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Caring for pregnant women and babies in the context of the Family Healthcare Program: an ethnographic study

O cuidado de grávidas e bebês no contexto do Programa de Saúde da Família: um estudo etnográfico

El cuidado de grávidas y bebés en el contexto del Programa de Salud de la Familia: un estudio etnográfico

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ABSTRACT
This study contributes to the conceptual discussion of healthcare, seen through an ethnographic approach to the care of pregnant women and newborns offered by health professionals working under the Family Health Program in a low-income neighborhood of Salvador, Brazil. Research involved Interviews and participant observation. In the article we analyze and compare professionals' and user's perspectives in two distinct contexts: The discovery of pregnancy and the decision to take it to completion; and attitudes and practices with respect to breast-feeding. We argue that, for both, care involves a permanent construction of "projects of the person". While professionals focus their interventions on women, seeking to implement guidelines and planned routines, users of the health centre resort to spontaneous behavior that attends to practical demands in which several relatives participate and where embodied experience is central. Differences between professionals and users are linked not only with subjective characters but with the social positions that they occupy.
Key words: Care, Family Health Program.

RESUMO
Este trabalho pretende contribuir para a discussão conceitual sobre o cuidado a partir de uma abordagem etnográfica com grávidas e bebês em um bairro popular de Salvador atendido pelo Programa de Saúde da Família. Realizamos entrevistas e observação participante. Com base na

análise de duas situações - a descoberta da gravidez com a decisão de levá-la adiante e o aleitamento - comparamos a perspectiva dos profissionais com a dos usuários. Argumentamos que, para ambos, o cuidado envolve a construção permanente de projetos de pessoa. Enquanto os profissionais centram suas intervenções nas mulheres, buscando dar orientações e aplicar rotinas planejadas, os usuários fazem referência a comportamentos espontâneos que respondem a demandas práticas e onde a corporalidade da experiência é central. As diferenças entre profissionais e usuários são relacionadas não apenas com características subjetivas, mas com as posições sociais que ocupam.
Palavras-chave: Cuidado. Programa de Saúde da Família.

RESUMEN
Este trabajo pretende contribuir para la discusión conceptual sobre el cuidado a partir de un planteamiento etnográfico con grávidas y con bebés en un barrio popular de la ciudad de Salvador, estado de Bahia, Brasil, atendido por el Programa de Salud de la Familia. Hemos realizado entrevistas y observación participante. Con base en el análisis de dos situaciones - el descubrimiento de la gravidez con la decisión de llevarla a buen término y la lactancia - comparamos la perspectiva de los profesionales con la de los usuarios. Argumentamos que para ambos, el cuidado incluye la construcción permanente de proyectos de persona. Los profesionales centran las intervenciones en las mujeres tratando de dar orientaciones y aplicar rutinas planeadas, los usuarios hacen referencia a comportamientos espontáneos que responden a demandas prácticas y donde la corporalidad de la experiencia es central. Las diferencias entre profesionales y usuarios se relacionan no sólo con las características subjetivas sino con las posiciones sociales que ocupan.
Palabras clave: Cuidado. Programa de Salud de la Familia.

INTRODUCTION

This study is a contribution to the conceptual discussion of care, seen through an ethnographic approach to the care of pregnant women and newborns offered by professionals working as part of the Family Health Program in a low-income neighborhood of the city of Salvador, Brazil.

Care of the health of pregnant women and babies is given high priority in the organization of primary care services in this country (Brasil, 2005, 2002, 1997a). This is especially so in the context of the Family Health Program, which is considered a strategic part of the reorganization of primary care in Brazil (1997b). On this topic, in addition to the classic epidemiological studies on health indicators for pregnant women and children (see, for example, Victora et al., 1997), there are many studies that seek to evaluate the effectiveness of specific actions, or to identify the factors that affect health indicators. Most studies use quantitative techniques to collect data in primary health care centers, obtaining the information both from medical records and through interviewing children´s mothers using standardized instruments (Carvalho et al. 2008; Feuerwerker, Merhy, 2008; Slomp et al. 2007; Ratis, Baptist, 2004; Oliveira, Camacho, 2002, Santos et al., 2000).

In addition, published research on care in pregnancy and during the early months of a baby´s life also commonly focuses on the mother's perspective, even in the case of those studies that make reference to the family´s point-of-view (Fleet, Barroso, 2005; Rabuske, Oliveira, Arpino, 2005, Moura et al. 2004). As a result of this characteristic, these studies fail to consider those other persons who also play an active part in care. Moreover, they help prolong the engrained habit among health professionals of making women, who are seen exclusively as mothers, the only focus of their interventions (Schraiber, 2005, Smith et al., 2002). In response to this failing, we propose here to include the diverse perspectives of the multiple stakeholders that are involved in this kind of care as well as the way in which these intersect.

In this paper we seek not only to describe practices - a common feature of research about care - but to reflect theoretically on these practices in relation to the concept of care. The way we approach care is inspired by Ayres (2009, 2004a, 2004b, 2001), for whom "care" is basically the construction

of ‘projects of happiness’ in order to achieve practical success - that is, the welfare of the individual who receives the care - and not just technical success, which refers to disease control. The author states, "... we have sustained the idea of the project of happiness as a kind of normative horizon implied by the notion of care "(Ayres, 2009, p.18). This is the reference that allows the professionals to understand what their clients expect from their technical capacities to act and that allows clients to understand what the professionals can offer them.
Ayres makes it clear that his existentialist concept of “project” is a development of Heidegger´s. Project is understood as

> "the repeated and relentless taking to oneself of the self, the other and the world that allows us to be forever coming to know our truest way of being and always reinvigorating our understanding of ourselves and the world and that places and moves us existentially, rationally and emotionally." (Ayres (2009, p.19) (our translation)

Ayres explains that his formulation of happiness does not refer to the commonsense idea of the word. Rather, it is a regulating idea that guides our decisions, showing whether we are moving along in accord with our projects. It is, in his words, a counterintuitive and “assintotic” idea, insofar as we never manage to achieve the experience of complete happiness.
We argue here that care can be thought of as *the construction of projects of the person which is expressed in everyday practices and which occurs in a framework of power relations between agents who occupy different social positions*. We show, through ethnographic analysis, that for the subjects, care necessarily involves work focusing on the person, as Thomas (1993) argues. Our conceptualization of work as taking the form of the construction of projects in everyday practice may both be connected to Ayres´ perspective and also held to be distinct from it. While Ayres restricts himself to examining care in a sphere delimited by restricted inter-subjectivity, in our research we show that it is in fact constructed culturally and socially within structured relations of power. The socio-historical aspects of care highlighted by Carvalho (1999) and other authors who work from a feminist perspective (Scavone, 2005), are also central to concept that is proposed here.
Projects of the person may be related to the multiple interests of caregivers occupying different positions within a social field, in the sense, with respect to this latter concept, ascribed by Bourdieu (1996, 1989). Such projects are not reducible just to a concern for practical success. Following Rabelo’s (1999) concept of project, which derives from Schutz and Merleau-Ponty, we argue that projects involve more than simple discursive or mental constructions. Indeed, projects can have corporeal expression without necessarily having passed through a level of mental representations; what is more, several projects may coexist in the same situation. Based on Rabelo´s contributions and upon anthropological discussion about the social construction of the person (see Bustamante, 2009), we argue that care (and with it the person) is always being built and rebuilt in this form – that is, as projects that indeed might not be spelled out discursively, in so many words.
This conceptual formulation draws upon a critique of a general tendency to universalize the meaning of care and, at the same time, proposes to widen the notion by showing that in fact care is built daily through diverse interactions, and not just out of a concern with happiness or well-being.
Based on this theoretical discussion, we argue that care is produced constantly in interactions between health professionals and users, and that it has different qualities which are related to the social positions of the interacting agents. The health professionals themselves understand that performing care depends on discourse – the act of giving guidance - and that it takes place in reference to planned routines. For them, care focuses on women seen as objects of these interventions. On the other hand the latter – the ‘users’ - understand that care takes place in a spontaneous way, both with reference to corporeality and as part of responses to situations that arise unexpectedly. Such spontaneous and situational care is done by relatives of both genders (and not just by women). Moreover, users build into their practices a negotiation with the projects of the person that are proposed by the health professionals, whereas, by contrast, the professionals tend to

keep to their original standpoint, without regard to the perspective brought to these encounters by the users.

With the research presented in this article we aim to contribute to a conceptual discussion that brings light to bear on day-to-day healthcare practices. This helps us to better understand the complexity of the situations that are part of the daily making of care and to identify those of its aspects that require further attention. This will help engender healthcare practices that are closer to the projects of the person - and of happiness – cherished by the users themselves.

Method

This analysis is part of a larger study on childcare in a low-income neighborhood of Salvador (Bustamante, 2009). The fieldwork, conducted between 2003 and 2006, involved contact with residents of 'Prainha' (our fictitious name for the neighborhood studied) which is located in a district of Salvador known as the Subúrbio Ferroviário (Railroad Suburb). As part of our research, we also studied a variety of institutions serving children in the neighborhood.

In what follows we analyze data obtained through participant observation in these settings and through interviews conducted both with health professionals who worked in the local Family Healthcare centre and with some of the residents of Prainha for whom they cared. We focus, in particular, on the members of seven households. As Toren (1997) observes, participant observation is the method that best characterizes the ethnographic approach. Through the researcher being simultaneously a participant and an observer s/he is always asking questions about her own and other people´s involvement in ordinary events. This attitude means that nothing that is said is considered irrelevant. As Toren points out, ethnographic analysis is not intended to be based on representative samples. Rather, the challenge is to know as much as possible about the people whose ideas and behavior are under view, and to be able to achieve this it is important to conduct in-depth interviews with some informants.

Ethnography is more than just a literary text in which the ethnographer tells the reader that she has, in fact, "been there" (Geertz, 1989). There are two criteria that we consider essential for thinking about the validity of ethnographic interpretations. On the one hand, as Jackson (1996) puts it, the credibility of discourse is not determined by seeming to allow the facts to speak for themselves, but rather by the way in which facts and data are organized into a narrative. On the other hand, as Pina Cabral (2005) emphasizes, interpretations should be constructed by starting out from a baseline - one where researchers and researched share a common world. He says: "The ethnographer, in his materiality, is co-existent with the subjects of the ethnographic study and it is only through the common world they share that he is able to make sense of his ethnographic observations." (Pina Cabral 2005:20) (Our translation)

As Wolf puts it, in this understanding ethnography is seen as a realistic work motivated "[….] by an urgent sense to place on record and testify to human experiences that 'speak' to us, without flippancy, about things that matter "(Wolf (1983, p.xi), apud Jackson (1996, p.43)). Thus, ethnography is more than one type of writing; rather, it is the best way to understand and show how people from different groups live and how they relate to others.

As far as the process of analysis is concerned, this was ongoing throughout the study, taking place hand in hand with the writing process (Becker, 1994). The interviews and field notes were transcribed, read and organized into folders ordered chronologically. The first readings of the material were of a general nature, with the purpose of clarifying the main theme of the thesis, through identifying key points. A second type of reading followed, involving the identification of important issues through organizing excerpts in related sections, resulting in the creation of additional files. New readings of this selected material - and sometimes a return to the original notes – took place as the arguments of the thesis were built up. A deeper understanding of the body of data grew out of this process. Some of the most important findings came about after rereading previously scrutinized notes.

The research project that led to this article was approved by the Ethics Committee of the Public Health Institute (Instituto de Saúde Coletiva) of the Federal University of Bahia. Ethical procedures

included the use of fictitious names in data dissemination. Full liberty was given to informants to decide on their participation, after being properly informed. Willing participants then signed the Consent Form.

Results and discussion

The neighborhood studied is similar to other low-income neighborhoods: It suffers, among other things, from inadequate public services, poor urban infrastructure, some unpaved streets, lack of green spaces and leisure facilities, and there is an ubiquitous presence of unfinished houses that are forever "under construction". Residents have a low educational level. They usually alternate periods of employment and unemployment. Among men, the most common jobs are in security and general services; among women, sales and domestic service. It is common to hear reports of episodes of violence, including domestic violence, fights between neighbors and police violence. However, there are increasing numbers of institutions – the fFamily Healthcare centre, schools, kindergartens, the police station - and social programs, such as the Family Grant Program (Programa Bolsa Família) and the Program for the Eradication of Child Labor (PETI).

The Family Healthcare centre serving our research subjects was established in 2002. Each of the three Family Health Teams there is composed of a doctor, a nurse, nursing technicians, a dentist, dental technicians and community health workers. Each team serves approximately one thousand families. Just as in other Family Health centers, programmed actions in Prainha include family planning, prenatal care and childcare.

Day-to-day care of pregnant women and babies in Prainha occurs in the context of the changes that have affected Brazil in recent decades. There has been a dramatic reduction in the birth rate (Dalsgaard, 2006), as well as increasing reduction in infant mortality rates. As a result, the number of children per woman is lower than in previous decades. In Prainha, there are differences between mothers of young children and their mothers: Younger women tend to have fewer children and, as in other parts of Brazil, expressed the desire to have only two (Bemfam, 1997). Cases of infant death are rare in recent generations, unlike amongst the grandparents of small children, who tell of having had at least four children and often of having lost newborns or infants before their first birthday. On the other hand, in Prainha one frequently hears about abortions, which are usually induced with Cytotec (misoprostol), a drug that is available on the market for the treatment of stomach ulcers, the use of which has significantly decreased mortality rates due to insecure abortions in Brazil (Menezes, Aquino, 2009).

For reasons of space we concentrate here on analysis of care associated with the discovery of pregnancy and with the early prenatal period, as well as on care during the first months of the child´s life, with particular emphasis on breastfeeding. We chose to focus on these topics because of their importance in the routine of health professionals and the lives of women and their families.

“To turn up pregnant" and the decision to continue the pregnancy

The health professionals interpret pregnancy among health center users as evidence of the failure of their "family planning" activities. Sometimes they lay the blame on their own work. For example, one day Dentist Ana[1] complained about a nurse´s lack of commitment to her team, citing as an illustration her work in family planning (for which nurses are responsible), commenting that "if it were done right, no woman would “turn up pregnant” (*aparecer grávida*) here at all[2]". However, most healthcare workers blame the women themselves. Among the professionals the predominant opinion is that a woman who “turns up pregnant” does so because she failed to follow their professional advice.

Along these lines Nurse Rose opined that the women who use the center are "too lazy" to go to the clinic to seek contraceptive methods, or to bother to learn how to use them, and that often this is due to the passive way in which they lead their lives. In Rose´s opinion a few “structured” families exist

[1] All names used here are fictitious.

[2] In colloquial Portuguese the expression *aparecer grávida* means both ‘to be seen to be pregnant’ and ‘to turn up pregnant’.

in which the couple actually plans to have children. In her view the possibility that a pregnancy be planned is associated with the existence of such a nuclear family.
"Family planning" is one of a nurse´s responsibilities and so as part of her routine she should be available for consultations and should talk with women about contraceptive methods. On a day-to-day basis, however, the service offered at the center does not meet demand, especially since most women seek injectable contraceptives. A woman we interviewed informally in the waiting room explained this difficulty in obtaining contraceptives. As well as complaining about the scarcity of such contraceptive medication in the health center, she also grumbled that her husband was not allowed to withdraw it (when available) on occasions when she could not because she was at work. According to this informant, the health professionals are inflexible and, moreover, "when we turn up pregnant they say that we didn´t follow their advice."
The situation faced by this informant is an illustration of the fact that health professionals´ "family planning" actions are concentrated on women, as Schraiber (2005) found in her study of the everyday practices of the Family Health Program in Recife. She notes that professionals direct their actions at women seen mainly as mothers and caretakers of the family, who are expected to be available to spend many hours at health facility at the provider's convenience rather than their own.
The above discussion shows that both users and providers refer to pregnancy as something that "*aparece*" (happens, turns up, becomes apparent). This is consistent with the findings of the GRAVAD survey held in three Brazilian cities. Most of the mothers interviewed said they had become pregnant without planning (Aquino et al., 2003). However, residents of Prainha refer to "turning up pregnant" or becoming pregnant "without planning" in a different sense from the health professionals. The following excerpt from a conversation with Paula and Ed, a couple with two children, illustrates this. One day I asked[3]: "How did you used to imagine what it would be like to have children?" and Paula said, "No, actually I never thought about what it would be like, because it was not a planned thing. It happened, but when it did, I was sure I wanted it [...]"
Often, when a woman turns up pregnant at the health centre, her pregnancy has already been recognized by her and the father of the child, as well as by relatives and neighbors. And this involves the choice to carry on with the pregnancy. Paula's experience with her second pregnancy follows this pattern. Both her pregnancies were unplanned and when she found out she was pregnant the second time, Paula thought about an abortion. Ed accompanied her to an illegal clinic they found in the city center. While she was waiting, Paula changed her mind and told Ed to take her home again: "After that I let the belly be, and all it did was grow." In this account, the decision to pursue pregnancy is followed by the act of displaying "the belly", allowing it to expand visibly. (However, this sequence of events is not the only possible one. There are some reports of induced abortions later on in pregnancy, a very delicate research subject (Menezes, Aquino, 2007), which will not be discussed here.)
The sisters Alicia and Lucineide both became pregnant "without planning", without a stable source of income, and both separated from their partners during the course of their pregnancies. However, each dealt differently with her circumstances. Alicia reported that she became pregnant because the couple did not do "family planning" during a very troubled period in which one of her children needed to be constantly taken to emergency services. She decided to "split up" after talking to her partner. He also decided to separate from her, firstly because he was away working in a country town, secondly because he had become involved with another woman. Alicia's mother thought it a huge "lack of responsibility" to have another child in these conditions, but nevertheless, accepted the arrival of her granddaughter. She helped when her daughter went into hospital, and provided care and support for Alicia´s other children. During her pregnancy, Alicia also obtained aid from a Pentecostal church: Parishioners organized a baby shower to help her get clothes, diapers and other objects for the child.
Lucineide became pregnant with her third child at age forty, when she was already the mother of two teenagers. She says that she did not expect to get pregnant, but knew that if it did happen, she

[3] The fieldwork was conducted by Vania Bustamante alone. For this reason, we occasionally use the first person with reference to some of our material.

would not induce an abortion, because it was her responsibility to "evitar" (avoid) pregnancy - something that she had not done. She decided to "deixar" (literally "leave" in the sense of "allow to proceed") regardless of the opinion of her partner. Coincidentally, he also wanted to have a child.
These cases show that there are differences between individuals and also that partners, relatives and colleagues are important in the experience of pregnancy, not just in the decision to allow it to proceed, but also to deal with the emotional and material challenges it occasions. Nurse Rose's discourse contrasts with what we find in the daily life of women and their families. Relatives and sometimes partners participate in the decision to continue a pregnancy as well as in the care of pregnant women and also in the preparation for the arrival of the baby. What is more, this does not depend on the existence of a nuclear family structure.
The health professionals base their practices on the premise that the women are uninterested and lazy, and that they do not follow their advice. The occurrence of pregnancy is seen as evidence of these attitudes. The possibility that it is a wanted pregnancy is associated with the existence of a nuclear family, where a husband has the role of breadwinner. The insufficient supply of contraceptives is not discussed by the professionals as something that contributes to unplanned pregnancies. According to Nurse Rose, there is always some method available, sometimes only the male condom, but even so, women do not use it. (The relationship between poverty and a preference for longer-lasting methods of contraception, including surgical sterilization, has been discussed elsewhere (see Dalsgaard, 2006)).
Users make constant reference to spontaneity and physicality when talking of such matters. This can be adduced not only in their use of the expression "to turn up / be seen to be pregnant," (*aparecer grávida*) but also in the manner in which women like Paula speak about "displaying the belly" and "letting it grow". Pregnancy is an expected occurrence in women's lives, and especially so in the case of the first child. This may be a spontaneous strategy to constitute motherhood, since women know that, in most cases, health professionals do not view the open expression of a desire to have children as legitimate, because of their precarious living conditions.
We argue that "*aparecer grávida*" can be thought of as part of an implicit negotiation between users and professionals. Without leaving aside the problems of access to contraceptives, it is fair to say that this expression evokes something of an unconscious desire to have children. This point is consonant with Menezes' (2006) discussion, based on the GRAVAD study conducted in three Brazilian capitals, which notes that it is common for women to say they did not actively want the pregnancy, did not think about it, were not trying to avoid it, and that the pregnancy just "happened.".
The care of newborn babies is also included in the officially prescribed routines set out in the Family Health Program. Giving advice on breastfeeding is of key importance to the program and we now turn to this topic.

Their "advice" and "our side of the story"

During the first weeks of a baby´s life a nurse and a dentist should make a home visit and community health agents should offer vaccination and supervision. A major objective at this stage is to encourage exclusive breastfeeding. In the "Pregnant Woman´s Diary" and other printed materials distributed at the clinic, there is plenty of space devoted to recommendations about breastfeeding. The benefits for the baby are highlighted, techniques useful in facilitating breastfeeding are taught and women´s labor rights with respect to maternity are explained. In this material there is no space devoted to possible reasons for not breastfeeding. Despite all this, breastfeeding is an area of active resistance by users. In this section, we discuss how users and professionals deal with this situation and detail how it is linked to the concept of good motherhood.
The following excerpt from the interview with Nurse Rose is illustrative of the health professional's point-of-view and its relation to the targets set by the Ministry of Health:

> "These targets are given by the Ministry, you have to have a percentage 'x' for each program, you know? [...] Now breastfeeding would be what? Seventy percent would be a reasonable

> level. But, sometimes you get to eighty, then before long you go down to fifty, then you get to seventy. Then you're fluctuating up and down, because of the business of *mingau* (cornstarch or cereal porridge), the woman who goes to work, and her mother, neighbor and mother-in-law [say], 'This child is not gaining weight!' And there goes all your hard work down the drain because the mother the mother-in-law give the baby *mingau* and end of story, they are the ones who have the final say: 'I brought my kids up just fine, so don´t you go inventing new ways of doing things!'. So there you have it [...]".

In the course of our research we confirmed Rose´s observation that mothers often do not breastfeed, giving *mingau* to their children instead, helped by older women. However, they try to keep this hidden from the health professionals. The first weeks of newborn Thaddeus provide a case in point. On the same day that his family proudly returned from the health center, after taking him for a check-up with the nurse and getting him vaccinated, I witnessed Dona Aurelina help her daughter-in-law Cristiane give *mingau* to Thaddeus. In Dona Aurelina´s opinion 'poor' women like Cristiane are not able to breastfeed a child, so in these cases *mingau* is the baby food of choice. When asked if she had talked about it with the professionals of the health centre, she said "No", and added: "One should not speak of this with the doctor, they do not understand our side of the story."
In our understanding this reluctance to reveal non-compliance on breastfeeding has to do with its association with good mothering. The following story involving Lucineide, her friend Claudia and the latter´s husband Milton is illustrative:

> "Lucineide talked about Claudia, a colleague who has a three month old baby. She remarked that the child was very fat and wondered whether it was because Claudia had started giving him *mingau*, juice and other things, only a few days after he was brought home from hospital. I asked her if Claudia had stopped breastfeeding. Lucineide said she did not know (it seemed to me that she did not want to say so in so many words), but she did say that she herself had advised Claudia to breastfeed exclusively until the baby reached six months. In reply Claudia had said: 'But when I go out, what am I gonna do ? He's just got to stay home hungry?'And Lucineide had said, 'No, as long as he breastfeeds, you have to take him with you wherever you go.' Claudia said she could not do that. So Lucineide thought it was for this reason that Claudia had given solid food to the baby so early. She also commented that people prefer to feed *mingau* to their babies, because it is 'heavy in their bellies' and thus stops the child waking up during the night. "(Field notes)

In the midst of this conversation I realized that Claudia is married to Milton, a man whom I already knew. The first time I had talked to him, he was out walking with his two month old son in his arms. I was pregnant at the time and this was already quite evident[4]. Without my asking, Milton said his son was fat because his only food was breast milk. Milton's comment and Lucineide´s story together show the high value placed on exclusive breastfeeding. On the other hand, Claudia´s concerns show how difficult it is to maintain this practice.
Although health professionals are expected to make the encouraging of exclusive breastfeeding a top priority, some observations at the health center indicate that they spend little time talking about the many aspects involved:

> "I was in the waiting room talking to a lady who was with a child. She said she was going to talk to the doctor because the child's mother did not have enough milk for breastfeeding. I asked what relation she was to the child, and she said she was a grandmother, but that the child's mother (her daughter) lives with her. After a few minutes she was called in by the doctor. The consultation lasted less than three minutes, during which time she stood at the open door. On coming out she reported that the female doctor had said that they should not

[4] Vania Bustamante continued fieldwork throughout her pregnancy.

feed anything else to the baby and that the mother did indeed have enough milk, that ‘the problem is in the mother´s head”. (Field Notes)

This exchange can be thought of as a moment of care where the doctor just gives her advice and barely listens to the woman who is seeking it. The (doctor´s) project of the person seems to be restricted to just one person who is seen as needing to receive the appropriate information. The practical and emotional aspects are not contemplated.

Our discussion shows that, in line with recommendations from the Ministry of Health, the health professionals believe that breastfeeding is the best alternative for the child, without considering what the practical implications of this for women and their families may be. Some of our findings are similar to those of Azevedo et al.´s (2008) comparison of professionals’ and mothers’ points-of-view on breastfeeding, which noted that both groups consider that breastfeeding enhances immunity. Professionals and mothers differ, however, with respect to the causes of early weaning. According to the mothers, blame should be laid on the “weakness” of their milk and on the need to return to work. The professionals refer to lack of information - something that the team itself should offer - and to lack of interest.

In Prainha health professionals direct their interventions at mothers. Men are not included as a specific target for these interventions. They are expected to provide support, especially financial. However, among users, decisions relating to breast feeding are taken not only by the mother, but also by relatives, including other women, and also by partners - as in the case of Milton - although these persons are not included in health professionals’ practices.

Users have separate and distinct concerns about the feasibility of exclusive breastfeeding. Women and their families consider practical situations which they must deal with and which sometimes prevent them from breastfeeding their children. Yet they also feel it important to have access to health professionals and to be able to count on their care, so they do not openly declare "our side of the story". This shows that day-to-day healthcare practices involve negotiations that bring together and integrate the professional’s point-of-view (providing guidance, following planned routines based on ideas that have support in biomedical knowledge) with the user’s point-of-view (the need to solve practical problems and at the same time, to feel recognized by the health professionals). However, it is important to remember that care is constructed within unequal relations where professionals enjoy a superior position and dispose of major economic and social capital.

Final Thoughts

In this paper we have argued that care exists in all contacts between professionals and users, to the extent that within these exchanges projects of the person are constructed. As a result, the characteristics of care shift constantly. Nevertheless, we have also shown that the situations in which these encounters take place are structured in such a way that certain care practices are favored. Health professionals dispose of greater symbolic and economic capital and therefore their advice and practices are more highly valued than those of users.

We have shown that professionals prioritize the discursive aspects of care and seek to follow planned routines, displaying a tendency to devalue the behavior of users who do not comply with expectations. Instead of trying to understand the meaning of their behavior, professionals construe the 'do not follow the guidelines' as lack of interest or as an indicator of absence of family structure. Practices are built up from this perspective – for which we have coined the expression ‘partial project of the person’ - where the person is assessed by considering just a single aspect. Desire - for example, in relation to pregnancy - or autonomy to decide about infant feeding are simply ignored. Thus, professionals offer quick consultations during which they proffer guidance without hearing the user’s "side" of. the story.

We have identified ambiguities and contradictions among professionals that require further study. In some moments they seem more worried about going by the book and performing prescribed routines than in investing in contact with the users, as in the case of the doctor who gave fleeting attention to a grandmother concerned about her daughter's difficulty in breastfeeding her newborn

granddaughter. This may be related to the frustration these professionals express on the grounds that they believe that women do not follow their advice. They are also expression frustration because they think that other professionals do not give value to the work they do. Thus Rose commented, in reference to the Maternity Card that health professionals at the center fill in over the prenatal period, "when it comes to the day [of admittance to the maternity hospital for the birth] no one bothers to look at it". All this leads us to formulate the following as an important analytic possibility: To think carefully about care as the construction of projects of the person and to seek to understand how this labor fits into the projects that professionals have for themselves. By following such an analytical course we would gain the additional benefit of deepening our understanding of the experience of the professionals themselves.

When users engage with professionals they adopt their own strategies, giving ample space to spontaneity and physicality, an approach that contrasts with all the planning and the emphasis on discourse on the part of the professionals. Using these strategies users seek to give appropriate answers to practical problems. For this purpose they also consider the health professional's knowledge to be important. So, despite their differences, users do rate having access to the professionals highly and do recognize their high social value.

Thinking of care from the perspective proposed here, we could ask to what extent the lack of technical success - unplanned pregnancy or non-adherence to breastfeeding – implies the existence of problems. The way users care for themselves (turning up pregnant, not breastfeeding) can respond to practical needs or be part of strategies to deal with their own desires and with the limitations imposed on them by reality. To take this into account is central to the construction of health practices that might at once enable the building of genuine projects of happiness and of the person. At this point it should be evident that the concept proposed here and the work of Ayres stand in a complementary relationship to each other.

The development of care practices that adequately consider users' points-of-view demands including within interventions in the area of health, not just women's perspectives, but also those of members of the extended family. This includes not only spouses and other women (friends and kin), but also other male relatives such as uncles or brothers. This requires awareness that kinship cannot be conceived as restricted merely within consanguineal or co-residential relationships. Our work shows that when it comes to the participation of relatives in decisions relating to health care families differ among themselves. In some situations just the couple is involved (as in Paula and Ed's decision to abort), while in others co-resident relatives participate (such as in the decision to feed *mingau* to Thaddeus), and in still others a broad group of relatives and neighbors might take part (such the baby shower organized for Alicia).

This said, it is necessary to add that care cannot be thought of only from the perspective of exchanges between professionals and users. The concept of care proposed here includes socio-historical and cultural aspects. Thus, we must remember that health professionals and users both develop their practices within the context of very poor conditions, not just the working conditions of the professionals, but also in the face of insufficient infrastructure and a lack of working materials. This context makes it difficult to develop care practices that contemplate users' points-of-view and contributes to the broader frame - the high rates of maternal death and infant mortality that constitute Brazilian reality (Rattner, 2009).

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