pregnant woman, and just the formal connection of the services is not enough.

Theme 2 – Supporting the women during delivery

Respect for the woman during assistance is a fundamental presupposition for the humanization of delivery. In this sense, informing them about the different procedures to which they will be submitted, clarifying their doubts and relieving their anxiety are relatively simple attitudes that require, among other things, the professional's willingness to help (Brasil, 2003). These questions are present in Discourse 12, in which the women basically identify healthcare as the explanations they received during delivery:

DSC 12 – Then I was hospitalized and stayed with the nurse, who started to explain that it wasn't so difficult, that being nervous was no use, it wouldn't help me at all. And then everything happened nicely, a little painful, but I liked it. (*IC 12 – With the explanations I had a calm delivery.* Interviews n. 1, 4, 6, 12, 18, 20, 34)

With Discourse 13, it can be observed that effective healthcare is represented by the support received at the moment of delivery:

DSC 13 – The nurse held my hand, relaxed me, she helped me a lot there, even though she had little experience. She stayed there all the time and it was very good, she really calmed me down. These people care for us with tenderness. (*IC 13 – I was supported all the time.* Interviews n. 1, 9, 10, 12, 18, 21-23, 28, 32, 34)

Discourse 13 reveals the important role of the professional who supports the woman that is giving birth, and a positive feeling that she has in relation to labor. The woman's experience of parturition can be pleasant, positive or traumatic, depending on conditions that are intrinsic to it and to pregnancy – like her maturity and previous personal or family experiences – and even on aspects directly related to the health system, like the assistance received in the prenatal period and during delivery (Brasil, 2003).

Studies about the support provided by one single person during delivery (a doula, midwife or nurse) showed that the continuous physical and empathic support during labor results in benefits, like the reduction in its duration, in the use of medicines and analgesia, in the number of surgical deliveries and in neonatal depression (OMS, 1996).

According to PHPN, the healthcare units should appropriately receive the woman, her relatives and the newborn, which requires an ethical and understanding attitude on the part of the professionals, the institution's

organization so as to create a receptive environment, and the adoption of hospital conducts that break the traditional isolation imposed on the woman (Serruya et al., 2004b). The presence of an accompanying person, indicated by the parturient, during labor has also been recommended as a measure that favors the humanization of care. Today, it is a legally constituted right (Brasil, 2003).

A study developed in a maternity hospital that institutionalized several routines contained in the set of ideas of humanization evidenced that the professionals had only an initial resistance to the presence of the accompanying person, but this presence was subsequently stimulated by the team, as it represents a source of support that facilitates labor (Tornquist, 2003). A favorable representation of healthcare emerged from the testimonies when the above-mentioned right was respected:

DSC 14 – My aunt remained by my side all the time, the doctor authorized it... I didn't want to be alone and it was very good. (*IC 14- I wasn't alone and it was very good.* Interviews n. 1, 9, 12, 20, 28)

The preparation methods for labor generally aim to avoid the triad fear-tension-pain, because it is believed that knowledge destroys fear and avoids tension, controlling pain (Brasil, 2003). Lack of support, assistance or orientation can result in fear – fear of dying or of losing the baby – and in great suffering, as we can observe in Discourse 15:

DSC 15 – I started to feel pain at dawn. At the break of day, I went to the hospital, the doctor said it wasn't time and sent me home. Then I said: but the nine months have already passed, but she didn't say anything, and then I became scared. On the following day, my husband asked for the ambulance and took me there, because I was blocked and in pain. The doctor who assisted me said he wasn't going to operate on me… and then I was bleeding and very nervous, I was afraid of losing the baby. My pressure went up and I thought I was going to die. (*IC 15 – The doctor didn't explain, I was afraid...* Interviews n. 13, 24)

In the discourse, the representation that can be apprehended is that of unsatisfactory care, as the lack of explanation about what was happening made the woman start to view labor as a moment of danger, both to her and the baby. The search for a solution to the presented problems was in vain, that is, humanization aspects were not respected. The same can be seen in Discourse 16, in which there is also reference to pain. Pain is inherent in the physiological process of delivery, but it could be minimized by the presence of the accompanying person, emotional support, utilization of relief techniques and the team's support.

DSC 16 – I was hospitalized for two days, feeling pain and the baby didn't come out... The nurse was cruel, she called me "lady". The nurses and

doctors here pay no attention to you, they don't believe that we feel pain. Honestly, I thought I was going to die and nobody explained anything to me. (*IC 16- When I needed, no one paid attention to me*. Interviews n. 2, 3, 5, 13, 17, 24, 26, 30)

In some situations, differences in the conduct of the team members are clear, as shown by Discourse 17:

DSC 17 – I went back and forth, I felt pain and did not dilate and they didn't want to do the C-section… The doctor who assisted me wasn't very good, she was stupid, she made me feel like a pig, a clean pig, this is how I felt. But there's always someone nicer. Then the nurse held my hand and stayed there, waiting until I calmed down. (*IC 17 – There's always someone nicer*. Interviews n. 11, 14, 16, 24, 30)

In this discourse, the positive representation of care during delivery emerges as something related to tenderness, patience and solidarity. We highlight that humanizing means getting involved with people to better understand their fears, joys, anxieties and expectations, and in some way, be able to help, to give support (Rattner & Trench, 2005).

Theme 3 – The woman as the protagonist of labor

The preparation of the pregnant woman for labor encompasses the incorporation of measures, activities and care procedures that aim to offer to the woman the possibility of living this experience as the protagonist of the process (Brasil, 2003). The women should be seen as subjects who come from different cultures and have emotions and desires that are not universal (Tornquist, 2003).

Discourse 18 shows that sometimes, the women are heard:

DSC 18 – The doctor wanted to send me away, he said it wasn't time. I said I wasn't going home, because I was in pain. Then another doctor asked me: do you think you should stay or leave? I said: I want to stay. Then I stayed and she was born. If I had left, she would be born at home. (*IC 18 – They heard me, I stayed at the hospital and the baby was born*. Interviews n. 25, 26, 31)

Nevertheless, in many services, the woman continues not to be treated as the protagonist, as can be observed in Discourses 19 and 20:

DSC 19 – [...] the lady told me that the bag of waters hadn't broken but it had, then the doctor said it was 9 cm dilated and sent me to the pre-delivery room. The pain was too strong, I stayed in the room for a couple of minutes and when the baby was going to be born, I called the nurse and she didn't help me, she was even rude. Then they called the doctor, he saw the baby was coming out and told me to breathe and lie down immediately. The baby

almost fell to the floor. (*IC 19 – I called the nurse and she didn't help me*. Interviews n. 2, 3, 5, 15, 19)

DSC 20 – In the ultrasound they thought I was three weeks in advance compared to my calculation and on the 15th I was hospitalized. I was afraid, because I thought it wasn't time yet. Then he did the C-section, but the lung was premature. I had told them that it was too early. I almost lost my daughter, they took her out ahead of time and she almost died. (*IC 20 – I told them it wasn't time*. Interviews n. 11, 13)

The health professionals play an important role in delivery assistance, because they have the opportunity of putting their knowledge in the service of the woman's and baby's well-being, intervening at critical moments. However, they should understand that the woman, as the subject of the process, has the right to participate in the decisions about the birth, provided that this does not endanger labor evolution, nor her safety or the newborn's (Brasil, 2003).

Nevertheless, it should be highlighted that the women themselves have difficulties in assuming a participatory role in labor. Thus, to humanize childbirth assistance, it is necessary to raise women's awareness, discussing their needs and demands – this is the only way they will be able to claim for better care (Rattner & Trench, 2005).

Theme 4 – Technical quality of care

As discussed above, healthcare humanization, besides encompassing different aspects referring to the ideas, values and practices involving the relationships between health professionals, patients and relatives and/or accompanying persons, also includes the adopted technical procedures, the services' routines and the relationship within the health team (Rattner & Trench, 2005).

Discourse 21, presented below, provides negative representations of care, related to the form in which delivery was conducted from the technical point of view:

DSC 21 – In the examination room, I was losing liquid, the doctor delayed to see me. I had to scream, because they waited until the last minute. They told me he was very small and was coming out, but he went forward and backward. Then they pressed my belly very strongly, I fell down from the table, the anesthetist took me by the nightgown and my sister yelled: you're going to kill my sister! He (the baby) broke the clavicle and was born with the mouth deformed. (*IC 21- Because of delivery my baby had problems*. Interviews n. 2, 4, 13, 19, 24-26, 30, 31, 33)

The most important and complex point in the assessment of the health services' quality is the assessment of the assistance process, which comprehends competence in technical performance and competence in the quality of interpersonal relationships (Rattner & Trench, 2005). Although both of them are equally important and should be equally valued, the puerperal women's representations about healthcare during delivery were permeated by the unbalanced consideration of these aspects, exposing the women and their babies to inhumane situations.

It is a fundamental condition for care humanization that the health services adopt measures and procedures that are known to be beneficial to the follow-up of delivery and birth, avoiding unnecessary interventionist practices which, although traditionally carried out, benefit neither the woman nor the newborn, and which frequently cause greater risks for both (Serruya, Lago, Cecatti, 2004b).

Assistance to puerperium

The analysis of the representations of postpartum healthcare was compiled in one single theme: support to the development of the mother-baby relationship.

Theme 1 - Support to the development of the mother-baby relationship

The positive representations of healthcare provided in the puerperal period were related to aid during the first activities developed with the baby, as exemplified by DSC 22:

DSC 22 – On the first day the nurses came to ask me if I needed help to bathe her, to take care of her. Nurses and the doctor came to my room frequently, and asked if we wanted anything. (*IC 22 – Every little while someone came to help me*. Interviews n. 1, 5, 8-10, 12, 15, 17, 19-23, 25, 27, 28, 32-34)

After the delivery, the woman needs physical and psychical care and the relationship with her baby is not well developed yet. Therefore, attention should not be given exclusively to the child; at this moment, the target of the attention must be the puerperal woman (Brasil, 2003). Besides, it should be remembered that, after the delivery, exhaustion and relaxation are common, mainly if there was a long period without adequate hydration and/or food, not to mention the efforts of the expulsive period. Thus, there may be sleepiness, which requires rest (Brasil, 2003). However, sometimes this need is not respected, as can be noted in the two discourses below:

DSC 23 – They left me there with the baby, I was anesthetized, far away from the bell, and it was hard to turn and breastfeed, because I couldn't raise my head and couldn't call anyone... I was desperate; I was willing to go

home. (*IC 23 – I had no conditions to care for the baby, but I was obliged to.* Interviews n. 2-4, 13, 16, 18, 24, 26, 30, 31)

DSC 24 – Some nurses are like horses. I couldn't even walk, because of the C-section and of the Fallopian tube blockage; then she came and said: let's have a shower. I got up and when I arrived at the bathroom, she pushed me. I get scared easily, but at one moment even my husband got scared, he talked to his mother and she called the hospital at night. (*IC 24 – I was afraid of the nurse.* Interviews n. 7, 13, 14)

The absence of educational activities, as illustrated by Discourse 25, leads to the discussion of their importance in the puerperal period, as some subjects value this aspect as healthcare that should be received in this period:

DSC 25 – I didn't receive any orientation. I took care of him by myself, I put him to sleep, I did everything. But then he cried all night long and they called my mother and asked her to bring a small milk bottle and artificial milk. She did, the baby drank the milk and was quiet the entire night. (*IC 25 – I didn't receive any orientation.* Interviews n. 2-4, 13, 16, 18, 24, 26, 30, 31)

Immediate puerperium should be valued due to the beginning of the development of the mother-baby bond. It should be considered as the moment of "conclusion" of the delivery experience and as resonance time, which asks for the opening of a space of listening, when parents, grandparents, relatives and especially the mother are dilated, open (Rattner & Trench, 2005) and, thus, ready to exchange experiences. Through the representations apprehended here, it is possible to infer that the puerperal women's and newborns' vulnerability to problems seemed to be more evident when the required support was not received.

FINAL REMARKS

The perspective of public service users about healthcare in the pregnancy-puerperium cycle, focused in this study, allows us to consider that the moment of delivery can be characterized as of considerable medicalization, too strictly bound to norms and resistant to humanization. Also, in relation to this perspective, it is possible to consider that, in the prenatal and puerperal periods, care is not free from problems, as women are not usually treated as protagonists, in an assistance process that is sometimes marked by the absence of bonds with the health professionals.

Based on these considerations and in coherence with the PHPN principles, it is postulated that the woman should be recognized as the main participant in the process mentioned above, and her choices should be respected in the establishment of practices that, based on evidences, promote their security and well-being, as well as the newborn's. However, it is important to highlight that PHPN, by adopting indicators to assess the quality of care that

give importance to the number of prenatal visits, immunization and basic examinations performed, is not including aspects that really value other dimensions of care, like those related to gender issues.

Finally, it is considered that the perspective of humanization regarding the social representations that were apprehended here shows the importance of transforming the regional practices targeted at the attention to the pregnancy-puerperium cycle, mainly concerning interpersonal relationships, including receptiveness and effective support to all women, not only during the prenatal period, labor, and delivery, but also during the establishment of the mother-baby bond after birth. At the same time, this perspective confirms the essentialness of the technical quality of assistance and the correctness of the perception that the woman is the subject of the attention and, as such, she must participate in it effectively.

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