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Percepções de gestantes e puérperas acerca da sala de espera em uma unidade básica de saúde integrada à estratégia saúde da familia

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PREGNANT AND POSTPARTUM WOMEN PERCEPTIONS ABOUT WAITING ROOM IN A PRIMARY HEALTH CARE UNIT INCLUDED IN THE FAMILY HEALTH STRATEGY

Percepções de gestantes e puérperas acerca da sala de espera em uma Unidade Básica de Saúde integrada à Estratégia Saúde da Familia

Percepciones de mujeres embarazadas y puérperas acerca de la sala de espera en una Unidad Básica de Salud integrada en la Estrategia Salud para la Familia

Original Article

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ABSTRACT

Objective: To analyze the perception of pregnant and postpartum women about their experiences in the waiting room. **Methods:** A descriptive analytic study, of qualitative approach, conducted in a Primary Health Care Unit integrated into the Family Health Strategy (Estratégia Saúde da Família-PSF) in a municipality of the state of Rio Grande do Sul, Brazil. The data was collected in December 2011, through interviews with open and closed questions, and was analyzed using content analysis technique. The sample consisted of 10 women, seven of them being pregnant and three in postpartum period; all having received prenatal care and taken part in waiting room activities from September to December 2011. **Results:** According to the participants' perception, the waiting room is a space of attentiveness, promoter of tranquility, understanding and clarification of questions related to pregnancy and childbirth process. **Conclusions:** The formation of health education groups intermediated by problem-based dialogue, aiming to promote reciprocal learning and teaching, with focus on the extensive concept of health, is a relevant issue in the waiting room. It is also important to highlight the need to accomplish continuing education initiatives involving healthcare professionals, centered on a questioning approach of social reality and services, along with the integration of managerial, educational and political aspects. This shall contribute to the real construction of politicized knowledge in health, as report the official documents of health and education sphere.

Descriptors: Prenatal Care; Health Education; Humanization of Assistance.

RESUMO

Objetivo: *Analisar a percepção de gestantes e puérperas acerca de suas experiências vivenciadas em sala de espera.* ***Métodos:*** *Estudo descritivo, analítico, de abordagem qualitativa, realizado em uma Unidade Básica de Saúde integrada à Estratégia Saúde da Família (ESF), em um município do interior do estado do Rio Grande do Sul, Brasil. Os dados foram coletados no mês de dezembro de 2011, mediante entrevistas com questões abertas e fechadas analisadas pela técnica de análise de conteúdo. Os sujeitos compreenderam 10 mulheres, sendo sete gestantes e três puérperas, que realizaram pré-natal e participaram das atividades em sala de espera no período de setembro a dezembro de 2011.* ***Resultados:*** *Segundo a percepção das participantes, a sala de espera é um espaço atencioso, promotor de tranquilidade, conhecimento e esclarecimento de dúvidas relacionadas ao processo gravídico-puerperal.* ***Conclusões:*** *A formação de grupos de educação em saúde intermediados pelo diálogo problematizador, visando promover a reciprocidade do aprender e ensinar, tendo como foco a concepção ampliada de saúde, é um ponto relevante no espaço sala de espera. Ainda é importante destacar a necessidade de que sejam efetivadas ações de educação permanente junto aos profissionais de saúde, tendo como eixo a problematização da realidade social e dos serviços, bem como a integração de aspectos gerenciais, pedagógicos e políticos. Isso pode contribuir para a verdadeira construção do conhecimento politizado em saúde, como anunciam os documentos oficiais da esfera da saúde e da educação.*

Descritores: *Assistência Pré-natal; Educação em Saúde; Humanização da Assistência.*

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RESUMEN

Objetivos: *Analizar las percepciones de las mujeres embarazadas y puérperas acerca de sus experiencias en la sala de espera.* ***Métodos:*** *Estudio descriptivo, analítico, de abordaje cualitativo realizado en una Unidad Básica de Salud integrada en la Estrategia Salud para la Familia (ESF) en un municipio del interior del estado de Rio Grande do Sul, Brasil. Los datos fueron recopilados en diciembre de 2011 a través de entrevistas con preguntas abiertas y cerradas analizadas mediante el análisis de contenido. La muestra estuvo formada por 10 mujeres, siendo siete embarazadas y tres puérperas que tuvieron atención prenatal y participaron en las actividades de la sala de espera durante el período de septiembre a diciembre de 2011.* ***Resultados:*** *Según las percepciones de las participantes, la sala de espera es un espacio atento y promotor de la tranquilidad, del conocimiento y esclarecimiento de las dudas relacionadas con el embarazo y el proceso del parto y posparto.* ***Conclusiones:*** *La formación de grupos de educación en salud intermediados por el dialogo problematizado, promoviendo la reciprocidad del aprendizaje y la enseñanza centrándose en el concepto ampliado de salud, es un aspecto relevante en el espacio de la sala de espera. También es importante destacar la necesidad de que las acciones de educación permanente sean realizadas junto con los profesionales sanitarios teniendo como eje la problemática de la realidad social y de los servicios, así como la integración de los aspectos administrativos, pedagógicos y políticos. Esto puede contribuir a la verdadera construcción del conocimiento politizado en salud, como anuncian los documentos oficiales de la esfera de la salud y la educación.*

Descriptores: *Atención Prenatal; Educación en Salud; Humanización de la Atención.*

INTRODUCTION

Currently, policies of the *Ministério da Saúde - MS* (Ministry of Health) and theme of studies address the increase in access and the improvement in quality of actions taking place in the context of primary health care, seeking, among other things, to qualify the health care for women in its many aspects and therefore, the assistance in pregnancy-puerperium cycle. As an example, studies report data that refer to disarticulation and partiality of prenatal care performed in the Unidades Básicas de Saúde - UBS (Primary Health Care Units) and within the *Estratégia Saúde da Família - ESF* (Family Health Strategy)[1,2].

The prenatal care, as opposed to the mechanistic logic that splits the unity of subject and refutes his leading role, is carved on the principles of the *Sistema* Único *de Saúde - SUS* (Unified Health System) and humanization, therefore, it emphasizes the comprehensiveness of health, welcoming and bond in assistance to pregnant women, parturient and postpartum women and their participation in care as well[3]. Thus, coated and surrounded by educational activities that promote critical awareness, prenatal care gains recognized effectiveness in generating positive impact on maternal and child mortality. Similarly, it meets the dictates of public policies formulated in view of the comprehensive health care of women.

Thus, assistance with such features is the one that reconciles with the goals touted in public policies for women's health, such as the *Política de Assistência Integral à Saúde da Mulher*[4] (Policy of Comprehensive Healthcare for Women) and programs that were based on guidelines with the same content that have predecessed it, such as the *Programa de Assistência Integral à Saúde da Mulher - PAISM* (Program for Comprehensive Healthcare for Women).

In accordance with those policy propositions, attuned to the principles of the SUS, women health care within the ESF is not displaced from the entire life cycle of the human being or the context which includes the family. Moreover, in line with the assumptions of that Unit: pregnancy, childbirth and puerperium need to be experienced from the interrelated perspective.

It is still important to note that the activities planned by PAISM assume an educational practice that focuses on acquisition of knowledge relating to health with the same broad scope as stated in the 1988 Federal Constitution, which means being regarded as quality of life and citizenship right. In addition, seeking the right to a humanized, safe and appropriate assistance, the *Rede Cegonha* (Stork Network) was implemented in June 2011, consisting of a set of care to ensure women's right to reproductive planning and humanized attention to pregnancy, birth and postpartum, as well as ensuring the child's right to safe birth and healthy growth and development[5].

In this context, the importance of educational activities in obstetric care is emphasized, given that prenatal constitutes such an important locus for the development of activities in order to help women to think, consciously, the period experienced by them, contributing to the enhancement of the capacity of decision about their health and the strengthening of their autonomy.

Thus, this is where the woman should receive better guidance so that she can live pregnancy and childbirth positively, with less risk of complications in the postpartum and more successful breastfeeding[6]. Such arguments, since defending actions favorable to achieving lower rates of maternal and infant mortality, meet the goals set out in the *Pacto pela Vida* (Covenant for Life)[7].

With regard to prenatal care, inspired by the integral nature of public health policies targeting the attention to woman, which were created in the wake of the SUS, it

is suitable to see the waiting room as a place that has an educational, properly teaching function, linked to issues of technical-scientific and sociopolitical knowledge. It is worth noting that the design of the waiting room, erected in the context of changes in the health system, created by the Constitution of 1988, is a space sympathetic to the changes that are taking place in the social field. In other words, it means a locus appropriate to discuss issues that relate to the way society structures and organizes the answers to health problems, as well as the effectiveness of practices imbued with the exercise of citizenship and with critical and reflective thinking[8].

In this territory, it is reiterated that education can contribute significantly to health promotion, disease prevention and referrals to other activities. Furthermore, it fosters the improvement in quality of care, ensuring greater acceptance and good relationship between the user, system and worker writing up a way to humanize the bureaucratic services[9].

It is worth emphasizing that the waiting room constitutes an educational space, which enables individuals to think and reflect about their conditions and thereby generate transformations. Thus, by promoting health education, critical awareness and questioning by the subjects will be promoted, allowing the commitment to change[8,10].

From this perspective, this study sought to analyze women's understanding about their experiences in the waiting room at a Primary Health Care Unit (UBS) included in the ESF and whether this understanding points to a humanized practice in prenatal and postpartum period.

In view of this problem and considering that the education organ this study was originated in, namely *Residência Multiprofissional Integrada em Sistema Público de Saúde, da Universidade Federal de Santa Maria - UFSM* (Multiprofessional Integrated Residency in Public Health System of Federal University of Santa Maria), is committed to the consolidation of health practices addressing the triple integration - interdisciplinary, intersectional and inter-institutional - supported by the pedagogical trend paradigm of health promotion, the present study's primordial aim was to analyze the perception of pregnant and postpartum women about their experiences in the waiting room of a Primary Health Care Unit included in the ESF.

METHODS

This research is a descriptive analytical study, of qualitative approach. The qualitative research methodologies are 'those capable of incorporating the issue of meaning and intentionality as inherent to acts, relationships and social structures, the latter considered both in its advent and its transformation as significant human constructions'[11,22,23]. Thus, this method is based on the interpretation of what the subjects say and express.

Therefore, considering the objectives of this study, which are meant to understand, rather than measure, issues related to the experience of women in the waiting room, qualitative research was chosen to guide the path in this methodological research.

The research took place in a Primary Health Care Unit comprised in the Family Health Strategy (ESF), in the municipality of Santa Maria-RS, in December 2011. The unit is located in the western region of Santa Maria, covering a population of 13,000 people, distributed in three villages (Prado, Jóckei and Caramelo). It includes two Family Health Teams and receives support from students of Physiotherapy, Nutrition, Nursing and Pharmacy of the *Centro Universitário Franciscano - UNIFRA* (University Franciscan Center). It also encloses physicians and multidisciplinary residents of UFSM.

Regarding attention to pregnancy and puerperium, prenatal and postpartum attendance is performed by the student of Multiprofessional Integrated Residency in Public Health System - UFSM, lacking, until the moment of data collection in this study, collective actions of education systematically addressing this health lifecycle.

The activities in the waiting room, which are proposed to focus on the prerogative of its group character, were created from an intervention project suggested by the aforementioned residence and mediated by two residents of that program. They also reckoned on the participation of scholars from other educational institutions and eventually on the resident from the multiprofessional team of the ESF, who performed the prenatal visit.

The implementation of activities, as agreed with the ESF staff, underwent the stipulated schedule time for prenatal appointments, conducted on Mondays, in the afternoon. Thus, there was an overlap between the schedules of antenatal attendance and the educational group activities, creating some limitations to the development of such actions.

Between the months of September and December 2011, 13 meetings were held with an average of three to five participants, and some days five or six prenatal visits were performed. Usually, there was the participation of family members or caregivers, along with pregnant or postpartum women who were present, although they did not have an appointment at that time.

The study comprised 10 women, seven pregnant and three puerperium women. All had attended the waiting room for at least one of the meetings held in the UBS while awaiting prenatal visit and voluntarily participated in conversations about the topics addressed.

In this research were included pregnant women or mothers over 16 years of age, who had understanding and oral expression conditions and accepted to participate voluntarily, by signing the Free Informed Consent Form (FICF).

Data collection was conducted through semi-structured interviews related to the research topic. They occurred singly at homes or in boxes in the UBS, guided by open and closed questions, with data on the characterization of the subject and on the significance of participating in the activities in the waiting room. It also contemplated the opinion of women on the methodology of activities, theme discussed and the professionals involved. The interviews were taped and transcribed verbatim.

Data was analyzed based on the contents of the interviews, which were submitted to the steps provided by the reference content analysis of Bardin (2009), systematized into three steps: pre-analysis, material exploration and results treatment[12]. Thus, through detailed reading and rereading the material, the construction of categories of interests was performed, and they were nominated 'waiting room as a place to talk' and 'waiting room as a place to learn and ask questions'.

With regard to ethical principles, the rights of participants were respected, taking into consideration the recommendations of *Resolução 196/96 do Conselho Nacional de Saúde* (Resolution 196/96 of National Health Council)[13]. Thus, the research objectives and the FICF were presented to the interviewees, being guaranteed the maintenance of confidentiality and anonymity. Therefore, they were identified with the letter G (pregnant) or P (postpartum), accompanied by a number randomly distributed (G1, G2, P1 ...). It was also assured the right to drop out the survey at any time, as well as free access to the results obtained through this. All participants signed the FICF.

The study was approved by the *Núcleo de Educação Permanente em Saúde da Secretária de Saúde de Santa Maria e do Comitê de* Ética *da Universidade Federal de Santa Maria - CEP/UFSM* (Center for Continuing Education in Health of the Health Secretariat of Santa Maria and the Ethics Committee of the Federal University of Santa Maria, under protocol number 23081.013029/2011-65.

RESULTS AND DISCUSSION

From the interviews conducted and the results obtained from the content analysis it was initially presented the data about the characterization of the subject, followed by the analytic categories, classified as 'waiting room as a place to talk' and 'waiting room as a place to learn and ask questions'.

Characterization of the study subjects

Concerning the level of education, all women were equated with complete and incomplete high school;, in terms of occupation, the majority reported being 'home'; monthly family income ranged from R$545.00 and R$1,500.00; and the age ranged from 18 to 40 years.

Concerning the participation in activities in the waiting room, half the participants were present at only one meeting.

Categories

Waiting room as a place to talk

The waiting room serves as a space where exchanges occur among people through dialogue. It is a locus where health conditions can be detected and also where health professionals evaluate, interact, go over myths and beliefs, getting to understand the users in their integrity[9].

Based on the conceptions of women, it was realized that their experiences in the waiting room make this space to be regarded as a place to 'talk' as it is stated in their discourse:

> *To me, it was good because the attention to pregnant women [...] sometimes there is the need to talk to someone [...] there's no one to talk to, so I think it's very good, it's an attention for us, I guess. (G5)*

> *[...] Each person reacts in a way. There are some who spend their pregnancy quiet [...]. To myself, this one was a very difficult pregnancy. Earlier, I had a complication and they were good (sic) me [...]. So they talked. I think it's important, yes. It is important improves. (G5)*

> *Look, it was right at the beginning, so I was kind of sickened because I did not expect pregnancy. So the girls talked a lot, so they conveyed a lot of tranquility. Pretty good. (G8).*

> *I think that conversation like this is so very good [...] very important for everything, right? (G8)*

It is important to highlight that an efficient conversation can create bonds between worker and user, produce knowledge of the actual health needs of the individual, convey trust and responsibility, as well as fostering autonomy in the promotion of their health[14]. Furthermore, listening without prejudice or judgments allows the woman to feel safe, causing her to speak of intimacy and feel serenity in her walk until delivery, contributing to a peaceful and healthy birth[15].

Thus, the professional should be careful to listen to the users, understand the other in its entirety and ensure that it's provided a humanized health care in the waiting room[16].

Talking about having a space for conversation makes us figure a health service with humanized care. It is understood by humanizing the valuation of different subjects involved

in the production of health. The values that guide this policy are the subject's autonomy and leadership, the responsibility shared between them, the solidarity bonds and collective participation in health practices[17].

Devices for health education are shown as an environment where takes place the exchange of living experiences and feelings between professionals and users, besides favoring their proximity toward the service, making them the protagonists of their disease process, while it helps to guide them regarding their responsibility[18,19].

Thus, there is the need to build a new perspective on health education through dialogical relations and appreciation of popular knowledge. For transformations to occur in people's lives, theories, drugs and information are not enough, it is but needed to understand them in their uniqueness, with their problems and their differences, their values and beliefs, within a community, the collective and the environment[20].

In this context, what makes all the difference in the educational process is to meet people's ideas, know their life story and the activities they carry out in the environment they are inserted in; moreover, to understand their culture, tradition and worldview[21].

It is worth mentioning that, among the women assessed, the team spirit was not found, since the characteristics of gathering prevailed.

While playing and performing activities, people cease to be a gathering where each individual is assumed as one participant and have been given the right to speak, opine, express their views and to be silent, because they have their own identity, different from the others, despite sharing a common goal of the group. Furthermore, the benefits of grouping are to facilitate the collective construction of knowledge and reflection over the reality, enabling the fragmentation of the vertical relationship between professional/patient, and facilitate the manifestation of needs, hopes and anxieties[22].

The formation of a gathering can be evidenced by the fact that most women have attended a single meeting, not constituting members of a group. Most of the time, two residents were present in the educational activities, being part of the talks and a pregnant woman who was waiting for prenatal consultation.

The small number of participants was partially due to the prenatal visits being scheduled each 30 minutes, not allowing collective participation in the meetings. Another factor that probably interfered with the low adherence to the activity proposed by residents was the lack of involvement of professionals.

The absence of the spirit and the concrete practice of grouping in health care in the ESF leads to the inference that the SUS's assumptions and linked policies are not references that guide the management and attention within the Unit. Furthermore, it is assumed that the talks performed in this environment follow the same direction, thereby refuting approaches which recognize the pedagogy of autonomy as mediator of quality of life and health.

Waiting room as a place to learn and ask questions

The experiences in the waiting room, according to the women's manifestations, although referred as moments of learning, do not allow to infer that they are bound to a broad concept of health, as stated in the current Constitutional Charter, nor to an educational perspective pointed to the subject's autonomy, the health service user's active role or to the critical-reflective knowledge, which are public policy recommendations that diffuse health care humanization. This is evident in the following speeches:

> *[...] It was great, I learned a lot there [...]. I took away all my doubts [...]. Everything I learned here today, I'm dealing with it very well [...]. I had more opportunity to take over my doubts (sic) [...]. (P1)*

> *Yeah, they were able to take my doubts. All I asked was answered by them [...]. (P7)*

It is seen that, in the underlying form, the women emphasize a teaching-learning relationship that does not converge with the values espoused by the prenatal care humanization, since the 'learn and ask questions' designed by subjects is supported by the references of banking education.

The traditional model of health education is strongly rooted in the educational practices carried out by health professionals themselves, where the transmission of technical-scientific knowledge is privileged, the educator being the holder of knowledge and the pupil a tank to be filled. It is also pointed out that the dialogic model of health education presents a construction of knowledge, which should be linked to dialogue, so that educator and student assume active role in the learning process through a critical and reflective approach to reality[23].

In this sense, education goes beyond the bounds of 'guessing', 'accommodation' and 'failures'; it goes beyond that, because it takes the principles of equality, knowledge exchange, coexistence and circle of culture[24].

Thus, one can infer that learning process developed in the waiting room needs to distance itself from the neutrality and technical omnipotence to deconstruct relations marked by alienation that submits the popular knowledge to the scientific one. On the other hand, it needs to cross the boundaries and curtailment of practices reinforcing the assumption that the learner does not teach and who teaches does not learn.

Therefore, that space needs to be designed, for whoever attend it, as a significant part of learning. Consequently, able to both solve and raise doubts, since this is something inherent in spaces committed to building citizenship, comprehensive care and increasing the subject's autonomy, as it is proposed by the policies that support health services humanization.

It is pertinent to remember that 'signaling paths, so that the emancipation manages to be manifested in daily activities by the community in need of health services and by the professionals they interact with, is a basic assumption for the waiting room to be, in fact, a place tuned with politicization'[8].

Corroborating this view, it may be noted that health education is an excellent strategy to be used in prenatal services in order to empower pregnant women as protagonists in health care. To do so, it should be developed 'for all professionals within the health unit staff, be inserted in all activities and must occur in all contacts between health professionals and clients'[6].

Demonstrations denouncing the existence of a close alignment between the women's conception about the experiences in the waiting room and the technical vision of health education can be observed when they repeatedly used words that are part of the language pertaining to prenatal care to express an understanding of the experiences in this space. This is shown in the speech fragments transcribed below:

> *It was in labor, that's when I was afraid. And also after the birth we spoke [...] about before, the time of delivering and the postpartum too. (P2)*
>
> *Regarding Caesarean delivery, that I did not know much [...] about postpartum, to prevent pregnancy again, it was very interesting. (G3)*
>
> *The contraceptive that one uses inside, I did not know, I did not know [...]. And the intrauterine device (IUD) I didn't know it. (G4)*
>
> *I think it's very productive [...] very interesting for us to have more knowledge of what happens in pregnancy [...]. (G8)*

The above expressions reiterate the inferences that the site in question still gives priority to educational approaches of technical-scientific nature, contrary to the propositions of health policies that signal the role to be assumed by health education in the awakening of the subject, to the attainment of socio-political knowledge, essential to the achievement of individual autonomy and social leadership.

The everyday practice of health education is strongly related to depository and vertical education, as opposed to a broader perspective that meet the complexities of the new public health, which presents an approach aiming to strengthen the people's critical consciousness for an active participation in designing their life circumstances[25].

Thus, the waiting room favors debates regarding the processes of everyday life and creates spaces to reflect and talk critically about building a quality of life by encouraging the participation of all[8,10].

It is worth noting that the waiting room inflection towards the educational trend that outweighs the technical expertise renders it difficult for that space to join in the guiding principles of the humanization policy, which value the subjective and social dimension in all management and health care practices.

Despite this observation, the conclusion arising from the women's speech makes it possible to comment that it's in such a place where moments happen approximating some elements recognized as attributes of humanization: talking, listening and attention to certain needs required by the biological dimension of the woman experiencing the pregnancy-puerperal period. The other factors that constitute comprehensive integrated care seem to be situated apart or enjoy reduced access to health care team in ESF scenario.

All these considerations, along with others that denote lack of knowledge about everyday issues related to the use of contraceptive methods, lead to the understanding that there is a conflict established between what the official document stresses on humanization of services and prenatal activities and how this is performed in the process of care.

It should also be emphasized that there is an urgent need for the ESF to focus its efforts on the operationalization of educational actions, prioritizing critical approach, due to its potential to encourage the construction of subjects. Likewise, it should invest in the continuing education of professionals, for them to constitute true protagonists in the consolidation of the *Política Nacional de Humanização* (National Humanization Policy) and the *Programa Nacional de Humanização do Parto e Nascimento* (National Program for the Humanization of Delivery and Childbirth), which will positively impact on reducing maternal and child mortality.

FINAL CONSIDERATIONS

The experiences in the waiting room, as conceived by pregnant and postpartum women participating in the study, point it as a place of attentive service, promoter of peace, understanding and clarification of doubts related to pregnancy and childbirth process, especially in regard to its biological aspect. The issues related to pregnancy, childbirth, baby care, postpartum and contraception were core elements of the talks held in this space. Furthermore, the possibility to ask and solve questions related to the biomedical dimension of prenatal care was a point stressed by them as important.

Such considerations, along with the lack of activities characterized as group activities in prenatal care in the studied UBS, point to the indispensability of reviewing the emphasis that has been attributed to the biomedical aspect during conversations conducted in the waiting room. That means the theoretical approach and the methodology employed in this venue should be changed in its conventionality, since it opposes healthcare and educational precepts espoused by SUS.

The uniqueness involved in prenatal care, where only the nursing resident performs the individual monitoring of pregnant women and the educational activities characterized as grouping are not systematic, gives rise to suggesting that the health team in the ESF, along with the professional residents who work in this area, revisit the concepts and underlying principles of such strategy. It is possible that this attitude rekindle the service and the academia's commitment through the materialization of the management logic and attention that seeks to overcome a model marked by the dictates of the biological/mechanist paradigm.

Even in this scenario, it becomes vital the formation of groups in health education intermediated through problematizing dialogue, in order to promote reciprocal learning and teaching, with a focus on broad conception of health. Moreover, it stands out the need to perform actions on permanent education for the professionals, guided by the questioning of the reality and social services, as well as the integration of managerial, pedagogical and political aspects existing in the mentioned space.

It must be recognized, though, how challenging it can be for health professionals the work in the waiting room from a perspective that seeks to overcome the biomedical view. Such requirement, however, is crucial when one aims to contribute to the effective construction of politicized knowledge in health, as proclaimed by the official documents in health and education dimension.

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