THE PUERPERIUM IN PUBLIC HEALTH POLICIES IN BRAZIL: HEALTH NEEDS OF WOMEN?
O PUERPÉRIO NAS POLÍTICAS PÚBLICAS DE SAÚDE NO BRASIL: NECESIDADES DE SAÚDE DAS MULHERES?
EL PUERPÉRIO EN LAS POLÍTICAS DE SALUD PÚBLICA EN BRASIL: NECESIDADES DE SALUD DE LAS MUJERES

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ABSTRACT
Objective: to reflect on the puerperium in public health policies directed at women, with reference to the decree and the Ordinance establishing Rede Cegonha. Method: a descriptive study which was based on critical reading and analysis of publications of Health from databases. Practices and health actions remain directed to the reproductive period, centered on the maintenance of healthy woman’s body, the postpartum period is associated with breastfeeding and the return of sexual practices. Results: MS documents provide guidelines and principles that reinforce the humanization and comprehensive care, but continue focusing on a model of care focused on reproductive health. Conclusion: there is a need to extend the concept of women’s health and insert health actions in order to address the health needs of women in puerperium beyond the physiological needs. Descriptors: Health Policies; Women; Puerperium.

RESUMO
Objetivo: refletir sobre o puerpério nas políticas públicas de saúde direcionada às mulheres, tomando como referência o decreto e a Portaria que institui a rede cegonha. Método: estudo descritivo que se baseou em leituras críticas e análise de publicações do Ministério da Saúde a partir de bases de dados. Práticas e ações de saúde permanecem direcionadas período reprodutivo, centrada na manutenção do corpo da mulher saudável; o puerpério é associado à amamentação e ao retorno de práticas sexuais. Resultados: os documentos do MS apresentam diretrizes e princípios que reforçam a humanização e a integralidade da atenção, mas continuam enfocando um modelo de atenção centrado na saúde reprodutiva. Conclusão: há necessidade de ampliar o conceito de saúde da mulher e inserir ações de saúde a fim de contemplar as necessidades de saúde das mulheres em puerpério para além das necessidades fisiológicas. Descriptores: Políticas de Saúde; Mulheres; Puerpério.

ARTICLE

RESULTADOS

Conclusión: hay una necesidad de ampliar el concepto de salud de la mujer e introducir acciones de salud con el fin de atender las necesidades de salud de las mujeres en puerperio, más allá de las necesidades fisiológicas. Descriptores: Las Políticas de Salud; Las Mujeres; Puerpério.

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INTRODUCTION

This article aims to reflect on the puerperium and its insertion in the guidelines of public policy, from the year 2000, with the implementation of the National Policy for Humanization of Prenatal and Birth (PNHP) until the promulgation of Decree 7508 establishing health networks, including Rede Cegonha.¹

In Brazil, the history of public health policies for women, was for the most part, tied to the concern of the state in maintaining maternal and child health, for this, the actions and health programs, for the most part, were directed to the reproductive function of women, particularly focused on pregnancy and, in recent decades, delivery, depending on the persistence of high rates of maternal mortality.

Although there are occasional advances in recent decades, the Brazilian public policies for women do not have to encompass the needs of mothers, having failed to mobilize the public system toward an effective improvement in the quality of care provided to women beyond issues such as reproductive and nutritional maintenance imposed by breast-feeding.²

The main objective of the first health policies created by the state was to impose a number of obligations to parents and children in order to produce a greater number of children having good life.² Among the various measures of control over their bodies is biopower (biopower acting on the species “in the body type, the body pierced by the mechanics of living and to support biological processes”.²¹) term used by Foucault² for the analysis of disciplinary practices used in the eighteenth and nineteenth centuries and its techniques of power over the body.

The term bio power is employed by another author such as to³-⁵, ⁷⁶ “analyze the power over life (biological life policies), including policies of sexuality, its object is the living body support biological processes (birth, death, health, duration of life)”. The new form of power will take care of the proportion of births, the rate of reproduction, mortality and fecundity of the population.⁴,⁵

Having these actions used in the past mentioned centuries above, the understanding of the physiological and pathological processes related to pregnant women, childbirth and newborn care has advanced with scientific and technological development, enabling medical intervention for improvement of maternal health child.

In 1970, the Program for Maternal and Child Health (Programa de Saúde Materno-Infantil (PMI)) portrayed the Brazilian state policy intended to protect both mother and child, and in the 1980s, the legal regulation of the right to health is emerging not only based on the unilateral interest of the country, but driven by strong pressure from social movements, culminating in the adoption of laws and policies. This movement expanded throughout the 1990s and lasted until the 2000s, with the formulation and implementation of strategies and public health programs focused on maternal and child care.

In 1983, the Ministry has formulated a program that, much more than a guideline, was a policy that reoriented attention to female conditions: the Program for Comprehensive Healthcare for Women - known as PAISM - which represents a recognition of the struggle of the feminist attention to the expansion of health care.⁶

The PAISM proposed a completeness in regard to women of all ages, in all cycles of life, in all their roles in society and, of course, all their problems and health needs.

In 2000 the United Nations sets out through the Millennium Declaration eight development goals, including the promotion of gender equality and empowerment of women, with targets to be achieved by 2015, including the reduction of maternal mortality. In this sense we can see a growing recognition movement towards women's health, culminating in the creation of the Special Secretariat of Policies for Women by the Federal Government in 2003, thus established a series of actions that have contributed to improving the lives of all Brazilian, reaffirming the commitment to the women of Brazil.⁷

In 2004, the First National Conference on Policies for women is held out, expanding the participatory process that eventually results in the democratic construction of the National Policy for women who aimed to reaffirm the Government's commitment to building the equality genres. On the occasion, sexual and reproductive rights of women were widely discussed and recognized as fundamental in achieving the right to health and should be respected in their ethical, political and legal devices to combat domestic and sexual violence and ensure women the right to conception and contraception.⁸

Considering that the welfare of women was a priority, MS with other partnerships, prepared the document “National Policy for Integral Attention to Women's Health - Principles and Guidelines,” PNAISM for the period 2004-2007. The document has as
guiding principles completeness and health promotion with a focus on gender, seeking to consolidate the advances in the field of sexual and reproductive rights. Some emphases are identified: obstetric care, family planning, attention to unsafe abortion; combating domestic and sexual violence and the prevention and treatment of women living with HIV / AIDS, suffering from chronic diseases and gynecological cancer. One of the guidelines states PNAISM recognition of the importance of singularities and the subjectivity of women in the health field to reiterate that:

The comprehensive care to women's health care comprises the woman from a heightened perception of their life context, the moment has given demand, as well as their uniqueness and their condition as a subject capable and responsible for their choices. 8-6:64

The increased focus of the proposed MS from 2004 reflects the concern to meet the principle of comprehensive health care. However, when analyzing the strategies of area planning and management of health services, the MS guides the deployment of Inter federal pacts that unify the processes of agreed indicators and targets. These agreements were instituted in 2006 through a compromise between the SUS managers of the three spheres of government (federal, state and municipal). The so-called Pact for Health has three dimensions: Via Covenant in defense of the NHS and Management.

In the Management Pact, the areas of management are defined and health responsibilities and support among entities too. The priorities of health are buoyed by national, regional and municipal targets inserted in the Commitment Management. States, municipalities and health regions should agree the necessary actions to meet the goals. Among the six priorities, three are directly related to women's health: the control of cervical and breast cancer and reducing child and maternal mortality, with emphasis on deaths due to pneumonia and diarrhea. 8

Considering epidemiological data, it can be argued that the Pact neglects many other important demands of women's health, for example, cardiovascular diseases and deaths due to violence, which are among the leading causes of mortality in the female population. So, it becomes fragile the ability to fully meet the health needs of the public concerned in the proposed goal of PNAISM. If, on the one hand, public policies have been building in search of ways to meet the principle of comprehensive care, on the other, society in general has shown changes in their health needs, influenced by the pace of life in big cities, being necessary constant revisions in health care offered. 10

MS recommends that primary care to be the gateway priority for SUS users, proposing, by Ordinance No. 648, of March 28, 2006:

Consider the subject in its uniqueness, complexity, in full, the sociocultural integration and the pursuit of your health promotion, prevention and treatment of diseases and harm reduction or suffering that may compromise their ability to live in a healthy way, plus the full effect in its various aspects, namely: integration of programmatic and spontaneous actions; articulation of actions for health promotion, disease prevention, health surveillance, treatment and rehabilitation, working in an interdisciplinary and team, and coordination of care in the service network. 11-12

From the establishment of the SUS, MS has been trying to transform the model of health care through the principles of comprehensiveness, universality and equity, so that the integral is the guiding principle of the organization of services. Build comprehensive practices implies revising strategies, forms and ways of caring and evaluating health education and training of professionals. As for the actions and public health programs offered to women in the reproductive period, there is an emphasis on prenatal care, childbirth and birth. With respect to the puerperal period, however, there is a focus on physiological functions of breastfeeding and reproductive function. 2

Contemporaneously, many public policies have contributed to establish health as a social right. In contrast, they also act to control programs of prescriptive and normative actions of how to live well, how to keep the body healthy, how to be a good mother. Thus, control of life becomes the object of power over it, indicating measures, qualifications and hierarchies in order to conform processes. 2 Considering the mentioned prospect, it is possible to question the logic of control over the bodies of mothers-women policies public health. They are subjected to numerous processes of subjectivity and its singularities are being constructed in the process of generating, giving birth and becoming a mother.

It is known that the causes of maternal mortality are influenced by other factors and not only by pregnancy or childbirth and its complications. 11 The cultural, social and economic conditions, poor access and low quality of care are complicating roles in these cases, it is necessary to have services,
professional and public health policies are articulated to ensure intersectoral activities covering all different areas and effectively reflected in the well-being of women.

The guidelines for the organization of the NHS provide comprehensive care with priority to preventive activities, without prejudice to assistance services. When considering the comprehensiveness as doctrinal principle, as described in the Health Law (Law 8.080/90 and 8.142/90), two approaches can be highlighted: the services and practices involving assistance. The first manifests itself as a set of actions and preventive and curative services, individual and collective required for each case at all levels of system complexity. The second has to do with the care practices performed by health professionals that occur through individual actions, collective, or programmatic demand.

The completeness, the Federal Constitution (FC), happens to be willing in the discourse of the state, and therefore a guiding of public health policies and standardizing the management of the population. Based on this principle, it was argued in a study:

Health, then, becomes a reality that operates certain existential processes while it is only possible from certain transactions, certain fields of knowledge, in which transport occurs, translations, interpretations - forms of objectification, to make sense of certain phenomena, produce modes of relating with us.

As already mentioned, in the 1980s, actions related to women's health conditions were related to more incidents of that population. In the case of the well-being of women 15-49 years were high rates of maternal mortality related to hypertension in pregnancy and bleeding during delivery and postpartum. From this scenario, the MS problems focused efforts to meet health inspection of most significance and which concentrated mainly on maternal and child health, ie to combat mortality in this group.

Face to the demand to reduce the mortality rates of mothers and children, the actions of MS became focused on prenatal and childbirth, and thus letting out other aspects that should be included, since the proposal was to offer integral attention to women's health. Reinforcing the idea mentioned, was shown in a study that lives daily in service with programmatic actions aimed at intervening in the health problems of the population living conditions and the risks and harm welfare.

In bibliographic study on the completeness and the reorganization of services from light technologies and expanded clinic, the idea that there should be a closer relation between professionals and users was defended, to the extent that the actions to be guided by the needs of individuals and collectivities, breaking thus imposed via pipelines with health programs. Arise, then, by means of studies in the field of public health, research and reflections on other factors that contribute in planning and proposition of health policies, not only the biomedical and epidemiological research. There are inserted in the work other components, such as culture, sociology and anthropology, and the demands and health needs of SUS.

Among the studies, one can cite the body of work on integrated care and health care developed between 2000 and 2002, the result of research on innovative experiences that emerged from the consolidation of SUS, in partnership with the University of São Paulo, State University of Rio de Janeiro and MS. The results helped in understanding the meanings of completeness in health, as well as in the development of analysis tools for programs and services centered on this guideline.

One study examined the health needs and their implications for health work, especially for nursing, reinforcing the argument that the health sector has as one of its goals help meet individual and collective needs. However, faced with priority targets for controlling certain health problems identified as a significant expression of epidemiological, around which there is social demand, such as cancers of the colon and breast, limited thus practices a restricted framework of morbidities and restricting assistance to the health needs of women.

Such a narrow focus is evident in research conducted by Almeida and Silva in the state of Bahia, on the needs of women in the puerperium, in which it was found that most studies focused on the health of the mothers made the last two decades was limited to breast maternal and child care. Confirming the situation, a scientific study on trends in nursing research related to women's health in the period 2001-2005, showed that the topics most discussed are those related to pregnancy, childbirth, the breast and uterus, in breastfeeding, sexually transmitted diseases and acquired immunodeficiency syndrome, with the theme of the puerperium, not contemplated. This reflects the emphasis given to public policies adopted by MS, which are strengthening actions focused on the reproductive period.

The literature shows that the model of comprehensive health care for women has
undergone significant changes, especially represented by initiatives aimed at reducing the rates of caesarean section and the humanization of birth. Still, however, advances are related to a specific portion of the overall health needs of women (sexual and reproductive rights), remaining significant gaps that need to be addressed in a comprehensive care setting.\textsuperscript{7,22}

To illustrate this point, we can use the case of childbirth and prenatal care for the devices which have been created to encourage natural practices, such as the National Policy for Humanization of Prenatal and Birth (PNHP) in 2000, which had aimed at the qualification of care during pregnancy, childbirth and postpartum, and orientation between their policies that unnecessary interventions should be avoided and the privacy and autonomy maternal preserved.

In order to qualify the time of delivery in 2005 is enacted Federal Law 11,108 which guarantees women the right to have a companion of their choice for the duration of labor, birth and postpartum, in the Unified Health on the same direction in 2007 is enacted law 11,634, which guarantees every patient the right to knowledge and the link where you will receive maternity care. No sufficient coverage for maternity within a context that takes into account the partner or the person meaningful and relevant to the pregnant woman, not a guarantee that the service may welcome with their uniqueness and their desires, for access to the service or always occur in a timely manner to carry out a pre-natal care and decisive.

According to the report of the Health Situation in Brazil\textsuperscript{23}, only 16\% of women have some attendant at delivery. Even after having spent seven years of the enactment of the law that guarantees this right, health services are not prepared and do not welcome the companions of pregnant women in maternity wards at birth. Even the most consistent health actions will have no impact unless they commit to modify conditions limiting health and create vulnerability.\textsuperscript{24}

To have comprehensiveness as guiding principle to affirm the SUS is associated with the formulation of policy attention to problems and specific populations, the needs of people and their living conditions and the interpersonal relations that arise.\textsuperscript{12,25} Pinheiro, Ferla and Silva Junior say that taking comprehensiveness as a priority health policy means overcoming obstacles and implement innovations in everyday services.

Despite the emphasis on the principle of comprehensiveness as health care, policies concerning the care of women continue to be limited to the reproductive period and the biological functions, following certain regulations on how a healthy body “should” work.\textsuperscript{9}

The experiences of women in contemporary contain the complexity of, among other causes, by constant changes and challenges that enlargement of female participation in social life is producing. Yet, little attention has been given by health policies to their singularities. How to refer Ceccim and Stedille\textsuperscript{26} the point of view of health, women have been less valued for their unique demands and more particularly by their representation in public health, considered indicators. This situation refers to goals and actions to the field of reproductive health, leaving aside a whole range of health needs of poor visibility on the epidemiological logic.

It is indeed a growing concern about the humanization of health care for women at all stages of the life cycle, expressed in programs and health policies over the past few years.\textsuperscript{7,22,23} However, there is still little effective actions that emerge from the experience of women in the postpartum period, especially those relating to female subjectivity, which change with the arrival of a son and as emotional and socio-cultural context in which they operate pregnancy, childbirth and postpartum.

Women's health begins to be thought of not only reproductive perspective, but now from a context, guaranteed human rights, to be born with dignity. This denotes the widening of the horizon where the birth will be recognized not only as a physiological act or an obstetric procedure, but as a human event full of meaning and significance.\textsuperscript{13}

The changes in the contemporary world provoke reflections on investment policies and health programs, particularly in the field of women's welfare. Social and cultural factors such as increased life expectancy, changes in sexual behavior of the population and cultural patterns and the inclusion of women in labor camps are increasingly diverse elements that influence the health of women, demanding a constant review of processes health work, to meet needs that are not included in the federal pacts or public policy, bringing thus the shares to the comprehensive care\textsuperscript{27}.

In response to the problems related to maternal and child health in the country, the Ministry instituted recently, in June 2011 Rede Cegonha, which is: “Art 1st. [...] A network of care that aims to ensure women's right to reproductive planning and humanizing the pregnancy, birth and postpartum, as well as the
The proposal focuses on networking as a guideline in the process of pregnancy and birth, including the reduction of maternal and infant mortality. Thus, the network actions will mitigate or reduce any complication, and the risk of maternal death, or even health problems of the child. Even more involving society actors, including financial incentives to states and municipalities for their deployment, strengthens again, the focus of health initiatives for women in reproductive function.

Regarding the satisfaction of health services in the postpartum period, according to the Ministry of Health in a survey with 82,005 women, it was possible to identify that some 60,168 used health services and 21,566 women did not use any health services in post delivery and 217 did not answer.

The attention to women and newborns in the immediate postpartum period and in the first weeks after delivery is essential for maternal and newborn health. It is recommended that the home visit in the first week after discharge baby. According to this survey, only 36.9% of women were visited by community health agents (CHA) until the first month after birth. Within the 38,550 women who received a visit from ACS, 81.9% assessed its performance with notes.

This reinforces the need for a health service qualified and humanized care for women and newborns to the health service, 7-10 days after delivery, should be encouraged in all components of the network of women's health care from the prenatal to the postpartum period. Therefore it is necessary to continue reflecting on a humanized multi that meets the needs of life of women in all stages of their life.

**FINAL REMARKS**

The postpartum period requires greater focus by the formulators of public health policies, so it is necessary to extend the concept of women's health, thinking about the health of postpartum women. Period this very peculiar, for generating transformations of all kinds, not just physiological. Just like pregnancy, childbirth and labor requires actions that address not only the maintenance of physiological functions, but which, above all, recognize their health needs from a comprehensive care model and not only its biological dimension the puerperium must be recognized as a complex period that requires greater involvement on the part of health professionals as well as managers of health services, both in the formulation of their actions as health practices.

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The puerperium in public health policies...