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REFLECTIVE ANALYSIS ARTICLE

HEALTH ANTHROPOLOGY: THEORETICAL CONTRIBUTIONS TO THE INTERPRETATION OF BIRTH PROCEDURE ANTROPOLOGIA DA SAÚDE: CONTRIBUIÇÕES TEÓRICAS PARA A INTERPRETAÇÃO DO PROCESSO DO NASCIMENTO ANTROPOLOGÍA DE LA SALUD: APORTES TEÓRICOS A LA INTERPRETACIÓN DEL PROCESO DE NACIMIENTO

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ABSTRACT

Objective: introducing theoretical elements of the anthropology of health as a contribution to studies of the cultural meanings of the birth process. **Method:** a descriptive study of reflexive type analysis, from Geertzian understanding about the culture. This is the Anthropology of Health in the light of the thought of Kleinman and Menéndez. **Results:** the Anthropology of Health, represented by Kleinman, branch of interpretive aspect, proposes subsidies for the analysis of cultural factors that mediate the meanings of health and disease and are useful for the study of cultural systems of health care. Menéndez, representative of critical anthropology, argues for the existence of different modes of health care, among which stand out the "self-attention" and "hegemonic medical model." **Conclusion:** these two different theoretical models, but complementary to each other, prove useful for the study of the birth process, supporting the development of culturally congruent practices that respect the plurality of knowledge. **Descriptors:** Parturition; Pregnancy; Postpartum Period; Nursing; Cultural Anthropology.

RESUMO

Objetivo: apresentar elementos teóricos da antropologia da saúde como aporte para estudos dos significados culturais do processo do nascimento. **Método:** estudo descritivo do tipo análise reflexiva, a partir do entendimento Geertziano sobre a cultura. Trata-se da Antropologia da Saúde à luz do pensamento de Kleinman e de Menéndez. **Resultados:** a Antropologia da Saúde representada por Kleinman, ramo da vertente interpretativista, propõe subsídios para a análise de fatores culturais que medeiam os significados relativos à saúde e à doença e que são úteis para o estudo dos sistemas culturais de cuidado em saúde. Menéndez, representante da antropologia crítica, defende a existência de diferentes modos de atenção à saúde, dentre os quais se destacam a "autoatenção" e o "modelo médico hegemônico". **Conclusão:** esses dois modelos teóricos distintos, mas complementares entre si, mostram-se úteis para o estudo do processo do nascimento, fornecendo subsídios para o desenvolvimento de práticas culturalmente congruentes que respeitem a pluralidade dos conhecimentos. **Descritores:** Parto; Gravidez; Período Pós-Parto; Enfermagem; Antropologia Cultural.

RESUMEN

Objetivo: introducir elementos teóricos de la antropología de la salud como contribución a los estudios de los significados culturales del proceso de nacimiento. **Método:** un estudio descriptivo de tipo análisis reflexivo de comprensión geertziana sobre la cultura. Esta es la Antropología de la Salud, a la luz del pensamiento de Kleinman y Menéndez. **Resultados:** la Antropología de la Salud representada por Kleinman, rama del aspecto interpretativo, propone subsidios para el análisis de los factores culturales que median los significados de la salud y la enfermedad y que son útiles para el estudio de los sistemas culturales de atención de la salud. Menéndez, representante de la antropología crítica, aboga por la existencia de diferentes formas de atención de la salud, entre los que se destacan el "auto-atención" y "modelo médico hegemónico". **Conclusión:** estos dos modelos teóricos diferentes, pero complementarios entre sí, resultan útiles para el estudio del proceso de nacimiento, el apoyo al desarrollo de las prácticas culturalmente congruentes que respeten la pluralidad de conocimientos. **Descriptor:** Parto; Embarazo; Período Postparto; Enfermería; Antropología Cultural.

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INTRODUCTION

This objective reflection presents theoretical elements of the anthropology of health as a contribution to studies which have as their object the cultural meanings related to birth (PN), which is here understood as a multidimensional event that includes pregnancy, childbirth and post-process childbirth, and that involves biological, psychological, social and cultural aspects. Therefore, the PN is associated with the health/illness (PS/D); a view also extended to this latter process. Culture refers to a network of meanings contained in symbolic systems and socially established, under which a group of people interpret experience and guide their actions.¹

It is noteworthy that the concern with the cultural aspects of PS/A is not new among healthcare. In nursing, the studies started in the 1960s by Madeleine Leininger, highlight the relevance of including aspects of culture in the nurse-patient interaction, aiming to culturally congruent and effective care.² From this perspective there is the (re) cognition practices of distinct attention produced by the biomedical framework, as well as the search for interpretation of their meanings, which often have more symbolic value than actually specific efficacy, not the least being that for those operating such care practices.³⁻⁴

A theoretical review indicates interest, especially in Nursing, about the cultural dimensions of health care practices, undertaken by separate social joints, interactions with each other or curators of different models of health care. On examination of eight papers published between 2000 and 2005, which was the conceptual support of anthropology, the themes were: experiences/meanings of living/sick/caring; relations staff/health/client/family; and family relations in the process of living/getting sick.⁵

In a search conducted in April 2014, the catalogs of theses and dissertations of the Center for Studies and Research in Nursing (CEPEN), available online from 2008 to 2012 (except 2011 catalog, not-available), is located four studies related to issues related to the birth culture. It was in search of those from this group that were somehow in the form of an article, by locating the three. One concerned the knowledge and care practices that permeate the pregnancies of women attended in Basic Health Units; another was a review of the cultural influences on the food of pregnant teenagers' behavior and last was about meanings of the body and physiological

processes during pregnancy and their impact on sexuality.⁶⁻⁸

In a study prepared in the form of thesis, aimed to interpret the cultural meanings of BW for women living in the field and how these meanings over time, modeling and transforming self-attention practices related to this process was used as matrix of theoretical interpretation of the findings for the anthropology of health and birth; its interpretive aspects. From this experience we prepared this reflection that addresses the anthropological framework of health from the perspective of Arthur Kleinman and Eduardo Luiz Menéndez Spina.

The use of this reference in investigations interested in understanding the symbolic aspects related to health care and, in the case of the thesis, at birth, rests on the perception that specific cultural knowledge can be used by health professionals, among them nurses as well as by policy makers in this field who are interested in developing practical and culturally congruent care, which involves the introduction of intercultural dialogue⁹.

Through this dialogue, meaningful and respectful relationships in view to understanding the behavior and thinking of the "other" are established, based on their personal and cultural perspectives. Thus, we seek, beyond the grasp of symbolic elements, the understanding of the political and socioeconomic issues related to PN and knowledge of the issues of power and domination involved in human interactions, often in the intercultural communication.¹⁰

OBJECTIVE

- Presenting theoretical elements of the anthropology of health as a contribution to studies of the cultural meanings of the birth process

METHOD

Article drawn from the thesis << Cultural meanings and practices of self-attention relating to birth for women living in the countryside >> developed by the School of Nursing of the Federal University of São Paulo in the Graduate Program in Nursing, specifically in Interinstitutional Doctorate (DINTER) "New Frontiers", Federal University of São Paulo (UNIFESP), Federal University of Rio de Janeiro (UFRJ) and Federal University of Santa Maria (UFSM). São Paulo-SP. 2014.

This is a descriptive study of reflective analysis type. Through this reflection, we chose to elucidate, first, what is the purpose to which it is proposed interpretive

anthropology and, thereafter, addressing the culture in the sight of Clifford Geertz, being noted anthropologist who thought that serves as a matrix for current interpretive anthropology of health. The concepts of Arthur Kleinman are also presented shortly following, trying to establish this relationship with the thought of Geertz, in relation to anthropology as a theoretical guide to interpret the PS/D. Then gives some contributions from Luiz Eduardo Menéndez Spina, tries to explain the possible interfaces of these frameworks with the cultural issues of PN and self-attention practices related to it.

RESULTS AND DISCUSSION

• Interpretative Anthropology: one of the anthropology of health headquarters

Anthropology, as a branch of knowledge, objectives the identification of cultural patterns shared by individuals; searches deduce what is common in the actions, assignments of meaning, meanings and symbolism addressed, individuals and social groups, the material world and "natural"; and also analyzes the experience of living in society, the sick and taking care of, from the understanding that this is a relational experience, endowed with intersubjectivity and mediated cultural phenomenon.¹¹

The interpretative anthropology, founded by Clifford Geertz, as a project of cultural analysis, it is proposed to understand the basis of the interpretation. For the author, the man is tied to webs of meaning that he weaves, and that is what constitutes culture. Moreover, culture is an interpretive looking for the meaning of these webs.¹ Thus, culture is made up of a set of elements and qualifiers mediators of mental or physical science activities, which are not determined by biology, but are shared by different members of a social group, and for which individuals give meaning to their actions and concrete interactions, sustaining existing social forms, institutions and their modes of operation.¹¹

Through interpretivism we seek to unravel the meanings embedded in the social relations. Culture is thus a context in which social events, behaviors, institutions or social processes can be described in an intelligible way, ie, through thick description.¹ This description seeks to unravel the structures of meaning socially established. For this, penetrates between the lines of symbolic discourse and considers the meanings vary according to cultural codes and symbolic systems which emerge.¹²

• Anthropology of health in light of the thought of Kleinman

The anthropology of health is concerned with the meanings of health and disease for each company, because it considers that the records of normality and abnormality are determined primarily from socio-cultural values of each scenario. From this perspective, Arthur Kleinman prepares a group of concepts that are keys to the analysis of cultural factors involved in the health field and also to build a comparative model between medical systems. Health and disease in this approach are socially and symbolically constructed realities those mingle with the biography of individuals and their social groups, and serve as guides to interpretations of the disorders that are subject.¹³⁻⁴

Although the birth is not always placed on the list of "disorders", can make use of these concepts and definitions to interpret such experience, since the slope of interpretative anthropology enables glimpse the cultural web that involved subjects construct and reconstruct, surpassing therefore the biologicist character of PN, in which event the relevant difficulties are almost always marked by the researchers and / or health professionals as disorders resulting from organ failure, not of experiences constructed by social actors.

Kleinman's approach highlights the different dimensions of the disease, which serve as a matrix for possible explanatory models on this phenomenon (and, in our opinion, on the PN, which is composed of similar perspective). These dimensions are expressed in English words that are synonyms, but for which there was the proposal of a semantic distinction. The terms are "disease" (disease process), "illness" (disease experience) and "sickness" (social disorder).¹³⁻⁶

This "disease" refers to abnormalities in the structure and function of organs and systems, which limit the capacity of the individual or their life expectancy and can be diagnosed and treated as an objective phenomenon. In this logic, it is "measured" by means of laboratory tests, direct observation or other signs seized by biomedical semiology.¹⁶ Constitutes a dimension closely identified with the biomedical model of care to saúde.⁹

The "illness" refers to an experience that brings changes in states of being and in social function of patients subject, relating to more subjective or psychological dimensions of ill health that are usually the most immediate concern for people who Includes.¹⁵ To experience a group of 'symptoms' that often

cause concern, both for the immediate discomfort as for its effects on the ability of social functioning, or by which individuals and social groups think they can predict.¹⁶ It therefore the disease as an associated experience to networks of symbols and meanings, with its own structure and, unlike those of biomedicine logic, they are consequent social interaction and depends on the characteristics of the subject's life and the sociocultural context in which it is produced and interpreted.⁹ "Illness" is thought of in terms of PN, suggests, for example, that this is a process that yields a body of family and popular sectors own knowledge.

It is worth mentioning that the "disease" affects isolated individuals, even when it affects a population. Have the "illness" almost always reaches others also, like social networking, family and sometimes even an entire community.¹⁷

The "sickness" refers to the social dimension of the disease, can be understood as the inability of the obligations of group life, due to the individual being defined by others as someone not healthy because of a "disease" or an "illness".¹⁵ In another sense, it relates to macro-social forces (economic, political and institutional) that contribute to placing certain social groups under certain risks or to make them more vulnerable.¹⁸

The appropriation of these three concepts (disease, illness and sickness), which enable the study of cultural systems of health care, seems appropriate, as we said, in investigations that interpret cultural meanings of PN. This is justified because, from this set of notions, one realizes that the proposition to interpret the birth experience ("illness") in its uniqueness and collective meanings is fundamental in establishing a positive interaction between the health care professional in that includes nurses, and women and / or their social group. In this logic, through which there is the perspective of understanding the culture of the PN, the professional will watch the subjective elements involved in this process as well as will dissolve the intricacies of social relations and issues of power inherent in them, trying to understand the practical that women and their social groups operate in interaction with different sectors of the health care system during the PN.

Beyond these notions, it is a reflection that there is an understanding that, in all societies, those relating to the practices of health and disease activities are more or less interrelated, constituting as responses within the anthropology of health, socially organized

the demands of individuals and social groups, thereby resulting in a "special cultural system: the system of health care".^{13:24}

In every culture, the disease, the responses of her subjects and the social institutions with which it is related and systematically interconnected, and all of these interrelationships constitute the cultural system of health care. This system, based on their characteristics and cultural system based on the object that concerns you, brings together the health-related components of society, which correspond to the patterns of belief about the causes of diseases, the rules governing the choice and evaluation of treatment, the roles socially legitimated to individuals, relations of power, the settings of interaction and institutions.¹³

Users of health services and professionals are also basic components of this system by entering into specific scenarios of cultural meanings and social relations, which demand to be understood in this context. The disease and the cure also fit into the health care system, articulating how experiences and culturally constituted activities. Therefore, in the context of culture, the study of users and carers and also illness and healing must begin with an analysis of health care systems.¹³

From these assumptions, Kleinman proposes a method that contributes to the understanding of how the terms explained before (disease, illness and sickness) are interpreted and operated (and often in a complementary way) by different sectors of health care. The author also draws up an Explanatory Model on the behaviors adopted by people from different groups in coping with health problems.¹⁹ In this sense, the model of the proposed health care system examines how people act and how to use this system its components, including their beliefs (largely unspoken and unconscious part) on the system as a whole and their patterns of knowledge and behavior, which are governed by cultural rules.¹³

The author argues that the health care system meets the definition of a cultural system Geertz. Thus, it constitutes both a model "for" as a model "for" a special area of behavior.¹³ From this perspective, it is understood that the individual to act in the world, is based on a **model** provided by the culture - **model** - and when he acts in the world, is to produce a model for culture, so the statement that the individual is influenced by the culture at the same time the influence, ie that it is individual and the social actor in the context of culture.

Like any other cultural system, the health care system needs to be understood in terms of its instrumental and symbolic activities, noting that the beliefs and behaviors that constitute these activities are influenced by several factors.¹³ Transporting up to such factors PN, these refer: a particular social institutions such as hospitals, professional associations, health bureaucracies; performance of different roles, such as the role of a healthy, sick person or liminal state, as it seems, in many social groups,²⁰⁻³ the case of women during pregnancy and childbirth; to interpersonal relationships, such as nurse-patient relationship; the interaction scenarios, such as the home, maternity or birthing center; the economic and political constraints; the available interventions, such as techniques for pain relief during labor; and, among others, to what is considered or not as a problem at birth.

It should, however, emphasize that although the generic elements related to the health care systems are presented in the explanatory model of Kleinman, the author emphasizes that these should be designed so that they have "local"¹⁴, which consequently applies to systems of care that take place during the PN, in particular because the local aspects reflect the more global contexts, revealing the power issues that threaten the social fabric.⁹

Allied to this, Kleinman points out those health care systems are forms of social and symbolic reality. The **social reality** refers to the world of human interactions existing outside the individual and between individuals; is the transactional world where everyday life is expressed; those are defined and implemented social roles and also in which people negotiate with each other in their relationship status, established under a system of cultural rules. In this logic, social reality consists of - and is - meanings, institutions and relationships accepted by society. Its internalization - as a system of symbolic meanings and norms that govern the behavior of a given subject, their perception of the world, your communication with others and understanding - both external and interpersonal environment in which it is situated as its intrapsychic space - occurs in the process of socialization of the subject in its various interactions with different social groups.¹³

Social realities differ from one society to another, between different social groups and even individual moments and distinct family. For some anthropologists, according to Kleinman, more traditional societies tend to

have more homogeneous social realities, while the most modern are more fragmented, more plural. Those already in development could be understood in a move that will supposedly unified social realities, the traditional world to the worlds of plural life of modern states.

Note the change from old to new social forms, expressed in their belief systems in their modes of behavior and its institutional structures, which represents profound implications for different social systems, of which the health care (and, among them, the system of care related to birth). These societies are social realities that are a curious amalgam of beliefs, values and traditional and modern institutions, woven into different patterns of assimilation, complementarity, conflict and contradiction. By the fact that modern medical ideas and practices often are associated with high-end technologies that accompany the process of modernization, systems of health care provide clear reflections of the tensions associated with social development.¹³

In this logic, Kleinman mentions that modernization tends to bring into the health care system problems traditionally located in other social systems, redefining and expanding the social reality of care systems. In this context, society is increasingly medicalized, resulting in increased use of medicine for purposes of social control. Health systems come to occupy a larger social space in modern societies and take to themselves functions previously carried out by other cultural systems.¹³

Still on the explanatory model regarding the cultural systems of health care, has been that **social reality** consists of three dimensions: psychological, biological and physical. The first concerns the inner world of the individual; the second refers to the infrastructure of organisms, including man; and the last relates to material structures and spaces that make up the non-human environment

For analytical purposes, Kleinman considers necessary to distinguish two aspects of social reality: the social and cultural world, described above, it is to be called social reality per se; and a **reality-bridge**, linking the social and cultural world with the psychological and biological reality. This reality-bridge is the **symbolic reality**, formed by the acquisition by the individual, language and meaning systems, which play an important role in relation to the subject's behavior in different social situations and interpersonal interactions. The internalization of symbolic reality allows individuals to make

sense of his inner experience, helping to shape personal identity, in accordance with the social and cultural norms. In this view, symbolic meanings influence basic psychological processes such as attention, consciousness, perception, cognition, affect, memory and motivation. The symbolic reality has the power to connect the physical environment to psychobiological processes.¹³

Kleinman wedge another expression: a **clinical reality**, which designates the socially constituted contexts that influence disease and clinical care, which are, in his opinion, mainly consisting of social and symbolic reality, but also on the realities and psychobiological Physics. Then there is the understanding that the clinical reality of the health system is mediated by symbolic reality.

Both health systems as their clinical realities, to be fully appreciated, require examination of how this biosocial bridge concerning culture, disease and treatment. Thus, health systems must be considered cultural systems that connect disease and treatment as they are anchored in cultural beliefs, social roles and relationships, as well as in individual behavior and experience. Its structural components are articulated by establishing a context of meaning and legitimacy within which the disease is labeled and health seeking behavior is initiated.¹³

The recognition and understanding by health professionals, among them nurses, about the functions of symbolic reality with the social reality per se and clinical reality justifies further dive (before mentioned) in the subjective world of individuals who experience PN, it assists in understanding the meanings of behaviors and cultural practices operated in this existential moment.

In Kleinman model, cultural health care systems are composed of impregnated generic and particular elements of culture. The internal structures that constitute a system of care are virtually the same across cultural boundaries, while content varies according to social, cultural and environmental circumstances of each system. Based on these assumptions, the author proposes a model of health care that is composed of three parts, or sectors appeals system: the popular sector (which here will be called popular/familiar - SP/F), professional (SP) and the traditional/folk (ST/F).¹⁵ The SP/F can be understood as an array that contains several levels: individual beliefs, family, social and community activities.

It is in the arena of popular/family culture that disease (and the meanings of the birth experience) is first defined and that the

activities of health care are initiated. It is, therefore, a layman, non-professional, non-specialist, and it industry that individuals decide to seek and abide by the instructions given in other areas of health/birth and what they'll do next, or not switching between different treatment options and even judging the effectiveness of these treatments. Thus, this sector serves as the primary source of care and the most immediate determinant. It connects to the borders of the other sectors of the health care system, containing the points of input, output and interaction between the different spaces. Thus, it interacts with each of the other sectors, while the others are often isolated from each other.¹³

The SP comprises the professions organized cure¹⁶, which, in the Brazilian reality, is represented by modern scientific medicine, which is still dominant biomedical paradigm. However, in other societies, there professionalized indigenous medical systems such as traditional Chinese medicine.¹³

The ST/F are a non-professional, non-bureaucratic, but specialized sector, which merges the two other sectors of the local health systems. Traditional medicine or folk is a mixture of many different components, some of which are closely associated with the professional sector, but most related to the SP/F. In poor societies of professionalization, the sectors T/F and P/F form the health system as a whole. Traditional medicine/folk cover sacred and secular practices such as shamanism, the blessing, herbal medicine, among others.¹³

This entire theoretical framework can be applied to the field of birth. So, in summary form, it can be said that in every culture, there is a cultural system of care at birth, which is the birth itself, as a process, the responses of subjects to it and social institutions that relate to him and are systematically interconnected, as well as of all these inter-relationships, in addition to other theoretical elements mentioned; meaning that, in studies that have as object the cultural meanings of the birth process, it requires "look" the system of care at birth in the aspects of social, symbolic and clinic. This statement is justified because the fabric of these meanings articulated, among other possibilities, the movement of women and their social groups the different areas that make up the systems of care at birth, which, in the Brazilian context, also with regard to space health care / disease since the PN was, over time, institutionalized and medicalized.

Despite the recognition of the contributions of Kleinman for the study of the birth process, it is to point out some limitations of this framework. Therefore, it is important to note that the dimensions of the illness, such as sickness, though not ignored by the author, are not discussed further in their studies, in that it is not very specific about the social forces that interfere with the production of illness and disease.²⁴ Moreover, the Explanatory Model Kleinman is slightly permeable to changes and almost no room for other knowledge. Another point to highlight is that questions existing power in the user / professional interactions and between different models of health care, expressed through conflicts, tensions and interests are considered by Kleinman as something that is out of such relationships and is sometimes seen as a negative aspect of the interaction.²⁵

From these limitations, although reiterating that contributions Kleinman are important for studies that propose to interpret the cultural meanings and practices related to the PN, it is considered that the contributions Menendez might complement the author and that is why are aggregated to this theoretical reflection.

As a result, here is present some contributions of reference proposed by Luiz Eduardo Menéndez Spina relating to existing models of care in health in Latin America, approaching the "self-attention", the "hegemonic medical model", the "transactional process" between different forms of care "and" the health/disease/care-prevention ". This decision is also justified by the fact that, when analyzing the empirical practice and literature ²⁰⁻³, one realizes that the experience of PN, both by women as by their social group, is permeated by self-attention practices produced by a transactional dynamics that occurs through the articulation of knowledge and doings coming from different areas / modes of attention, with prominent (although not only) purpose of prevention and protection, resulting in care.

• Contributions by Luiz Eduardo Menéndez Spina for the field of anthropology of health

Menéndez, anthropologist, with degrees in public health, supports the existence of different modes of health care, which, to be understood, they need the help of explanatory models, which organize temporarily, the social reality is complex and to some extent unattainable. The notion that he handles assumes a constant relationship between the constructed reality and historicity as an

archetype of this reality. These are assumptions that guide his studies on "Models of Care", in which, among others, include "self-attention" and "hegemonic medical paradigm."

Similar to the way that makes Kleinman, Menendez points to the existence of a "medical pluralism" in contemporary societies within the different social sets that are laminated, regardless of ethnic or class situation. The recognition of this pluralism refers to the use by the majority of the population, various forms of attention, even for the same condition or health problem.²⁶

Starting from the analysis and interpretation of the behavior of individuals and their social groups in relation to their sufferings, always considering that they are laminated social groups and / or differentiated because of their occupational, economic, ethnic, religious conditions, among others, the author considers that in Latin America, are potentially used the following **modes of attention**: a) **the biomedical**, referring to the first level of care and the level of medical specialties for ailments, physical and mental, type recognized by biomedicine like infirmity. Also, are formed by ancient and comparatively marginal forms within biomedicine, such as natural medicine, hydrotherapy, homeopathy and chiropractic. This includes, in addition, different ways of individual and community group psychotherapy, gestated, at least in part, from biomedicine. b) **the "popular" and "traditional"**, which are also expressed through specialized curators as ushers bones, herbalists, shamans, spiritualists, wizards, etc. type. In this role, is the role of healing of some religious groups (Christians and other cults), like the Pentecostals and Charismatics. c) **The alternative, parallel or new age (new age)**, referring to new healing community type religions, like bionergetic cures type. d) **from other academic traditions**, such as acupuncture, Ayurvedic medicine, Chinese medicine, etc.) **focused on self-help groups** such as Alcoholics Anonymous, which are organized and coordinated by the very people who suffer or co-suffer from some sort of problem.²⁶

This is a classification, among many possible since each mode of attention is not fixed and secluded setting in itself, because there is a dynamic between the activity originating in each form of attention, which does not always work in an exclusive way, may be an interaction between two or more modes of attention. This interaction occurs at two levels: in one, the initiative and the

attention sectors (as in situations where biomedical rests on support groups as part of the treatment, for example), on the other, the initiative of the subject itself or the social group that suffers from any problem to its health.

These joints occur through dynamic transactional permeated by relations of dominance / subordination. At the same time generate a variety of forms of care use by the simultaneous and sequential manner over time, which results in self-attention.²⁶ Thus, **self-attention** refers to the set of representations and practices that use the population, the subject and the social group level, to diagnose, explain, answer, control, ease, endure, resolve or prevent the processes that affect your health in real or imaginary terms, without the central, direct and intentional interference professional trustees, even though these may be in reference activity self-attention. It does not mean that among these representations and practices are not those prescribed or suggested by the professionals of different forms of attention. However, it happens that, depending on each specific case, social conditions or the situation of the subjects, at least part of that prescription and usage process becomes autonomous, even in terms of a relative autonomy²⁶, such as the spontaneous and trivial pursuit of prenatal care in our country today.

The self-attention is analyzed from the point of view of intentionality of individuals and social groups, occurs in two directions - one large and the other restricted. The **wide (or wider)** sense refers to modes self-attention necessary to ensuring the biosocial reproduction at the level of micro-groups, especially domestic ones, which are used from the goals and standards established in the culture itself. In this sense, fit-up from prevention of disease to the hygiene, sanitation, preparation and distribution of food, extending to those with death and the dying process, the different terms prescribed by the very culture.²⁶ In the field BP refers, for example, to "be with" the woman who will give birth to a child, which, among other objectives, aims to protect and support this woman and her baby as well as the group they represent. The **restricted or strict sense** of self-attention refers to meanings and practices intentionally applied to health/illness/care-prevention, ie, practices that individuals and their groups consciously perform to prevent or cure their disease (avoid physical exertion in the process pregnancy to prevent fetal loss, for example),

which confer certain value in order to do good or bad for health.²⁶⁻⁷

Each environment presents attention as a model "of" knowledge, which, after suffering a subjective and symbolic filtering part of the subject and their social groups are incorporated, and even possibly resignified ressemantized way, and now constitute models "to" care in the PN, renewing the meanings and practices of self-attention, which, in large part, are modeled broadly and not narrowly. The subjects then "exert agency over their own lives, realizing and acting upon their experience in collective life".^{27:326}

Despite the evidence of medical pluralism and permeability between the different modes of health care, Menendez notes that in Latin America, biomedicine remains hegemonic position, especially for its scalability, which is the structural axis biologicism. Such expansion occurs through a mechanism that is organized basically on two levels. On the one hand, refers to: the professional activities that take place and refer to the extent of coverage achieved by attention; the quantitative professionals, hospital beds, institutionally assisted deliveries, cesarean sections; the coverage of immunizations, etc. On the other hand, it is operated by a process of medicalization, which converts the vital diseases episodes, which are part of the conduct of everyday life and the subjects that become explained and treated as diseases when, before, were only events of citizens²⁶, which may explain the phenomenon of exponential growth of cesarean sections in our midst.

The author also examines some structural characteristics of Hegemonic Medical Model (HMM), referred to allopathic medicine, which allow us to understand the trends that govern the relations of biomedicine with social groups and other medical knowledge, highlighting: the biologicism; the doctor/patient relationship; the historical trend of reducing the time devoted to this interaction; the absence of the historical dimension in medical practice, including in the education process; the exclusion of the cultural aspects of the field, which, if included, could aid the understanding of other forms of the disease and care in understanding the significance and meaning of their use and the techniques produced in these spaces, in which resides largely a cultural function more than its specific efficacy; and scientific rationality that identifies biomedicine as "science" and therefore excludes, in addition to forms of health care are not identified with scientific criteria, the cultural dimension.²⁶

These features, among others, predisposes a relationship of dominance/subordination of biomedicine over other forms of non-medical care, so that tends to exclude them, ignore them or stigmatize them, despite the possibility of an acceptance criticism or even an appropriation or supplementary use, especially of certain techniques, but always subordinate character²⁶, in like the operating groups of pregnant women in relation to traditional prenatal care.

The explanatory model Menendez also stands out the concept of health/illness/care-prevention, which seeks to overcome proposals that focus only health and disease process because, for the author, all forms of suffering implies attention and prevention. "Thinking only in terms of health and illness is, to some extent, eliminate, or put in brackets, what individuals, groups and companies who can confront their infirmities".^{3:340} Thus, prevention is central in self-attention, because, to the author, every society creates conceptions and preventive practices prior to the conceptions of the trustees, including biomedicine.³

Thinking about the practices relating to PN, many of which make sense because in some social groups or the woman is a danger because of the time represented by the birth²³⁻²⁴, it is appropriate to point out that, as a central part of self-attention, preventive practices, incorporated in the socialization process of social subjects, are critical to the social and biological reproduction of a group. Therefore it is appropriate to state that companies and individuals create social conceptions and preventive activities to those aspects which they consider threatening.²⁶

From the theoretical framework proposed by Menendez, which articulates health/disease-prevention carefully, you realize that the concepts of transactional and self-attention, among social subjects and the different modes of attention dynamics should be considered in studies aiming to understand cultural meanings and practices self-attention, for the PN and, from this perspective, contribute to the reorganization of public policy attention at birth. This is justified because the self-attention, constitutes the first real level of health care, with the articulating core (through transactional dynamics) of different modes of attention used by individuals and social groups in pursuit of preservation or restoration of health.²⁶

The self-attention is, therefore, in the field of relations maintained by the subject with their social groups and all of them with

professionals who work in different areas of health care (and birth) in which they circulate. Depending on this, the joints, the conflicts, tensions, finally, the power games that are produced there are relational in nature, and their study requires that all significant actors are considered³ - women who become mothers, their social groups and professionals who attend. Thus, there will be recognition of plural knowledge, autonomy of actors and global factors that are present in the local context.⁹

FINAL CONSIDERATIONS

Considering the theoretical framework expressed here and the complexity and dynamism inherent in the PN, one realizes that the cultural meanings and practices of care and self-attention concerning this process can be interpreted in a complementary way by the thought of Kleinman and Menendez. Armed with this input, nurses and other subsidies will have to stand in favor of better care practices and may be more prepared to face the structural and economic problems of the world of work reflected in these practices, and to think them and organize them the perspective of respect for plurality of knowledge of the PN.

And this reflection signals the relevance of a reconfiguration of the formation processes of these professionals, with a view to articulating humane and culturally congruent care practices PN, a meeting of different cultural systems whose foundation is dialogue, respect and guarantee the autonomy other.

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