

Experiencing care in the birthing center context: the users' perspective

VIVENCIANDO O CUIDADO NO CONTEXTO DE UMA CASA DE PARTO: O OLHAR DAS USUÁRIAS

EXPERIMENTANDO CUIDADOS EN EL CONTEXTO DE UNA CASA DE PARTOS: VISIÓN DE LAS PACIENTES

Roselane Gonçalves¹, Cláudia de Azevedo Aguiar², Miriam Aparecida Barbosa Merighi³, Maria Cristina Pinto de Jesus⁴

ABSTRACT

In Brazil, the delivery and birth care model in Brazil has been the topic of many studies and discussions about introducing obstetric practices that take women's autonomy into account in the parturition process. Birthing Centers propose models that represent a new scenario to deliver such care. The objective of this was to understand the experience of women in labor in the context of a Birthing Center located in the city of São Paulo. Data was collected from March to October 2007 and analyzed according to the Alfred Schütz social phenomenology framework. Seven women participated in this study. Results showed that women choose the Birthing Center expecting to receive humanized care and that, within this context, they have positive and negative experiences. It is imperative to discuss public policies for delivery care, as well as its implementation and impact on perinatal health indicators.

KEY WORDS

Women's health.
Natural childbirth.
Humanizing delivery.
Obstetrical nursing.

RESUMO

O modelo de assistência ao parto e nascimento no Brasil tem sido tema de muitas discussões e estudos sobre a incorporação de práticas obstétricas que considerem a autonomia da mulher no processo de parturição. O modelo proposto pelas Casas de Parto configura-se como um cenário para esses cuidados. Este estudo voltou-se para a compreensão da vivência da mulher parturiente no contexto de uma Casa de Parto situada em São Paulo. Os dados foram coletados no período de março a outubro de 2007 e analisados à luz do referencial da Fenomenologia Social de Alfred Schütz. Sete mulheres participaram da pesquisa. Os resultados evidenciaram que a mulher que escolhe a Casa de Parto para dar à luz busca pelo cuidado humanizado e que nesse contexto ela passa por experiências positivas e negativas. Faz-se necessário discutir as políticas públicas de assistência ao parto, sua implementação e seu impacto sobre os indicadores de saúde perinatal.

DESCRIPTORES

Saúde da mulher.
Parto normal.
Parto humanizado.
Enfermagem obstétrica.

RESUMEN

El modelo de atención del parto y nacimiento en Brasil ha sido tema de muchas discusiones y estudios sobre la incorporación de prácticas obstétricas que consideren la anatomía de la mujer en el proceso de parición. El modelo propuesto por las Casas de Partos se configura como un escenario para tales cuidados. Este estudio apuntó a la comprensión de la experiencia de la mujer parturiente en el contexto de una Casa de Partos situada en San Pablo. Los datos fueron obtenidos en el período de marzo a octubre de 2007 y analizados a la luz del referencial de la Fenomenología Social de Alfred Schütz. Siete mujeres participaron de la investigación, y los resultados evidenciaron que la mujer que escoge la Casa de Partos para dar a luz lo hace por el cuidado humanizado y, en este contexto, tiene experiencias positivas y negativas. Se hace necesario discutir las políticas públicas de atención del parto, su implementación y su impacto sobre los indicadores de salud perinatal.

DESCRIPTORES

Salud de la mujer.
Parto normal.
Parto humanizado.
Enfermería obstétrica.

¹ Doctor Professor at University of São Paulo School of Arts, Sciences and Humanities. Member of Grupo de Pesquisa em Enfermagem com Abordagens Fenomenológicas (Group for Nursing Research with Phenomenological Approaches). São Paulo, SP, Brazil. ² Midwife. Student of the Master's Degree Program at University of São Paulo School of Public Health. São Paulo, SP, Brazil. claudia.azevedo@usp.br ³ Full Professor of the Maternal-Child and Psychiatric Nursing Department at University of São Paulo. Leader of Grupo de Pesquisa em Enfermagem com Abordagens Fenomenológicas. São Paulo, SP, Brazil. merighi@usp.br ⁴ Associate Professor at Faculdade de Enfermagem da Universidade Federal de Juiz de Fora. Member of Grupo de Pesquisa em Enfermagem com Abordagens Fenomenológicas. Juiz de Fora, MG, Brazil. cristina.pinto@acessa.com

INTRODUCTION

The incorporation of delivery to the medical practice has added to the scene, which once had the woman and her child as the leading roles, other actors who took over the leading role in the act of birth and delivery. Those actors have changed the scene and scenery: home childbirths now take place at health institutions and the act of delivery is controlled by physicians and nurses, among other health professionals. The hospital is introduced as a controlled and safe environment and health professionals as those conducting the process.

In Brazil, the model of care for birth and delivery is characterized by high rates of intervention, which disagrees with the global recommendations regarding the criteria for using obstetrical practices, making a distinction between those considered useful and that should thus be encouraged; those that are clearly harmful or ineffective and should therefore be eliminated; those that do not have enough scientific evidence to support their use and should thus be used with caution until supplementary studies confirm their effectiveness; and those that are frequently but inadequately used⁽¹⁻²⁾.

In this perspective, several strategies have been implemented with the purpose of rescuing natural childbirth as an event that exceeds the scope of physiology, covering the complexity of the process of gestation, delivery and birth, in a way that the woman may recover the control over her body and her process of parturition. Hence, in 1998, the first childbirth was open in São Paulo, and, in 1999 law 985/GM dating of August 5th, 1999 is passed, thus creating the Natural Birthing Centers in the scope of the Unified Health System (the national public health system in Brazil, referred to as SUS - acronym for Sistema Único de Saúde)⁽³⁾. These institutions would adopt a model of birth care which permit to use the available technology according to specific criteria and to recover women's autonomy in the birthing process⁽⁴⁾.

Despite these initiatives, it is common for women to ask questions about the place where they will give birth. The birthing place is usually defined at the moment of its onset. Though the women are registered in the health care system, they do not have any guarantees in terms of the location where the birth will occur. The latter is often defined according to the availability of the obstetric bed in the city/region and, sometimes, may be at an institution distant from home. Therefore, most times, the women choose the place here they will give birth mostly based on how easy the accessibility is than on the model of care that they wish to receive.

In this sense, in addition to proposing a new model of birth care, considering its structure and process, in which obstetrical practices are evidence-based and individualized, it is essential to evaluate the actions performed at the Natural Birthing Center from the women's perspective. Only after such an evaluation can the actions be considered a model of care that actually has the potential to integrate women's care in the parturition process.

In view of these considerations, some questions emerge: how do women who search the Birthing Center experience the care they receive? Does the environment at the Birthing Center and the health care model adopted in this context guarantee that the care will be humanized?

Taking this perspective into consideration, the purpose of this study was to learn about women's experience during labor and delivery in the context of a Birthing Center, and the reasons that lead them to choosing that institution.

STUDY TRAJECTORY

The context

The women assisted at the Birthing Center arrive there by spontaneous demand or are sometimes referred there by professionals from the regional Primary Health Care Center. There is no restriction against women coming from other areas, i.e., women who do not live in the territory covered by the service. The Birthing Center is located in Southeast São Paulo and has two hospitals to where pregnant women, puerperae and newborns, whenever indicated, are referred to. However, the center is not a part of the reference and counter-reference system for obstetrical care in the city neither is it part of the unit controlling the availability of obstetric beds in the city.

As proposed by ordinance 985/GM/99, the staff at the birthing center under study is comprised by nurse midwives trained for neonatal resuscitation; nurse's aides; administrative workers; cleaning workers and ambulance drivers, distributed according to the daily working schedule. These characteristics agree with that described in other studies about Natural Birthing Centers⁽⁵⁻⁶⁾.

Regarding the service delivered, in 2006 there were an average 30 deliveries per month. The monthly rate of client transfers to the reference hospitals was 4.52%, mother intrapartum; 1.2%, mother postpartum, and 1.2%, neonatal. The rate of puerperal or neonatal infection was zero, corroborating with a study about this type of occurrence at another Natural Birthing Center⁽⁷⁾. The admission of the pregnant woman is always performed by a nurse midwife and may occur as of the 37th week of pregnancy or at the moment of labor, according to the pre-established clinical-obstetrical criteria determined as per an institutional pro-

...is essential to evaluate the actions performed at the Natural Birthing Center from the women's perspective. Only after such an evaluation can the actions be considered a model of care that actually has the potential to integrate women's care in the parturition process

tocol of care, designed according to the recommendations of the Ministry of Health and the World Health Organization^(2-3,8), which provide the bases for indicating the delivery at the Birthing Center or transferring the woman to the reference hospital.

METHOD

The study was approved by the Ethics Committee for Research Involving Human Beings at University of São Paulo School of Nursing (document number 570/2006/CEP-EEUSP), and at the Municipal Health Department (document number 0044/07/CEP-SMS).

This study used a qualitative approach and the framework was Alfred Schutz's social phenomenology, which aims at understanding social action⁽⁹⁾. Schutz proposed a method to capture the social reality that permits to understand it, recognizing that the meaning of an action involves the subjectivity of the agent and that to understand the other person it is central to make a genuine observation, which occurs when one interprets the meaning of what the other says or does through his or her actions⁽¹⁰⁾.

Participants were seven puerperae who gave birth at the Birthing Center and provided written consent. The number of participants in this study was determined by the descriptions themselves; considered sufficient to answer the author's inquietudes. Hence, the inclusion of new subjects ended based on the set of collected data, which evinced both the richness as the coverage of the meanings contained in the statements.

Data collection was performed from March to October, 2007. The women were approached in the postpartum period, while they were still under professional care at the Birthing Center. When the women were interested in participating in the study, the interview was scheduled as per their availability and within a maximum of seven days as of the date of the delivery. The interviews were held at the homes of the puerperae, and were recorded with their consent, with the aim of apprehending the meanings they attributed to the experiences of receiving care during the delivery process at the referred institution. The women were asked the following questions: what made you seek the Birthing Center to give birth? What was your experience of giving birth at the Birthing Center like? How was the care you received like?

Participants were between 16 and 41 years old. As for their level of education, one had completed higher education, another had incomplete higher education, three completed the Secondary School, one did not complete Secondary School and one did not complete Primary Education. Three participants informed they were housewives, one masseuse, one nurse, one seamstress and one hairdresser. The guidelines used in this study have been described by authors who adopt the referred theoretical-philosophical grounding in their studies⁽¹¹⁾. The descriptions of

the actions experienced and expressed by the subjects were obtained from the statements identified using fictitious names. By reading the descriptions carefully and for several times, the meaning units were obtained, which permitted to categorize the data to understand the studied phenomena.

The analysis of the thematic categories allowed for developing the process of experiencing labor and delivery of women who gave birth at a Birthing Center. This process begins by choosing the model of care for labor and delivery, analyzing the subject's experience and culminates with the perception of health care needs. The revealed thematic categories were: choosing the place to give birth; experiencing labor and delivery and the care needs.

RESULTS AND DISCUSSION

Choosing the place to give birth

The statements showed that choosing the place to give birth is based on the previous experiences lived by others or themselves in other occasions, or yet because these women were seeking a differentiated health care model:

I found [the birthing center] by accident. One day I was, like, surfing the web, and I found a website [...] and I saw that there were a lot of reports from pregnant women [...] and I could contact them [...] then she asked: 'do you know about the birthing centers?' Have you ever heard about it?' [...] Then, she referred me (Fernanda).

In their reflections about choosing the place where they would give birth to their children, some women used as reference the common routines of the medical models of birth care, as well as conducts that are usually adopted by professionals who follow models that are more interventionist:

...some time before, I actually looked for a hospital, thinking: 'I think I'll get a cesarean!' [...] and in the appointment with the doctor I realized that it wasn't what I wanted [...] he wasn't thinking of me, he was just doing it. And at the birthing center it's not like that! 'Look, we're going to wait, everything is fine!' So, ...I said: 'Now I'm going, and I'm calm about it (Valeria).

It is observed that the discourse about the care usually delivered to pregnant and parturient women at the traditional hospitals and the and the overcrowding at the services encourage the search for differentiated care, which not always occurs in a calm way, considering the pressure that women suffer when they chose to give birth at the Birthing Center. Delivery is still seen as an experienced that puts the woman and child at risk, and for that reason, when the pregnant woman chooses to give birth using a different service, and, specially, at an unconventional location (out of the hospital), the power of the social knowledge regarding care during labor and delivery of family members and also of the professionals involved with the prenatal care make the woman feel:

...I had already decided that I was not going to tell the doctor my choice about the delivery... but then she kept pushing me... then, she said: 'it's too dangerous!' [...] she made me panic... she said: 'What if he (the baby) has anoxia? He can become retarded!' [...] (my relatives) didn't like it... they got really scared. (Carina).

The routines of modern hospital obstetrics comprise a ritual filled with symbols that reinforce the ideas that women are no longer capable of giving birth without the medical technology and that their bodies, without that control, may not have the conditions required for parturition. In the hospital the woman and child will be protected by the technology that is offered there⁽¹²⁾.

The uncertainty about having access to a safe and welcoming place when the moment to deliver comes encourages the women to search for other alternative, which, for those with financial resources, includes buying medical insurance that would provide them with the service during labor and delivery, without any hassle.

It should be emphasized that the knowledge that the referred woman has gained throughout her existence, based on her own existence and from what she learned from relatives and close ones, includes the doctor that followed with her during her pregnancy. The man of natural attitude is biologically set in the world of life and uses the available knowledge as a reference scheme for every interpretation of this world and for the practical or theoretical activities regarding the future plans⁽¹³⁾. Hence the suffering, her doubts about giving in to the pressure of relatives and health professionals and choose the hospital delivery or choose this alternative of care - the Birthing Center.

When the woman overcomes the obstacles imposed by her own fears and by the criticism of others, she follows with her intent and realized the care within the context of the Birthing Center.

Experiencing labor and delivery

During labor and delivery the woman perceives the environment, the people, and their attitudes. However, as the process involves intense physical, emotional and psychological sensations, the woman appears to turn more towards herself, and the perception of her body becomes evident through the signs that it shows. Regarding the process of parturition, the pain from the contractions brings to the woman's consciousness the existence of the materialization of her body:

...the pain wouldn't go away, so, there were times when I couldn't sit, I couldn't lie down. I felt like getting it out quickly. Anxiety is really something (Marina).

All the experiences we have of objects are typical and not unique or particular. We receive a series of typification and forms of typification, generally admitted within the social group and which we use to achieve typical ends⁽¹³⁾. Pain is associated with labor and delivery as a typification

founded on the woman's previous experiences, which are concrete experiences. The woman identifies, reacts at that pain and acts according to her pace and own needs:

...it was very that y mother and my husband were there with me... I would say: 'help me, help me!', every time I had a contraction... my mother massaged me... And it would go away... because you husband participates, your mother participates, you feel comfortable... (Valeria).

At that moment, the acting presence of the companion and the professional is indispensable, keeping in mind that their behavior also affects the way that the woman behaves when feeling pain during labor. Through their own convictions, the companions' interventions may be positive or negative, as the women, at that moment, do not necessarily wish to receive orientations as to how they should or should not act.

...you are with your partner, because in my case my husband was there, right? He was there with me all along (Mabel).

The whole experience lived by the women at the Birthing Center allowed them to perceive themselves, their pairs and, most of all, everything that was happening around them. The conduct of the professional who welcomes the woman to the Birthing Center shows a differential in terms of the aspects regarding interpersonal relationship:

I felt safe there [...] they explained everything, they calm people down [...] all the nurses there were very nice [...] I was never alone. I think it was really important. They followed everything. It calmed me down (Marina).

It is important to underscore the importance that the interaction and the welcoming have so the care that is delivered is centered on the needs of the parturient woman. In this case, information is a key factor and consists of the basis for the parturient woman to have autonomy in accepting or refusing any procedure involving her body, by making choices that agree with and are pertinent to her wellbeing⁽⁶⁾.

In this study it was realized that, despite their delivery having been successful and their having been welcomed and cared after, some statements suggest there were doubts related to the type of delivery they had chosen, thus confirming findings of other studies that have shown that women generally refer to the delivery as a difficult and emotionally negative experience marked by pain and fear⁽¹⁴⁾. Those women expressed having contradictory feelings towards their emotions in the delivery process:

...that night... if you had asked me: 'What was your delivery like?' I would [say]: 'I don't know why I went through with this!!!' [laughs], 'Why did I come here?' 'I should have gotten a cesarean!', because I thought I had suffered a lot of pain, right?... So, because people talk about labor with analgesia, then I thought: 'Oh, I'm retroceding, I should be evolving! There should at least be some analgesia!' [laughs]. And during the delivery I would say: 'I won't handle it! I should've gone to the hospital!', I really thought that! [...] I thought: 'why am I here?' (Valeria).

The set comprised by the system of interests and of relationships in the natural attitude is fixed on the experience of the fundamental suffering and it does not separate from the pragmatic reason; thus the fears, the hopes, the wishes and the personal projects emerge⁽¹³⁾.

The women, facing the consummated act, that is, of completing her project to give birth at the Birthing Center, reflects about her action and that reflection turns to the inter-subjectivity of the moment of delivery, which while being individual, also include the woman's interaction with the nurse and her partner or family member. The social relationship referred to as face-to-face, considered essential to human interaction and as required for other forms of interaction, is valued by the women giving birth at the Birthing Center.

One aspect evinced from the woman's statement was the fact that, despite the Birthing Center being a place where the health care model is based on the presuppositions of humanization, the behavior/practice of the professionals is not always a welcoming, sensitive, respectful one. Some parts of the statement represent an important counterpoint, as they refer to the fragilities of the welcoming in the care practice:

...who did my delivery, [small pause] ... she was very cold, she was dry [...] when my water broke, it was around half past midnight, I had no one to call to bring me in, so I called the Birthing Center. Then that... who did my delivery, she answered the phone, and she didn't want to send me an ambulance. It was raining hard that Sunday and I said: 'Now, what?'. Because... it could, right?, take too long, or the baby could swallow dirt, I don't know! ...there were two ambulances there and no mothers in labor at the Birthing Center; only two who had already had their babies (Monica).

It is observed that the woman begins her stay at the Birthing Center with an unsolved issue regarding meeting the expectation that was created in the first days in contact with the service. During the process of labor and delivery, other negative experiences are reported:

...she [the nurse] said I was putting on a show and I really wasn't. The pain was really terrible! Then she would come and say: 'What are you doing in bed? You'll fall out of bed!' Then I would say: 'What do you want me to do? Tell me what and I'll do it?' (Monica).

The process of parturition does not qualify as a health problem. However, in this stage of the pregnancy-puerperal period women are vulnerable due to the physical limitations and because of the pain and other feelings they have, which involve insecurity, fear and a condition of dependence on others. In this experience, one of the women, though trying to meet the expectations of the caregiver, following the orientations/prescriptions she had received, does not find any support and that increases her insecurity, leading her to make decisions on her own about how to alleviate her suffering:

...I was in the shower, then I felt the baby was coming ...then I said: "I want to get out of the shower... Then she [the nurse] came in and said: 'You can't leave the shower!' [...] I thought I wouldn't have the strength to have the baby because 17 years had passed since my last delivery... She said: 'That way it will take long! And why are you putting on a show?' [...] I asked the other nurse: 'Why is she like that, you know, cold, and won't support us? Why?' (Monica).

If we think of the health service as a place for interactions and if we use active and sensitive listening, following a health care orientation aimed at integral care it is possible to produce some kind of answer to the demands of the users. In fact, in the referred case under study, the highest demand for technology and sophistication in the care was only human sensitivity, which is potentially present in every individual.

In the women's experience in the context of the Birthing Center, in addition to the professional-user relationship, other aspects of the care became evident, which also includes the physical structure of the service, i.e., one of the material aspects of the Birthing Center. Its furniture and facilities, the neighboring environment, and other aspects represent an important component of the care delivered in health institutions:

...oh, I thought it was cozy, ...the place I stayed during the labor, I thought it was nice because there was a bathtub [...] then, she [the nurse] said they served meals, that you could eat... I thought it was strange that this was a public service. I said: 'Gee, it's like another world!' (Carina).

The women describe the Birthing Center as a lighter and calmer place compared to traditional hospitals:

...the environment pleased me... There's one pink room, another blue room, another green room... they have a room full of pictures, testimonies from pregnant women... from fathers who watched the delivery... the environment ... it helped me a lot... [at the hospital] everyone wears white, everything is white, there are glass doors, everyone is serious, it's a hallway... then there is a picture with this little woman telling to be quiet (Dulce).

It should be noted that the natural childbirth centers, because of their physical structure and human resources, were created as a form to rescue the women's right to privacy and dignity when giving birth⁽⁶⁾. These attributes may be made difficult or easy when the material structure of a health institution is taken into consideration. This group of objects and people interacting simultaneously may or may not promote the exercise of autonomy and the access to the right of privacy in the process of parturition. During labor and delivery, most of the times, the woman is often submitted to conducts that are previously established in the health service protocols and the evolution of the labor and delivery is controlled, which keeps them from actively participating in the process. Autonomy during parturition implies respecting the women's right to participate in the decision-making process regarding the care they need and

recognize as important for their wellbeing. Autonomy, individuality and privacy are indispensable conditions for humanized care:

...I think that the main thing is to respect you... your individuality. I think that humanized means knowing who I am, knowing my story... and I should be unique in that moment... not being just another one. I was unique, I was Valeria, and she was Luana [the baby]... I think that is the most important thing... (Valeria).

Some health professionals believe that the humanization of delivery should express the attention to the woman's individuality, considering her cultural standards and feelings⁽¹⁵⁾. This presupposition of the model that is proposed to be rescued is essential for women to take control over their bodies and their life processes:

...you choose what to do... she told me: 'would you rather go for a walk?' ...I said: 'no, I prefer to stay right here, and she said: '... ok, just stay however you feel is the best for you; if you tell me you want to lie down, or sit, or walk, we let you free to do whatever you want (Mabel).

The proposal of humanizing delivery agrees with the women's expectations that experiencing labor and delivery will be an opportunity to assume a leading role, and changing delivery from a merely biological event to a human experience; one that should be lived according to their expectations, which may be demonstrated in a previously elaborated plan⁽¹⁶⁾. It is within this trust relationship that the other learns they can count with a timely and committed care:

...I didn't know if my water had broke [...] I said: 'I'm calling (the birthing center)! [...] the nurse answered, and she... gee, she was, like, really kind, I think we were on the phone for one hour, I told her everything that was going on [...] then she was really helpful [...] she made me feel safer, you know? That's why I wanted to go there (Fernanda).

In the lives of the women in labor, intersubjectivity is essential, and it has a social meaning. The meaning that is experienced in uniqueness, is, at the same time, experienced with the people who keep a straight relationship, in time and space, in the face-to-face relationship⁽⁹⁾. Little by little, in the statements, the women shift their attention from around them (people, things, care) and start to express their participation in the parturition process. Most practices described in the statements underline the procedures that were used, which include from the simple presence of the health professional and companions to the direct interventions, such as massages, baths, using a Swiss ball, inducing contractions, artificial rupture of amniotic membranes, adopting positions for labor, and others:

...I walked for some time... then, when I was feeling pain... she told me to squat[...] I walked fast [...] she put me in the shower, then I stayed there for about an hour... my dilation increased 2 cm, then, she came back, did the internal exam... she told me to keep moving on the ball, so I did... then she ruptured the amniotic membranes ... put me in the shower again... I kept walking around... (Carina).

On the other hand, though appearing to be an authoritarian and imposing professional attitude, one of the statements point at the severity of one of the nurse's conducts as indispensable for her attitude at the end of her delivery:

...they [the nurses] are mothers, because they are also strong, they are severe, like they should be, 'look, it has to be that way, and that's how it is going to be... you are already here, you are doing it, don't give up, you're a woman, you already have a daughter, so, they give you a few moral lessons that knock you out, you go like 'my God, it's true' ...So, if I hadn't gotten told on, I think I might have given up (Dulce).

Although the woman accepted the professional's severe posture as a point of support, the same statements also evinces the value that is given to the feminine role at the moment of delivery, as well as the power relationship that exists in the professional-user relationship. These findings at least impose a reflection about the aspects of the social construction of the gender and the form that the women's social role in the reproductive cycle and beyond it is understood. It is observed that the professional imposes on the women a performance that is compatible with what the common sense defines as being her social role, such as being a woman who is strong and was made for giving birth.

It should be emphasized that the knowledge of the woman in labor and of the professionals assisting her are within an objective context of meaning, that is, though it is a reference with a subjective meaning, it is a typical knowledge that may be changed based on the interaction between the woman, the relative, and the health professional. Typification is a reference scheme used in the sphere of practical life, which elements are used in interpersonal relationships. When the face-to-face relationship takes place these types can be modified: the participants are aware of each other, they are facing each other so it is necessary to reflect about what they say and what they do. In everyday life the typifications that we perform do not change our attitude in relation to life and its practical demands. We are not fixed types. There is a margin of liberty and indetermination that permits us to play the role that had been imposed by the type⁽¹³⁾.

It is interesting to observe in the following statement the acknowledgement that professional experience is important for a good performance in birth care:

...I think that they are no longer young girls, they are experienced, and most come from other hospitals...(Dulce).

While having the experience, at the same time, the woman evaluates the competence of the professional in administering the care, and, when the women evaluate the care they received at the Birthing Center, some of them point at other needs implied in the care process.

The care needs

The women's expectations in relation to the care recall social phenomenology as a human action. That action is planned based on a proposed project. As the action is subjec-

tive, its understanding will occur through the reasons of the action that are attached to the past rooted in the acquired knowledge, which will determine the project that refers to the goal to be achieved, which will trigger the action⁽¹³⁾.

Based on the context of meanings that are part of the experience of the woman in labor, when they are called to reflect about their experience of being cared in the Birthing Center environment, the study participants point at other needs; for instance, having the nurse that conducted the consultations beside them during the period immediately before the labor. Another aspect emphasized in the statements was the need to have, besides the nurse, other professionals and resources for care:

I think that, perhaps, there should be a pediatrician and a gynecologist in the same scheme, you know? The same scheme, like: humanized, correct [laughs], in their line of work... (Carina).

The statement above incites a reflection about the public health policy that, through the previously mentioned ordinance 985/GM/99, establishes the minimal material and human resources necessary for this type of service to work⁽¹⁷⁾. The adoption of the principles included in the referred ordinance, without considering ordinance 569/2000, which instituted the Program for the Humanization of Prenatal Care and Birth in the Unique Health System, which often incites criticisms about the proposed model, classifying it as a simplified and unsafe service. This evaluation is a factor that increases the difficulty for accepting the proposed model, on the behalf of the professionals as well as the users. It is observed that this controversy is maintained and can perhaps justify the poor adherence of professionals from the public health system, especially those involved with prenatal care, in referring pregnant women to the Birthing Centers, hence the service provided is quite below the capacity⁽¹⁸⁾.

Another aspect to be considered is the health service users' expectation regarding being assisted preferably by physicians, which is an attitude that is strongly influenced by the culture of the biomedical model that has been practiced in Brazil for a long time. At the same time, another study about the results of birth care at a Natural Childbirth Center pointed at the advantages of the intra-hospital unit, which increases the service's resolvability in several aspects, especially when there is a need for the pediatrician and the obstetrician, avoiding transfers, which are imposed in extra-hospital units⁽⁵⁾.

All these issues can imply on the organization of the public service for the care to women in the pregnancy-periperal period, as the hierarchy of services, according to the complexity of the care presupposes the existence of an effective reference and counter-reference system.

Although the discussions about the organizational aspects of health services, most of times, refer to the technical domains of the area, it was observed in one of the statements that the need for a reference and counter-reference system for birth care should be considered:

...I even felt a bit worried... because you are in their hands, like, they can send you anywhere [...] they [in the Family Health Program] don't even mention the Birthing Center. I never heard of it... I heard about this Birthing Center from a friend who gave birth there... (Dulce).

This statement addresses the problem of the lack of integration among the several programs proposed by the Brazilian health policy. To integrate actions it is necessary to organize a reference and counter-reference system that covers the needs identified by the primary health care services, so that the resources are optimized to solve the diagnosed problems⁽¹⁹⁾.

The users' understanding about the public policies strengthens their role in the society and represents a lot more than simply being a consumer of products and services. Through their participation, users discuss about and claim their rights, thus exercising their citizenship right.

Whatever the health care location for women in labor, in their life world, they expect to maintain a deep social relationship lived in the form of *we* that permits understanding the other as unique, particular⁽¹³⁾. Labor and delivery consist of a typical experience in the cultural world. It requires physical, mental, emotional and social efforts, because it involved the participation of people (the woman, the baby, relatives, and the community) and it always occurs in a bio-socio-cultural environment where the subjects interact through their knowledge, beliefs and values⁽²⁰⁾.

To talk about birth and delivery care implies to consider all the subjectivities, which surpass the real context where the labor and delivery occur. It can be at home, at a birthing center or at a hospital, this event is an experience with multiple meanings that needs to be appreciated from the perspective of integral care and crossdisciplinarity.

CONCLUSION

This study found that the women who choose the Birthing Center to give birth seek humanized care and, during the process of parturition within that context, they have positive and negative experiences.

The women revealed there is a need for having other health professionals available during their labor and delivery, which points at the importance of establishing dialogue between the several professional categories and the respect for the specific competencies of each profession. Hence, it is suggested that the Birthing Center be considered a place that promotes recovering the idea that labor and birth are not events with implicit risks; rather they are part of a process that can be experienced by the woman and followed by the professionals, either nurses or physicians.

It should be outlined that assisting in the delivery is not the role of one particular professional. On the contrary, it can include the participation of several others, with their several competencies. What should be guaranteed are the strengthening and the maintenance of the birth care model

that meets the precepts of humanism and those relating to the rational and safe use of the available technologies, according to the needs of the parturition and birth.

The present study findings about the women's experience when receiving care in the context of a birthing center suggest that the health care model that has been implemented has the potential to provide care that is centered on the needs of the parturient women; a care that does not depend only on the routines and physical structure of the place where the labor and delivery will occur, but also of a professional conduct that is committed with a form of providing sensitive and competent care. In reference to the

public policies for birth care, it is necessary to discuss its impact on perinatal health indicators, as well as to increase scientific production about the theme of care in labor and birth in contexts that guide their behavior according to evidence-based recommendations and the presuppositions of integral care. That production will make a great contribution to the development of obstetrical care.

In the teaching environment it is essential to include human and social sciences knowledge in the program content of health courses, particularly those that propose to assist women during the process of pregnancy, labor, delivery and birth.

REFERÊNCIAS

1. D'Orsi E, Chor D, Giffin K, Angulo-Tuesta A, Barbosa GP, Gama AS, et al. Qualidade da atenção ao parto em maternidades do Rio de Janeiro. *Rev Saúde Pública*. 2005;39(4):646-54.
2. Organização Mundial da Saúde (OMS). *Assistência ao Parto Normal: um guia prático*. Genebra; 1996. (Relatório Técnico).
3. Brasil. Portaria n. 985/GM, de 05 de agosto de 1999. Dispõe sobre a criação do Centro de Parto Normal - CPN, no âmbito do SUS [Internet]. Brasília; 1999 [citado 2009 mar. 20]. Disponível em: <http://dtr2001.saude.gov.br/sas/PORTARIAS/Port99/GM/GM-0985.html>
4. Hoga LAK. Casa de parto: simbologia e princípios assistenciais. *Rev Bras Enferm* [Internet]. 2004 [citado 2009 set. 6];57(5):537-40. Disponível em: <http://www.scielo.br/pdf/reben/v57n5/a04v57n5.pdf>.
5. Campos SEV, Lana FCF. Resultados da assistência ao parto no Centro de Parto Normal Dr. David Capistrano da Costa Filho em Belo Horizonte, Minas Gerais, Brasil. *Cad Saúde Pública*. 2007;23(6):1349-59.
6. Machado NXS, Praça NS. Centro de Parto Normal e a assistência obstétrica centrada nas necessidades da parturiente. *Rev Esc Enferm USP*. 2006;40(2):274-9.
7. Machado NXS, Praça NS. Infecção puerperal em Centro de Parto Normal: ocorrência e fatores predisponentes. *Rev Bras Enferm*. 2005;58(1):55-60.
8. Brasil. Ministério da Saúde; Federação Brasileira das Associações de Ginecologia e Obstetrícia (FEBRASGO); Associação Brasileira de Obstetrias e Enfermeiros Obstetras (ABENFO). *Parto, aborto e puerpério: assistência humanizada à mulher*. Brasília; 2001.
9. Schütz A. *El problema de la realidad social*. Escritos I. 2ª ed. Buenos Aires: Amorrortu; 2003.
10. Nery TA, Tocantins FR. O enfermeiro e a consulta pré-natal: o significado da ação de assistir à gestante. *Rev Enferm UERJ* [Internet]. 2006 [citado 2009 set. 7];14(1):87-92. Disponível em: <http://www.facenf.uerj.br/v14n1/v14n1a14.pdf>.
11. Carvalho GM, Merighi MAB, Jesus MCP. Recorrência da parentalidade na adolescência na perspectiva dos sujeitos envolvidos. *Texto Contexto Enferm*. 2009;18(1):17-24.
12. Dias MAB, Deslandes SF. Humanização da assistência ao parto no serviço público: reflexão sobre desafios profissionais nos caminhos de sua implementação. In: Deslandes SF, organizador. *Humanização dos cuidados em saúde: conceitos, dilemas e práticas*. Rio de Janeiro: FIOCRUZ; 2006. p. 351-69.
13. Capalbo C. *Metodologia das ciências sociais: a fenomenologia de Alfred Schütz*. Londrina: UEL; 1998.
14. Figueiredo B, Costa RPA. Experiência de parto: alguns fatores e consequências associadas. *Análise Psicol*. 2002;20(2):203-17.
15. Reis AE, Patrício ZM. Aplicação das ações preconizadas pelo Ministério da Saúde para o parto humanizado em um hospital de Santa Catarina. *Ciênc Saúde Coletiva*. 2005;10 Supl:221-30.
16. Dias MABD, Domingues RMSM. Desafios na implantação de uma política de humanização da assistência hospitalar ao parto. *Ciênc Saúde Coletiva*. 2005;10(3):669-705.
17. Pereira VM, Maranhão MASA, Andreoni S, organizadores. *Dispositivos legais relacionados à saúde da mulher e do recém nascido: manual*. São Paulo: Associação Brasileira de Obstetrias e Enfermeiros Obstetras; 2002.
18. Brasil. Ministério da Saúde. Portaria GM n. 569, de 1º de junho de 2000. Institui o Programa de Humanização do Pré-Natal e Nascimento no âmbito do SUS [Internet]. Brasília; 2000 [citado 2007 abr. 6]. Disponível em: <http://dtr2001.saude.gov.br/sas/PORTARIAS/Port2004/GM/GM-569.htm>.
19. Lucchese P. Introdução: Políticas Públicas em Saúde [Internet]. 2004 [citado 2009 set. 7]. Disponível em: [http://itd.bvs.br/itd-mod/public/scripts/php/page_show_introduction.php?lang=t&menuId=2&subject=healthPolicies&search=\(*\)*\(introduction/channel\)](http://itd.bvs.br/itd-mod/public/scripts/php/page_show_introduction.php?lang=t&menuId=2&subject=healthPolicies&search=(*)*(introduction/channel))
20. Chubaci RYS, Merighi MAB, Yasumori Y. A mulher japonesa vivenciando o câncer cérvico-uterino: um estudo de caso com abordagem da fenomenologia social. *Rev Esc Enferm USP* [Internet]. 2005 [citado 2009 out. 20];39(2):189-94. Disponível em: <http://www.scielo.br/pdf/reuesp/v39n2/09.pdf>