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The possible meanings of care: self-care and care-for-the-other

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The possible meanings of care: self-care and care-for-the-other

Objective. To understand and to reflect about care based on the experiences of managers, professionals and users of maternal and child health services. **Methods.** We developed an evaluative research with a qualitative approach in a Northeastern state of Brazil with extensive experience in the regionalization and implementation process of integrated health networks. Semi-structured interviews were carried out with 68 subjects and direct observation of the maternal and child health services. We adopted the theoretical reference framework of Gadamer's hermeneutics to analyze the narratives. **Results.** Some units of meaning were present, such as: perception and knowledge about oneself; exercise of autonomy; weaknesses in the provision of resources for the materialization of self-care; and difficulties in accessing health services and care practices. We perceive that care is dynamic, comprises various subjective aspects with respect to the singularities of the subjects and is related to the possibility of generating both individual

and collective transformation. **Conclusion.** Care is built based on a movement among the subjects and between them and the social and health services. Thus, when we intend to take care, we need to consider this instead of focusing care solely on the technical support of health professionals.

Descriptors: comprehensive health care; maternal-child health services; health evaluation; hermeneutics.

Los posibles sentidos del cuidado: el cuidar de sí y el cuidar de otros

Objetivo. Comprender y reflexionar sobre el cuidado a luz de las experiencias de directivos, profesionales y usuarios de los servicios de salud materna e infantil. **Métodos.** Se desarrolló una investigación de evaluación con enfoque cualitativo en un estado en el noreste de Brasil, con una amplia experiencia en el proceso de regionalización e implementación de redes. Se realizaron entrevistas semiestructuradas a 68 sujetos y la observación directa

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de los servicios de salud materna e infantil. Se adoptó el referencial teórico de la hermenéutica de Gadamer para el análisis de las narrativas. **Resultados.** Estuvieron presentes algunas unidades de significado, como la percepción y conocimiento sobre sí, el ejercicio de la autonomía, las debilidades en la oferta de recursos para la materialización del cuidar de sí mismos y dificultades en el acceso a los servicios de salud y a las prácticas de cuidado. Se percibió que el cuidado es dinámico, se compone de aspectos subjetivos diversos en relación con las singularidades de los sujetos y está asociado a la posibilidad de generar transformación individual y colectiva. **Conclusión.** El cuidado se construye a partir de un movimiento entre los sujetos y entre éstos y los servicios sociales y de salud. De esta forma, cuando pretendemos cuidar, debemos partir de este horizonte y no centrar únicamente el cuidado en el apoyo técnico de los profesionales de la salud.

Descriptor: atención integral de salud; servicios de salud materno-infantil; evaluación en salud; hermenéutica.

Os possíveis sentidos do cuidado: o cuidar-de-si e o cuidar-dos-outros

Objetivo. Compreender e refletir sobre o cuidado à luz das experiências de gestores, profissionais e

usuárias dos serviços de saúde materna e infantil.

Métodos. Desenvolvemos uma pesquisa avaliativa com abordagem qualitativa em um estado do nordeste brasileiro com vasta experiência no processo de regionalização e implantação de redes integradas. Foram realizadas entrevistas semiestruturadas com 68 sujeitos e observação direta dos serviços de saúde materna e infantil. Adotamos o referencial teórico da hermenêutica de Gadamer para análise das narrativas.

Resultados. Algumas unidades de significado estiveram presentes, como: percepção e o conhecimento sobre si; exercício da autonomia; fragilidades na oferta de recursos para a materialização do cuidar de si; e, dificuldades quanto ao acesso aos serviços de saúde e às práticas de cuidado. Percebemos que o cuidado é dinâmico, compreende aspectos subjetivos diversos em respeito às singularidades dos sujeitos e está relacionado com a possibilidade de gerar transformação tanto individual como coletiva. **Conclusão.** O cuidado se constrói a partir de um movimento entre os sujeitos e entre eles e os serviços sociais e de saúde. Desta forma, quando pretendemos cuidar, devemos partir deste horizonte e não centrar o cuidado, unicamente, no apoio técnico dos profissionais de saúde.

Descritores: cuidados integrais de saúde; serviços de saúde materno-infantil; avaliação em saúde; hermenêutica.

Introduction

The knowledge production about care has been intense and useful.^(1,3) Some authors alert that this concept is not limited and restricted to the health professionals' technical support.^(3,5) We believe that care actually departs from an expanded focus, in which technical support is one part of this process, but not the sole aspect to be taken into account. In a broader discussion, we include the aspects of comprehensiveness,⁽⁶⁾ coordination^(7,8) and problem-solving ability amidst humanization and affectivity.⁽⁹⁾ There seems to exist a close relation between care and all of these themes, so that they are mixed up. The current National Humanization Policy, which has existed in Brazil since 2003 and comprises health care and management, has focused on all of these aspects.⁽¹⁰⁾ In view of this complexity, we

outline a dialogue that intends to invite the reader to reflect on the care theme considering several of these aspects. This production resulted from the consequences of an evaluative research with a qualitative approach the authors executed about the integrated maternal and child health network in a Northeastern state of Brazil.

The theme maternal and child health service network results from an international macro-strategic movement in response to the expressions of social issues, translated in this context by the high Maternal Mortality Ratio and Child Mortality Rate,^(11,12) associated with the proposal to regionalize the health services.⁽¹³⁻¹⁵⁾ Its intention was related to the rationalization of the available resources, besides the approximation, communication, articulation and integration among the services. Over time, strategies have

been discussed to put in practice the care for pregnant and postpartum women from these different perspectives.⁽¹⁶⁻¹⁸⁾ In that sense, the objective in this study was to understand and reflect on the care in the light of managers, professionals and users' experience with maternal and child health services.

Methods

To support this study, we intended to implement a method to capture the strength of health production in the access to maternal and child health services. Therefore, we developed an evaluative study⁽¹⁹⁾ with a qualitative approach^(20,21) about the integrated maternal and child health network in a Northeastern state of Brazil. We identified four health institutions that are reference services for the tertiary level in the state, which had previously been mentioned as national highlights due to the high prevalence of maternal deaths in the country. We decided to hold individual and semistructured interviews with users over 18 years of age (pregnant and postpartum women) and health professionals from each of these services. The interviews were held between July and December 2015, after the researchers' previous immersion into these spaces and monitoring of the services. Throughout the research process, we used attentive and sensitive observation with records in research diaries⁽²²⁾ and the production of versions of meaning.⁽²³⁾ Here, the researcher's narratives were joined in his historical-social context, implied with and in the research, and resulting from his experiences and influences in the field.

In the same period, interviews were held with managers (local, regional and state level) and supporters for this thematic network. The local managers were the heads of the maternal and child health services who were practicing their functions at each hospital unit. What the regional managers are concerned, all coordinators of the health regions in the state related to these institutions were interviewed, as well as the state managers directly involved in the management

of the maternal and child health network. The supporters were professionals selected and hired by the central level in the country to discuss and monitor the implementation of the integrated networks in each region of the country. As a research project, the study complied with the ethical premises of the Brazilian National Health Council Resolution 466/12 to obtain the participants' informed consent and guarantee the confidentiality of the data. Approval for the project was obtained from the Research Ethics Committee at Universidade Federal do Ceará under opinion 1.320.567. Based on the theoretical saturation sampling procedures,⁽²⁴⁾ interviews were held with 12 managers, 15 health professionals and 41 users. The interviews were recorded, transcribed by the researcher and analyzed in blocks of three, interspersed with the field immersion process, without the use of any professional software, based on the theoretical reference framework of Hans-Georg Gadamer's⁽²⁵⁾ hermeneutics, associated with Paul Ricoeur's contributions.⁽²⁶⁾ To guarantee the protection of the interviewed subjects' identity, we used the identification "I" for all of them, using I1 till I12 for managers, I13 till I27 for health professionals and I28 till I68 for users.

Results

Based on the research subjects' narratives, four units of meaning were registered: self-perception and self-knowledge; exercise of autonomy; weaknesses in the supply of resources for the materialization of self-care; and difficulties in the access to health services and care practices.

The **self-perception and self-knowledge** was identified based on some women's narrative, when they reflected about 'feeling pregnant' or 'being pregnant': *I discovered that I was pregnant in the fifth month of pregnancy [...] my menstruation was very late already [...] my mother asked me to get tested [...] I went to the nearest hospital and it was positive* [I65]. In this movement of self-perception and self-knowledge, situations were acknowledged related to the decision process

and the exercise of autonomy. **The exercise of autonomy** was perceived in the narratives in which the women mentioned their decisions and the materialization of self-care even before they got pregnant: *I spent two years without taking and last year I got pregnant [...] I stopped taking the injection, because it was already harming me... I felt headaches and pain in my legs [...] the doctor told me to change the method and I didn't go looking for another method [I58].*

The **weaknesses in the supply of resources to materialize self-care** were identified in the health professionals and managers' narratives when they discussed the alternatives the health system made available. According to the managers, there were countless problems: *the guaranteed methods are not what the women themselves want [...] there is a lack of integrated primary care coordination with the teams in listening to these women so as to know what they prefer and produce the program [...] only a specific oral contraceptive is offered to the women [...] the injectable contraceptives are restricted and the insertion of the IUD is not guaranteed [I5].*

After they get pregnant, we recognize **difficulties in the access to health services and care practices**. In some situations, obstacles emerged as early as during the users' welcoming and admission. The health service itself raised functional barriers that impeded the access flow to care: *a patient without any comorbidities is not our profile [I25].* Other subunits of meaning were elaborated based on the difficulties in the access to the health services and the care practices, that is: the companion's participation; the bond; the requisites to seek care; and the information about the care to be provided.

The **companion's participation** before, during and after birth was also observed as an important aspect. Besides functional barriers, as appointed earlier, we acknowledge structural problems to welcome this demand. Nevertheless, the health services have sought to approximate the father to the woman: *we have worked a lot on the issue of the father's responsibility and his inclusion in prenatal care [...] for that man to feel responsible*

for that woman and that baby as soon as it is conceived [I2].

The **bond** was also perceived as a subunit of meaning in this study with a view to putting the care in practice. Nevertheless, some interference was identified, such as the turnover of professionals in the different care production spaces: *each day there's a different person here [I58].* Nevertheless, we perceive that the women prefer the hospitals as the first care option: *at the hospital, we feel safe because a physician is directly available [I64].* Some women demonstrated dissatisfaction with the available PHC services: *the health stations do not work correctly [...] there's nothing available [...] we are never attended to [...] you need to queue and wait for I don't know how many years for an examination [...] The Community Health Agent never visits other people's home [I65].* That outlined the **requisites to seek care**.

During the hospitalization period, other weaknesses were identified, such as the lack of **information about the care to be provided**. The women usually were not informed about the tests they were taking: *here [at the hospital], they do a lot of tests [...] we do that many tests that we don't even know what they're for [I64].* *When informed, they demonstrated feeling well and safe concerning the procedures and their health conditions: I'm fine [...] I came in yesterday at five o'clock [...] they did an ECG yesterday already and instructed me more or less what is going to happen [I60].*

Discussion

Based on the women, professionals and managers' experiences with the maternal and child health services, we elaborated a possible meaning for the care. It should be mentioned that we did not intend to deny other meanings previously presented in the literature about care, but to guarantee that the experiences of our research process are addressed and present in this construction. We know about the complexity related to this theme and have previously announced the singular

nature⁽²⁷⁾ the care assumes here based on the experience of each subject. We believe that the care is initially related to the knowledge and perception of oneself and the other. That can be translated through an exercise of tuning into oneself based on each experience (individual component) or the interaction among the subjects (social component). It is constructed as a process and comprises subjective and singular aspects that build the equilibrium and harmony of life, as Gadamer had already mentioned.⁽²⁵⁾

Each subject presents a particular movement towards the intimate self, and also towards the other, with different trajectories and intensities. Hence, we can affirm that the composition of care is not static. In this sense, the search for care is sometimes natural and sometimes social and motivated by the other. That happens because the subject gains new experiences and also interacts with the other to stimulate the expansion of meanings. The opposite is also possible and the subject can restrict to a limited care. The search process of new information for the sake of care for the self and the other aims for the appropriation and construction of a new horizon, besides the need to generate elements for empowerment.⁽²⁸⁾ That usually happens based on a discomfort or concern with 'feeling well'. It can be produced by an own movement or by contact with the family group or social and community network the subject is part of. This movement also permits the expansion of this mode of perceiving and feeling. The perception or knowledge about the other, then, imprints complementary requisites, such as the bond for example.⁽²⁹⁾ The bond is established through the encounters and opening of a world particular to the subject and which can now be explored. As this permits and operates a transformation process, the care itself happens. The care is motivated by the subject(s) and that is where the being capable of doing appointed by Gadamer takes form.⁽²⁵⁾ Another aspect that should be considered in the care proposal is the possibility of putting oneself in the other's place.⁽³⁰⁾ This concept once again refers to the relation between the 'I' and the 'other'. As one subject permits this type of movement, (s)he dives into a

context and a scenario that used to be unknown and now becomes close or sensitive. Thus, we can elaborate two concepts, which are: self-care and care-for-the-other. Each of them relates an own movement based on knowledge, perception, interaction and bond, adopting the subject(s) as a reference and aiming for a transformation process.

When demands are perceived the subjects do not apprehend, they go beyond their family and community groups and other means are sought to obtain a response, such as contact with a health services, that is, care. These means are not necessarily related to the other and can be linked to the care potential of the health service or equipment. The health care possesses specific characteristics and is part of a list of possibilities that characterizes the health care. Health care overcomes the logic of care, as it goes beyond the individual demand for contact with the health professional or service. It remits to the managers, professionals and users' activities, in view of putting in practice a public policy coherent with the demands presented, and takes into account other socioeconomic, cultural and environmental contextual aspects, besides items of health promotion, disease prevention, diagnosis, treatment and rehabilitation.

It is important to highlight that healthcare may not result in a transformation. It can temporarily reestablish the balance without making a change. It can produce potential elements for the harmony, but without operating any impact. In this case, the care has not been put in practice. The care is more comprehensive and closely related with this possibility to produce an individual and collective impact in health. This study permitted getting somewhat further into this theme based on women's experiences in different situations. As they acknowledge the possibility of conceiving a new life, for example, they seek methods for this to take place. The opposite can also happen and the woman can seek to join means for this not to take place. In this study, we do not intend to judge the woman's decision, but to mention that something should be devised and granted to subject for the sake of care.

When a new experience puts the **self-perception and self-knowledge** at risk, like in the case of pregnancy and birth, for example, care demands are produced. Acknowledging the care demand in this situation initially represents an exercise of self-perception. There is not pattern to be established and, in that sense, it is important to recognize each singularity. This movement is particular to the subjects and is intended to consolidate the autonomy,⁽²⁸⁾ which is fundamental for the exercise of self-care. That does not depend on the timeframe.

Community groups for women have been appointed as a power to exercise self-care and care-for-the-other and are related to this perception and knowledge we are discussing. These spaces were created to promote the encounter among the subjects, in the attempt to share knowledge and practices about the balance and harmony of life, besides strengthening family and community bonds.⁽³¹⁾ Through this type of device, we could exchange experiences, take a fresh look at some situation among the subjects involved and promote health. These groups should not be limited to the state the woman is in, whether during pregnancy or postpartum. Different encounters should take place to the extent that the woman presents a need for perception and knowledge about herself and the other subjects, about her family environment or about the surrounding social, community or intersectoral context.

Nevertheless, this type of practice has been hardly valued in primary, medium and high-complexity care. Restricted community groups have been observed in the form of a course, in which the attendance and punctuality are key elements. No open and spontaneous contact with the groups is possible, which allow the women to take part anytime and anywhere. Overall, these strict and hard proposals do not permit an own movement. As opposed to what this device permits, this type of action has been elaborated to respond to a demand by the health service or professionals, and not by the subjects involved. Thus, opportunities are lost among the subjects from the perspective of self-care and care-for-the-

other, which the community groups would permit at each encounter.

When considering the self-care practice, we can mention other situations observed through this study. On some occasions and based on the desire not to get pregnant, the woman uses contraceptive methods to establish 'self-care'. We believe that, at that moment, she apprehends a list of possibilities to attend to one of her needs and makes a decision. The contact with this type of method can vary in the country.⁽³²⁾ Nevertheless, many women required the public service to put it in practice. In that sense, they were limited to the resources available for this end. Some of them reported signs of alert towards the use of some contraceptives obtained from the public service. Then, they visited a health professional to report on these problems and received alternatives to incorporate new methods. Nevertheless, difficulties were perceived to accept this new prescription established and, in that sense, many of them quit using these methods, mentioning other signs and symptoms that compromised their state of equilibrium. Without the contact with other methods, the women followed their life routines and fortunately got pregnant. When that happened, it did not seem to be a reason for concern for the large majority of them. Recognizing the signs of alert the use of some contraceptive caused, for example, means perceiving that something breaks their state of balance. That is the **exercise of autonomy**⁽²⁸⁾ reported earlier. No longer using medication due to the emergence of signs and symptoms that interfere in their health and seeking other alternatives are also understood as an opportunity for self-care, as the subject decides not to take the risk or not to experience this situation of disequilibrium, suffering and discomfort.

Nevertheless, simply giving up using medication does not permit a safe conclusion about the care. In fact, when she stops using contraceptive methods, the woman attests that she was not granted possibilities to re-establish the balance coherent with her need. In this case, the expanded care perspective, extensive to other

subjects, failed. Women also reported the lack of alternative medication available through the health system or even errors in its distribution or dispensing. These were some **weaknesses in the supply of resources to put in practice the self-care**, perceived by each of them. Therefore, as health managers and professionals, we should permit the contact with different alternatives for care, qualifying the subjects and respecting their decision on the practice of self-care.

In case of a suspected pregnancy, the women mentioned seeking different resources to confirm it. In general, they visited laboratories, private clinics or pharmacies to have access to the tests that confirm the pregnancy in an easy and fast manner. That raised questions about the contact and access to the primary health care services, the bond and interaction between the subjects and professionals, scheduling and practice of consultations and tests, the public services' response time and forwarding. That should be one of the most common alternatives for the women during the confirmation phase of the pregnancy, as the Primary Health Care (PHC) logic is related to the territory and community allocated to a health service.⁽³³⁾ Nevertheless, the access barriers, such as long queues, bureaucracy, difficulty to take tests and delay to get the results, in combination with the woman's judgment and the health team's violent approach make this alternative unfeasible.

The Brazilian maternal and child health policy prescribes the accomplishment of rapid tests in the PHC services. Nevertheless, we believe that other health and social services are potential devices to permit access to this type of test. The PHC teams would be responsible for mapping these services within the territory and agreeing on strategies to facilitate the access to this type of demand, as well as to qualify different actors for this type of approach and establish a communication network among these services. It should be mentioned that these types of strategies are not intended to control the different services and the subjects, but to permit better qualification of the spaces to provide care. The perspective the subject is granted about this topic should consider the care, instead of an

assistance practice, aiming to control the situation or achieve input for health indicators.

After confirming the pregnancy, an expanded care is needed, which comprises the woman, child and family's health. In that sense, strategies need to be reinforced to guarantee the right to health of one and the other in an integrated manner. We perceive that, sometimes, the pregnancy departed from the woman's desire to get pregnant, from the result of a daily relationship, whether stable or not. In other cases, the pregnancy derived from a lack of information, the difficulty to get access to the health services, the weak contact, trust and bond with health professionals, the lack of alternatives or the non-acceptance of contraceptive methods the public services offers, among others.

In the course of the analysis, we observed the women's difficulties to perceive their own body and the possibility of being pregnant. Some of them noted changes in their body and only realized they were pregnant after the fifth month of pregnancy, as mentioned. This fact did not necessarily compromise the care. As we discussed earlier, the care starts with the self-perception and knowledge. Nevertheless, this happens in different periods of the woman's life and, in that sense, we need to offer resources for this awakening. Recognizing oneself as pregnant is an exercise of self-perception and construction of a new identity, of knowledge about oneself and self-care.

The health policy urges the woman and the health professional to recognize the pregnancy as early as possible with a view to permitting the start of the care. That has been observed through the countless health indicators created, in combination with the transfer of financial incentives to the Brazilian cities.⁽³⁴⁾ Nevertheless, the care is constructed and deserves time, space and preparation for this to take place. That does not mean a denial of the scientific evidence to welcome the woman early at the start of pregnancy and elaborate a care plan to minimize the risks for the woman and the child's health. It is important to think of a care plan that permits the woman to go through the perception and knowledge phase, the recognition of her needs,

search for information and contact other subjects to empower care for herself and the other. As we mentioned earlier, an interaction process takes place in the movement in favor of care.

In that sense, the practice of an active search, merely considering the procedure, to the detriment of the woman's appropriation and empowerment, the strengthening of the social and community network she is part of and the construction of a care network does not stand. Our efforts should focus on the subjects instead of the compliance with targets established with the health service. In that interval, discussing the health actions and services will be highly relevant, but by itself does not guarantee the care. Expanded efforts are needed for this to take place. As for the contact with the health services, the women mentioned particularities of the contact with PHC and the bond with the team. Some of them indicated not visiting the health center frequently or seeking care only when they were ill. Other women directly visited the hospital, independently of their demand. They did so due to the lack of professionals at the health service or because that was the place they preferred.

From the care perspective, the autonomous search for the service should be considered as a strength, in view of the possibility to expand the care the subject assumed. In this sense, a network should be constituted that is immeasurable and cannot be delimited easily; we cannot apprehend it. This place where the contact among the subjects is established should permit the welcoming.⁽²⁹⁾ That should not depend on its complexity level or technological density. This place can be related to the space the woman chose or was indicated as a reference for care. In addition, it may have been the place where the encounter with the health professional took place.

Nevertheless, the care has not been possible due to the subjects' restricted view in each of these spaces. Hence, **difficulties to access the health actions and services** were perceived. At services of different complexity levels, a care transfer routine exists and their co-accountability towards

the subjects is compromised, independently of the clinical situation that responds to that health service's profile or not. Here, the network possibilities are denied which each of us can help to weave in a singular manner that is appropriate to the subject, instead of the service. In view of the mistaken contact with the health team, other aspects should be mentioned: the lack of dialogue, lovingness, trust, bonding and violence interfere in the practice of care.^(1,2,10,27) That happens independently of the professional category and can result in a demand instead of care.

For the women, attention to some aspects is due in order to establish a relation among the subjects from the perspective of care. The fact of putting oneself in the other's place, manifesting lovingness, attention, respect, demonstrating concern, permitting the dialogue, all of this should be addressed. That is not only related to the health professionals. It extends to the subjects who maintain the intent to take care and who participate in the re-establishment of the individual or collective balance and harmony of life. That can be explained based on the expanded health concept that relates other dimensions and the need for an intersectoral practice. After the women are admitted to prenatal care, we perceive the difficulty for the partners to approach and participate with the women. That was appointed in the subjects' narrative as the need to extend the care. The woman usually felt safer and strengthened at the side of a person she chose when she visited a health service. Here, she put trust in her companions, and also in the health professionals and the institution in order to establish the care; she gave up the self-care and allowed the care by other people to overlap.

What this theme is concerned, the Brazilian policy in force has encouraged the participation of the partner in prenatal care with a view to guaranteeing his/her participation during the consultations, as well as the reduction of vertical infection transmission.⁽³⁵⁾ That would be a proper time also to discuss man's health and establish a self-care potential not only for the woman, but also for the family. Hence, it is important to encourage the partner's participation

not only in the prenatal care appointments. During the contact with the hospitals and maternities, that is also necessary, as the companion tended to play a support role for the health team and to further the care in this environment.

That has been defended since 2005 and its regulatory base guarantees the parturient women the right to the presence of a companion in the labor, birth and immediate postpartum period in the context of the Brazilian health system, in line with the humanization policy. This measure has seriously strengthened the partner's bond and participation in all phases of the pregnancy-postpartum cycle and is fundamental for father-child bonding.^(36,37) Without the companion, the health team's effort should compensate for this type of relationship. Nevertheless, in the hospital network, there is a turnover of professionals, in view of the organization and functioning of the services. The women perceive this and this makes the establishment of **bonding**⁽²⁹⁾ and the continuity of care impossible. In addition, we observe accommodation difficulties in the hospital environment that would interfere in this type of practice. Some women already demonstrated that they naturalize this type of situation and mentioned that it does not make a difference. They believed that they would truly have to go through this type of situation and merely the fact of being in the hospital environment already calmed them down. These aspects delimited the **requisites for the search for care**. That raised our concerns, as the starting point for this assessment did seem to be the suffering process. During the hospitalization period, other weaknesses were identified, such as the lack of **information about the care to be provided**. The women usually did not receive information about the tests they were taking. They recurrently complained about this type of situation and about the large number of tests. When the health professionals informed them about the procedures they would be submitted to, they demonstrated feeling well and safe about the procedures and their health condition.

In the exercise of self-care, it is important to socialize what is being provided to the subject to

enable her to appropriate herself of her current condition. The lack of knowledge about her health condition puts the subject in a situation of tension and discomfort without any perspective. Hence, we mention the need to inform the subjects with a view to guaranteeing a right they are entitled to. That includes the diagnosis, treatment and any other procedure related to her health. Concerning the choice of the birth type, another problem was identified. The high c-section rates have been appointed from a negative perspective, as the service dominates the woman's health condition.⁽³⁸⁾ The women mentioned that they did not participate in this decision. That is incoherent with the subjects' empowerment⁽²⁸⁾ we had discussed as being necessary. In fact, if the woman does not participate in this type of choice, we are ignoring her right and her perception and knowledge about her health condition. This type of decision also needs to be discussed when we want to establish a care plan for the woman.

Finally, we reflect more broadly on the care, based on the prioritization of the subjects, instead of merely considering the health services' perspective and the health professionals' technical support. That conforms to the humanization proposal the Brazilian policy is strengthening. Humanization is the essence of care^(10,27) and, therefore, it is important to join efforts and bring together resources, with a view to the dialogue, information, interaction, listening, bonding, participation and lovingness in the relation among the subjects. Based on the interpretation of the meanings emerged in the narratives, we believe that the care is constructed based on the subjects' movement and between them and the social and health services. Thus, when we intend to take care, we should depart from this horizon and not center the care solely on the available services and the health professionals' technical support. Nevertheless, we perceive some research subjects' relative lack of understanding about this dimension, highlighting the construction of barriers that make it impossible for the care to take place.

It should be mentioned that the study revealed the complexity that permeates the transformation

process aimed at the care and the reestablishment of health and points towards the adoption of systemic rationalities and further attention for the organization and functioning of the services in networks that value all of these aspects. Acknowledging these limitations and having strategies in place to transform them in favor of the subjects are challenges to guarantee the quality of care. We hope that the information is this research can contribute to the realization of the care practices and respect for the subjects' singularities. It is important to mentioned that this research comes with some limitations that should be taken into account: restriction of the interviews to professionals from the hospital network; and lack of interviews with the municipal managers. Therefore, we acknowledge the need for new studies that mention these subjects' narratives to enhance the universe of understanding about the care theme.

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