SEXUAL AND REPRODUCTIVE HEALTH IN THE PUERPERIUM: WOMEN'S EXPERIENCES

SAÚDE SEXUAL E REPRODUTIVA NO PUERPÉRIO: VIVÊNCIAS DE MULHERES

SALUD SEXUAL Y REPRODUCTIVA EN EL PUERPERIO: VIVENCIAS DE MUJERES

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ABSTRACT

Objective: to understand how women deal with sexuality and reproductive life in the puerperal period. **Method:** this is a qualitative, descriptive study. Interviews were carried out with puerperal users of the Family Health Unit. Results were presented by means of figures and the Analysis of Senses. **Results:** the main results showed the challenges for the incorporation of sexuality and reproductive planning as part of women's health care in the postpartum period. Gender issues have been expressed in the ways women deal with their bodies and sexuality. **Conclusion:** it is necessary to develop educational strategies and practices based on integral care, allowing spaces for discussion and empowerment of women in order to guarantee their sexual and reproductive rights. **Descriptors:** Postpartum period; Contraception; Women's Health; Sexuality; Sexual and Reproductive Rights; Gender and Health.

RESUMO

Objetivo: compreender como as mulheres lidam com a sexualidade e a vida reprodutiva no período puerperal. **Método:** trata-se de estudo qualitativo, descritivo. Realizaram-se entrevistas com puérperas usuárias de Unidade de Saúde da Família. Apresentaram-se os resultados por meio de figuras e da Análise de Sentidos. **Resultados:** mostraram-se, pelos principais resultados, os desafios para a incorporação das temáticas da sexualidade e do planejamento reprodutivo como parte da atenção à saúde das mulheres no período pós-parto. Expressaram-se as questões de gênero nas formas como as mulheres lidam com seus corpos e a sexualidade. **Conclusão:** torna-se necessário o desenvolvimento de estratégias educativas e práticas baseadas na integralidade do cuidado, possibilitando espaços de discussão e empoderamento das mulheres de forma a garantir seus direitos sexuais e reprodutivos. **Descritores:** Período Pós-parto; Anticoncepção; Saúde da Mulher; Sexualidade; Direitos Sexuais e Reprodutivos; Gênero e Saúde.

RESUMEN

Objetivo: comprender cómo las mujeres tratan con la sexualidad y la vida reproductiva en el período puerperal. **Método:** se trata de un estudio cualitativo, descriptivo. Se realizaron entrevistas con puérperas usuarias de Unidad de Salud de la Familia. Se presentaron los resultados por medio de figuras y del Análisis de Sentidos. **Resultados:** se mostraron, por los principales resultados, los desafíos para la incorporación de las temáticas de la sexualidad y de la planificación reproductiva como parte de la atención a la salud de las mujeres en el período postparto. Se expresaron las cuestiones de género en las formas como las mujeres tratan con sus cuerpos y la sexualidad. **Conclusión:** se hace necesario el desarrollo de estrategias educativas y prácticas basadas en la integralidad del cuidado, posibilitando espacios de discusión y empoderamiento de las mujeres para garantizar sus derechos sexuales y reproductivos. **Descritores:** Periodo Posparto; Anticoncepción; Salud de la Mujer; Sexualidad; Derechos Sexuales y Reprodutivos; Género y Salud.

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INTRODUCTION

It is necessary, for a reflection on motherhood and the puerperal period, to recall the historical construction on women and their bodies, in which patriarchy, a system in which men have power and social privileges, has spread the idea that women are inferior and that their bodies are seen as mere objects, so that autonomy over their own choices is not legitimized.

It is known that, when it comes to sexuality and contraception, the main responsibilities of women, when they do not "correspond" to this role, are social punishments through unwanted pregnancies, unsafe abortions, and the discourse that holds them accountable and blames.^{1,2} It is explained that there is also the almost always unilateral attribution of responsibility to children and to the home, which leads to the burden on women of contraceptive practice.³

In view of this historical-cultural construction on the feminine role, the theme of sexual and reproductive rights becomes part of the political agenda as a result of the action of feminist movements focused on women's control over their bodies, sexual and reproductive lives, a fact that helped to introduce the subject in health care services.²

The first expanded definition of Sexual and Reproductive Rights was established at the International Conference on Population and Development held in Cairo in 1994. These rights are defined by the Ministry of Health for all women, such as law to decide, freely and responsibly, whether or not they want to have children, how many children they wish to have and at what time in their lives and right to exercise their sexuality and reproduction free of discrimination, imposition and violence. The right to safe sex for the prevention of unwanted pregnancies and STD/ HIV/AIDS and the right to information and sexual and reproductive education are highlighted, among sexual rights.^{1,4}

Due to the lack of guarantee of sexual and reproductive rights, the increase in maternal morbidity and mortality among women of reproductive, neonatal and child age, associated with short gestations and unsafe abortion.⁵ There is also access to reproductive planning services as a key element for the promotion of social and economic equality, since low-income women are at greater risk of unintended pregnancy and lack of possibility to decide on maternity tends to limit their educational possibilities, civil participation and economic growth.⁶

The effectiveness of reproductive rights is shown as a challenge for the Brazilian context. In a study carried out in Ceará (CE), some of the obstacles that are highlighted are: the limited supply of contraceptive methods and the lack of

multiprofessional awareness and influence of the medical power, followed by inadequate physical space, lack of professional qualification and a dialogical attention that understands the context of each woman.⁷

It is pointed out that, when attention is paid to the puerperium, the period after childbirth, sexuality is even more delegitimized, since the needs of women are often forgotten and even neglected in the face of the demands of motherhood and the newborn.⁸

It is understood that sexuality involves physical, psychoemotional and sociocultural dimensions, so it is identified as an inherent and fundamental aspect in the lives of women as well as men. It is noted, however, that, culturally, especially in the health services, sexuality is related to the concepts of reproduction and contraception, especially with women who are going through the puerperium. In this way, the reduced look at this field of women's life is highlighted, since the widened look at sexuality, in addition to reproductive issues, is part of an integral health care.^{3,9}

Among the factors that interfere with women's health during the puerperium, the beliefs brought about by culture directly affect the freedom of choice and the realization of their rights. It is revealed that, even today, most women exercise maternity in a compulsory manner, often without conditions for it to be safe, socially supported and pleasurable, a fact that evidences gender inequality.^{2,7}

It is understood that sexual and reproductive health care is highly permeable to social values and that depending on how it is exercised; it can both promote empowerment and generate a sense of impotence. In this perspective, the work of health professionals is fundamental to the construction of a relationship with the users that allows the recognition of their beliefs, their sexual experiences and their understanding about gender, which in turn structures their affective - sexual relationships.² It is necessary to know their life projects in view of their vulnerabilities and characteristics to the structural conditions in which they live to understand their demands and, especially, the place of motherhood and reproduction in their lives.¹⁰

It is possible, through the health team's work in the postpartum period and through the development and implementation of health education strategies, to gradually increase autonomy for the self-care of women in the postpartum period.¹¹ The objective of this study was to understand how women living in a popular neighborhood of a city in the interior of São Paulo and users of a health unit of the territory deal with sexuality and reproductive life in the puerperal period.

OBJECTIVE

- Understanding how women deal with sexuality and reproductive life in the puerperal period.

METHOD

It is a qualitative study, since it had its interest in the experiences, beliefs and values that can not be quantified.¹² It was guided through the constructionist perspective and prioritized the discourses and aspects that imply the construction of reality, which focuses on the senses that are produced through the discursive practices present in the interactions of daily life.¹³

The study was composed by five participants. They were listed as criteria for inclusion: to be a user of the Unified Health System (UHS), to be over 18 years old and to have more than 40 days of puerperium, taking into account that the orientation of the 40-day waiting period for the resumption of life is a widespread and recommended practice in health services.

As a data collection technique, a script with social questions and a semi-structured interview were used, which allows a dialogic interaction and sharing between the participants and the interviewer, in which one could get in touch with different perspectives of a reality. The data was collected from January to June 2018.

The women who participated in this research were invited to participate in the study through a project to extend a university that happens monthly in a health unit. Some difficulties are highlighted here during data collection. An interview was scheduled, however, the participant did not attend and two guests refused to participate due to the study theme. The number of participants was determined by considering participants' responses and the established objectives.

The interviews were scheduled, according to the acceptance, according to the desire and

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The interviews were recorded with the consent of the participants and these lasted, on average, fifty minutes. The consent form was signed by all the study participants, and they received a copy of the same, and they had their identity preserved, being optional their participation in the research.

Fictional names were used in order to preserve anonymity. During the interview, one of the participants was shown the need for therapeutic care, thus, referrals were made.

The interviews were transcribed in full and then began the process of analysis and interpretation of data guided through the reference of the analysis of the senses. One sought to understand the discourses through the re-readings of the material and the creation of a dialogical map for each interview, thus seeking to identify the nuclei of meanings present in the stories.¹³⁻⁴ From this, the elaboration themes that were articulated on the shared meanings about sexuality and contraception in the puerperal period proceeded to be done.

Ethical aspects were followed by the norms for research with human beings established in Resolution N. 466/12 of the National Health Council. The study was approved by the Research Ethics Committee of the Federal University of São Carlos under protocol CAAE: 74766217.1.0000.5504.

Initially, authorization was requested from the Municipal Health Department of the municipality and then from the Coordination of the Health Unit where the first contact with the women was made and the interview scheduled.

RESULTS

It was verified that the participants' mean postpartum time was eight months, and the social and obstetric data are presented in table 1.

Participant	Age	Occupation	Marital status	Race/ Ethnicity	Education	Religion	Obstetric Data *
Camila	36	Informal worker	Married	Brown	Complete high school	Evangelical	3G 3NC
Sara	29	Housewife	Married	Black	Complete high school	Evangelical	2G 2NC
Joana	20	Housewife	Married	White	Complete high school	Evangelical	1G 1NC
Amanda	19	Housewife	Married	Brown	Complete high school	Evangelical	2G 1NC
Micaela	22	Housewife	Married	White	Complete high school	Catholic	1G 1NC

*G: Gestations NC: Normal Childbirth

Figure 1. Social and obstetric data of participants. São Carlos (SP), Brazil, 2018.

In the analysis of the reports, the different senses present in the experiences of the puerperal women present in figure 2.

Figure 2. Senses related to the body, sexuality and reproductive planning shared by participants in the puerperium. São Carlos (SP), Brazil, 2018.

Through the process of analysis, three final themes were considered: *Body and sexuality: visible or invisible?* *Reproductive planning: maternity, a choice of who?*; *Contraceptive methods: challenges for women's access and choice.*

◆ **Body and sexuality: visible or invisible?**

Women were dissatisfied with their bodies in the puerperium. It is reflected by the partner's opinion directly on the way women deal with and see their bodies.

From time to time, he says, "Oh, your belly got weird, it was strange after the baby." [...] I wanted to lose weight, but I can not [...]. If the husband is not complaining, it's okay. (Sara)

Another negative perception that women had with their own bodies after childbirth was related to the idea that the woman should please her partner.

It's something that, like this, I do not like looking at myself in the mirror, it's an image I do not like to see, no matter how much I get dressed, I can not seem to like myself. [...] sometimes I put my head to work like a man and I think that as a man I would be very demanding. I think so. I get too demanding of myself. (Camila)

One sees the vagina as something ugly, that must be hidden, that can not be looked at and, much less, touched.

So I think it's such an ugly thing that it's not to look at it, not [...]. If I could, I'd have the horns, uterus, ovary, everything, [...] throw it all in the trash because it's only here to make children and sickness. (Camila)

I, curious, first daughter, right, I put the mirror there and WOW! I was scared and never looked again. I do not look ... everything comes back and everything is right. (Sara)

It is emphasized that, in postpartum, the woman's body undergoes hormonal changes and in the pelvic floor that gradually regress.

I looked at her (first daughter) that I took 12 points and was scared. I did not look the other way, I took seven points. (Sara)

However, there were different reports in the context, as in the following case, where the woman was able to see the need to self-observe to identify the changes of her body.

I looked yes, with a mirror. It's normal [...] you have to see how it is. I do until today! (Micaela)

In this account, the question is asked of the imposition and collection of women in relation to their own body.

It's time for me to stop, I say that I want to lose weight to look beautiful like those women on television. Then, I stop and think, "Who is it for? I'm all right!" (Sara)

There is insecurity about the return and autonomy over one's own body that is related to the medicalization present in society in which the professional has the power to say if everything is okay or not.

They told me: "Come back for a year here so your body returns to normal". I was so frustrated that I did not go back anymore, there's something I feel and I do not complain anymore, I'm quiet. Then I'll tell you what, will not I? I'm not a professional, I did not study, I'm just a patient [...]. " (Camila)

It has also been shown in the reports that postpartum health care is focused on the newborn, which makes the demands of women often invisible.

They only asked me how the birth was, as it was, if I was respecting the diet and alone. He did not take any, nor did he look, because I did not take point [...]. We talk more about the baby than about myself. (Camila)

It is believed that one of the important issues for women is the resumption of postpartum sexual life, since few scientific materials and informational space are available on this restart, resulting in a concern of the interviewees and their partners about the consequences of this resumption.

It is followed by women, their feelings and feelings about the return of sexuality in the puerperium, and fear, physical discomfort and lack of libido were present.

In the beginning, I was kind of "I do not want" [...]. Then, I went to his part, that I was afraid of having another child [...] The first time I felt discomfort, be normal, huh?? (Sara)

But I think, right after I got her (daughter), I got kind of frigid. I do not know if because of how the relationship was going, I do not know if it

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was because of the birth, right, because they say you start wanting to be more mother and forget to be a woman. I got cold. Such a strange thing. (Camila)

It is added that, in the case of the report below, the participant told that she had a desire to resume her sexual life a few days after giving birth and she had doubts about what she should do. It was seen in this report how the experience of sexuality is individual and how health professionals follow restricted, generalized protocols without looking at the individualities.

So, in fact, the doula told me that I did not need to wait the 40 days; with 20 days, my uterus would already be in place, there, I said: "Really? Oh, good, thank God! "[...] Then I told the gynecologist and he said: "No, girl, you're in a lot of hurry, you have to wait 40 days. do more!" (Amanda)

In addition, other factors that bothered the partner were raised, such as in relation to breast milk at the time of sexual intercourse.

The chest [...]. Oh, he does not even come close. Always in a bra. Because he does not like it. Catch a nuisance since pregnancy. That colostrum, that stupid business, was coming out, and he did not like it anymore and I did not either. After it has dried, who knows, it will return to normal.. (Sara)

It was also reported that fatigue resulting from breastfeeding, baby care and housework required by the woman during this period prevented them from living their sexuality in the desired way.

Then I feel very, very tired [...] I'm very moody, my body is weak. The baby sucks everything I have. (Joana)

It is evidenced by the reports that, often, women submit themselves to orientations of people from their social networks. It was mentioned, for the most part, to have undergone several restrictions in the period called "shelter", by the conduct of relatives and friends related to food, rest, sleep and sexual activity for the puerperium.

We respect the 40 days of the ancients. It's to be right, right; They say it's better for women. My mother and these old people would not let me do anything, I had to stay very quiet, but, for me, I would do everything because the recovery was good. (Joana)

Reproductive planning: motherhood, a choice of who?

Most women are given a speech in which the exercise of motherhood is a decision that is often not shared.

From the reports below, it is shown how the birth of a child leads to conflicting changes and feelings in these mothers in the face of what society expects of the woman in the exercise of motherhood.

[...]so I told him that I did not want a son because I did not know what it was going to be

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[...] but it was his dream, so I did what he wanted, but for me, I would not have [...]]. The most difficult, then, is to think, "Am I going to be a good mother"? So, I guess I had more psychological difficulty than physical, so, to be with her. (Amanda)

The same participant of the above speech was found in a new pregnancy when the interview was conducted and she reports the surprise of the discovery.

[...]There, I went and tested positive, I almost had a crap, my baby with six to seven months and I discovered that I was pregnant, as well? (Amanda)

The importance of creating spaces for reproductive planning was mentioned by women.

[...]I think it's interesting for women to talk about this because they have women who are ashamed and repressed for being embarrassed to comment on it, and sometimes the person can even help you, give you some advice, you can have more experience than you and talk What can you do to improve this?. (Camila)

♦ Contraceptive methods: challenges for access and choice of women

It has become apparent in women's reports that they are engaged in using a particular method, such as oral contraceptives, even if they do not feel comfortable with the medication and its side effects.

Compressed is a tricky business. You have to put it right in my face, so that I can look in the morning, remember to take the blessed tablet, if not [...]. Condom, he does not like it. There's a lot in there, but it's been about three months. (Sara)

Ah! It was making me sick, I was vomiting, I was sleeping too much. Then I stopped taking. (Micaela)

It is inferred that, of all the interviewees, only one person has had access to the information previously.

I researched the internet and had a class at school, so I already knew what each one was for. So, I already told you that I wanted this one (quarterly injection). (Micaela)

It is reported that the knowledge about the breadth of contraceptive methods among the interviewees is notorious, considering that, when asked, responses were limited to oral contraceptives and IUDs. The latter receives a resistance that is influenced by the knowledge and experiences of other women in their social networks.

I was offered the IUD, but this IUD business, I do not trust it. There, there are a lot of people who get pregnant with this guy from this IUD, who leaves the place, goes to one side, goes to another. (Sara)

I was even thinking about putting the IUD, but they told me that it was abortive, then, I've been kind of like that and I do not know and I'm thinking now what I'm going to use. (Amanda)

The limitations of the lack of accessibility are hampered by the guarantee of the reproductive rights of women.

[...]I took the first one I had at the post; the second I did not have it; I went to buy it at the pharmacy and it was very expensive, so I went in the same tablet, which is cheaper [...]. You are depending on the post, there, you have a month you have and a month you do not have, you do not expect to arrive [...]. Then I miss a day of taking the shot, that's it: a tragedy is happening [...] I asked to operate when I was pregnant with it, but they did not operate because I'm not yet 30 years old. What is the difference? I wanted to do the surgery. At least there is no risk. (Sara)

DISCUSSION

The results of this study point out the challenges faced by women in the postpartum period, in their relationship with their own bodies, partners and reproductive planning.

Frustration has been pointed out by women in relation to their bodies in the puerperium, and this frustration goes beyond the changes inherent in the process of gestation and birth, as it is a reflection of the dictatorship of the perfect body imposed by society, which induces women to insert themselves in a certain pattern. The reports were permeated by a pressure lived by the expectations of their partners; therefore, body self-image is strongly impaired, and this is intensified by engaging with gender issues in which men and women internalize and reproduce culturally constructed roles and responsibilities.¹⁵

It is understood that patriarchy and the reproduction of expected social roles for men and women also present themselves in the form of the containment of female sexuality. Girls are always taught to hold certain social behaviors as a way of perpetuating patriarchal patterns and one of these impositions is the restriction of the libido in order to preserve its purity and image as docile, timely to the husband and the home. It is often reflected in the control through the adoption of mechanisms of discipline, the discomfort of women when they look or touch their own body, especially the genitalia, placing this act as immoral, interfering directly in the knowledge of the same about their own body, since they feel constrained by feelings of curiosity about themselves.¹⁶

It is considered that there is a difficulty for women to look at their own vagina, especially when they undergo traumatic deliveries and/or receive suture on the pelvic floor,¹⁷ as was the case with one of the interviewees, who places the points as potentialisers of this difficulty. It is explained that these points in the perineal region can often result from episiotomy, a surgical incision in the perineum for the passage of the fetus at the time of delivery, whereas the perineal laceration consists of an unintentional rupture of this structure and, in its vast majority, are simple

lacerations that do not cause so much damage and suffering for women. The new guidelines and good practices of childbirth care of the Ministry of Health¹⁷ have increasingly discouraged the performance of episiotomy, but this is still a recurrent practice in health services.¹⁸

The women in this study were reported to have intact perineum and spontaneous lacerations of first or second degree. However, it is important to say that many women are not informed about the episiotomy at the time of delivery and will often only know that the procedure was performed later, which is a type of obstetric violence.¹⁹

It is considered that these questions directly reflect on the sexual life and the way women experience sexuality, and it is important to consider that women's self-knowledge favors the improvement of self-esteem and helps to deal with the care and changes of the body. It is worth, in this context, the theme of sexuality greater attention.

It is evident that it is difficult to approach sexuality in health services, especially with women in the puerperal period, since this theme is not well valued and professionals have few tools and strategies to address this issue. It is accepted that the guidelines on the return of sexuality are diffuse, especially in relation to the "shelter", which is passed in a different way, depending on the professional. It is reported that the Myles Textbook for Midwives, a book aimed at Midwifery professionals, states that most women are able to resume painless sex six weeks after giving birth, but it is not a rule. It is concluded, by the author of a recent compendium of scientific evidence-based guidelines in the field of Obstetrics, that there is insufficient evidence on the forty day period for the resumption of postpartum sexual life.²⁰

It is added that what is clear, from the interviewees' discourses, is that information is lacking for women, which generates their vulnerability, which are waiting for a "certain shelter time". An Australian survey corroborates the experiences brought by the participants, since the women studied resumed some type of sexual activity after about six weeks of delivery (53%). It is possible that this interval of time has been influenced by several factors, but, in general, it demonstrates the necessity of the couple to wait for the confirmation of a normality of the body after the events occurred in the childbirth and after it.²⁰

In a study carried out with women who gave birth in the 60s and 70s, experiences confirm that beliefs directly influence the recovery of the puerperal woman, considering that close relatives and older generations believe in the following of absolute rest and the progressive return of their activities for forty days. Some segregations are

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used, such as seclusion, sexual and food prohibitions, brought in the puerperium to integrate women into a new social role: that of motherhood.²¹⁻²

In this regard, health services are presented as privileged places to establish intergenerational dialogues between beliefs, cultures and care that respect individualities and enable exchanges so that women's voices are heard and that they can make their own choices in the puerperal.

In this context, and in light of the above, it is pointed out that primary care has the potential to develop actions that promote and guarantee women's rights. The educational actions should include reproductive planning, postpartum sexuality, the exercise of autonomy over whether or not children and contraceptive counseling, since the knowledge of the methods can contribute to the women feel more confident to choose the most suitable for you.^{3,10}

The lack of sharing about the decision to have or not to have children favors the feeling of insecurity experienced by puerperae in relation to the exercise of motherhood, which is expected in the execution of the maternal role, considering that what is expected is that women assume the most of the responsibilities.^{2,16}

It is pointed out that health services have the potential to create spaces for discussion about reproductive planning, since many women end up having consecutive pregnancies without having been approached about their will, preparation or conditions, both of them and of their partners.⁵ A study shows the dissatisfaction of puerperal women in relation to the family planning received in which 61% reported not having had their needs met. It is believed that this topic is of great relevance, since maternal, neonatal and infant morbidity are high, and infant mortality rates associated with short gestation intervals, particularly those younger than 18 months, are high. The role of the health team should be taken into consideration when creating bonds with puerperal women in order to collaborate with alternatives to offer conscious choices in this period. In addition, community-based programs can increase the use of effective contraceptive methods in the postpartum period.⁵

Asymmetrical gender relations create an environment in which only women are motivated to practice contraception, with the notion that only they become pregnant, ignoring pregnancy as a social fact that crosses the biological dimension. The notion that the responsibility for controlling fecundity and its failures rests with women, by creating a cultural scenario of greater accountability of women and minimizing the participation of men in contraception is characterized by the technological commitment to greater effectiveness of women's methods.³

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It is revealed from the reports shared in this study that there is a belief that the IUD is an abortive method, which is a religious one. In addition, the misconceptions about the adequacy of permanent methods for postpartum women are further justified by the greater exploitation by health professionals.

In a study carried out with women in Teresina-PI, similar results are obtained, since most women report knowing only what the methods are for and how to use them, ignoring the disadvantages of the methods they used.²³ Male condoms are mentioned by women of another research, which their partners do not like to use, and thus they are only responsible for the action of avoiding gestation,⁷ the same experience brought in the reports of women in this study.

It is supported, by studies, on the process of insertion of the intrauterine device (IUD) in the postpartum period, as a recommendation for puerperal women who wish to avoid pregnancy from early repetition, but they emphasize the need to improve postnatal counseling, which have complete information about all the options, in order to adapt to their lifestyle, needs and desires, allowing the choice of a method of contraception without coercion or strenuous factors, improperly influencing the patient's decision.^{5,24-5}

It is recommended by the Family Planning Law (Law 9.263/96),²⁶ that the provision of reversible methods of birth control is free of charge by UHS, however, this offer in many places is still unsatisfactory. In addition, the law requires sterilization to be authorized by the partner to whom it is performed, confronting rights of bodily autonomy and contrary to principles of public policies, since this obligation impedes the realization of reproductive planning in a free way and unconditional. It should, however, be noted that a large part of the women refer to the desire for sterilization, that choice be problematized with women so that they can consciously and informally make informed choices based on the guarantee of their rights.

It was reported in practice by women only to have received information on certain methods, without an effective participation or openness to doubts. It is understood that an alternative used to reduce women's accountability in this period is the incentive for shared decision-making, where the health team is responsible for contributing with its scientific knowledge, while the couple provides knowledge about their own values and preferences. It was pointed out in one study that women who reported having shared decision making during contraceptive counseling were more likely to be satisfied with the experience of reproductive planning.²⁷

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There was a lack of fundamental information about methods in a study carried out with users of a Basic Health Unit, especially when the focus was on functionality, indications and contraindications, as well as their effectiveness. It is demonstrated by this lack of knowledge that women leave these areas without sufficient information about the use, side effects and possible risks and benefits of contraceptive methods, jeopardizing the effectiveness of their reproductive and sexual rights. It is considered essential, through the study, clear and individual clarification through an interpersonal communication to ensure that the puerpera is socially responsible and able to stand in front of their sexual and reproductive health.^{7,23}

It is advisable, considering that the experience of the puerperium is an essential component of the quality of individualized and integral health care, as well as the fact that the exchange of information favors the development of autonomy of women's choices in this period, which the team of health has a fundamental role in promoting women's health in the puerperium and guaranteeing their rights, in order to promote spaces for discussion and empowerment.

CONCLUSION

In this study, it was shown that the themes of sexuality and reproductive planning in the puerperium still belong to the sphere of invisibility, since in this period, culturally; the woman should be focused on motherhood. It is understood that gender issues are present in relationships with the partner and in the way women deal with their own bodies and sexuality. The biological and fragmented health care model is often limited to turning attention to the demands of the newborn, which prevents women from having space to share their experiences, doubts and anxieties.

It is necessary that the health team, which acts in the care of women in the puerperal period, understands the need for bonding and the development of spaces for discussion in the health services in order to guarantee the sexual and reproductive rights of puerperal women, contributing to their autonomy and choice of contraceptive methods, facilitating cultural change and reducing gender inequality through the empowerment and encouragement of these women to experience their sexuality and to make their choices with freedom, security and autonomy.

In this way, the aim of this study is to listen to the voices of women, to recognize that it is necessary to listen to health professionals and to know the challenges of services in the implementation of programs and educational actions in reproductive planning for the complete understanding of the scenario and for the

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implementation of new practices. It is pointed out, through this study, the need for the development of new investigations that make possible proposals and changes in the scenario of women's health care.

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