ORIGINAL ARTICLE

Hegemony and counter-hegemony in the process of implementing the Casa de Parto Birth Center in Rio de Janeiro*

HEGEMONIA E CONTRA-HEGEMONIA NO PROCESSO DE IMPLANTAÇÃO DA CASA DE PARTO NO RIO DE JANEIRO

HEGEMONÍA Y CONTRA HEGEMONÍA EN EL PROCESO DE IMPLANTACIÓN DE LA CASA DE PARTO EN RIO DE JANEIRO

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ABSTRACT

This study addressed the process of implementing the first Casa de Parto Birth Center in the Unified Health System in the city of Rio de Janeiro. The purpose of this qualitative study was to identify the determinants of the process of implementing the Birth Center and analyze the influence that hegemonic and counter-hegemonic groups have on that process. The theoretical framework used was the concept of hegemony. Data analysis was guided by the dialectic method of contradiction, totality and historicity. Semi-structured interviews were performed, from January to July 2007, with four municipal health administrators and 11 technical-administrative professionals assigned to implement the Birth Center. This study showed that the implementation of the Birth Center was determined by the counter-hegemony established in providing care during pregnancy and physiological deliveries.

KEY WORDS

Birthing Centers.
Humanizing delivery.
Health policy.
Women's health.

RESUMO

Estudou-se o processo de implantação da primeira Casa de Parto no Sistema Único de Saúde (SUS) da cidade do Rio de Janeiro. Por meio de pesquisa qualitativa objetivou-se identificar os determinantes do processo de implantação da Casa de Parto e analisar a influência dos grupos hegemônicos e contra-hegemônicos neste processo de implantação. O referencial teórico foi o conceito de hegemonia. O método dialético orientou a análise dos dados por meio das categorias metodológicas: contradição, totalidade e historicidade. Foram realizadas entrevistas semiestruturadas no período de janeiro a julho de 2007. Os entrevistados foram quatro gestores da saúde municipal e onze profissionais técnico-administrativos designados para implantar a Casa de Parto. A síntese deste estudo revelou que a implantação da Casa de Parto foi determinada pela contra-hegemonia estabelecida na assistência à gestação e parto fisiológicos.

DESCRITORES

Centros Independentes de Assistência a Gravidez e ao Parto.
Parto humanizado.
Política de saúde.
Saúde da mulher.

RESUMEN

Se estudió el proceso de implantación de la primera Casa de Parto en el Sistema Único de Salud (SUS) en la ciudad del Rio de Janeiro. Por medio de una investigación cualitativa se objetivó identificar los determinantes del proceso de implantación de la Casa de Parto y analizar la influencia de los grupos hegemónicos y contra hegemónicos en ese proceso de implantación. El marco teórico fue el concepto de hegemonía. El método dialéctico orientó el análisis de los datos por medio de las categorías metodológicas: contradicción, totalidad e historicidad. Fueron realizadas entrevistas semiestructuradas en el período de enero a julio de 2007. Los entrevistados fueron cuatro gestores de la salud municipal y once profesionales técnicos y administrativos designados para implantar la Casa de Parto. La síntesis de este estudio reveló que la implantación de la Casa de Parto fue determinada por la contra hegemonía establecida en la asistencia a la gestación y parto fisiológicos.

DESCRIPTORES

Centros Independientes de Asistencia al Embarazo y al Parto.
Parto humanizado.
Política de salud.
Salud de la mujer.

* Extract from the thesis "O Processo de Implantação da Casa de Parto no Contexto do Sistema Único de Saúde: Uma perspectiva do referencial teórico de Gramsci", Anna Nery School of Nursing, Federal University of Rio de Janeiro, 2007.

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INTRODUCTION

In the past decade, the Brazilian government has established healthcare policies to improve obstetric and perinatal care. Among other measures, the Ministry of Health has encouraged normal delivery by limiting the payment of cesarean sections in the Unique Health System – *Sistema Único de Saúde (SUS)* and including the procedure named *normal childbirth without dystocia, performed by a nurse-midwife* after 1998. In spite of these actions, cesarean childbirth is still one of the most common forms of delivery in Brazil. This type of surgery amounted to 38.1% of total deliveries in 2001. However, this ratio was higher among women aged 19 years or older, highly educated and living in the South and Southeast of the country. In the range of those with higher education (12 years or more), the cesarean ratio was 65% in 2001. It is worth noting that the World Health Organization considers that there is no justification for cesarean rates to be higher than 15%[1].

This situation happens because obstetric care is highly medicalized in the country[1]. Medicalization determines care concepts, values, rules and practices, both among healthcare professionals and in the general population, reflecting in the professional culture, where childbirth is considered a risky event, and the clientele sees medical intervention as an indicator of care quality[2].

Medicalization determines care concepts, values, rules and practices, both among healthcare professionals and in the general population.

In response to this context, the Ministry of Health implanted the Normal Childbirth Centers or Childbirth Houses in the SUS through Regulation/GM #985, issued on August 5, 1999. These centers aim to promote humanization and quality of care for women, by assisting them with normal deliveries without dystocia or those with low risk. They can work either physically integrated or isolated from the hospital, and nurse-midwives are the minimum required professional team.

This regulation makes the implantation of the Normal Delivery Centers feasible in local healthcare systems. As a consequence, the City Secretariat of Health of Rio de Janeiro – *Secretaria Municipal de Saúde do Rio de Janeiro (SMS/RJ)* implanted a Normal Delivery Center in the West of the city, in the Realengo area. It has been operational since March 8, 2004, and was named *Casa de Parto David Capistrano Filho*. The term *Childbirth House – Casa de Parto* – was used in this study due to that denomination.

The CP was regulated by the City Secretariat of Health through Regulation #1041, issued on February 11, 2004. This document states that it should work as a 24-hour healthcare unit, provide another option for low-risk pregnant women and work in partnership with a Reference Maternity and Healthcare Units of the Program Area it belongs to. The nurse-midwife in charge of the mother and the baby is the exclusive technical responsible for the care provided at the CP.

The initiative of the SMS/RJ to institute the first CP in Rio de Janeiro mobilized and promoted discussion among segments that were either favorable or opposed to its existence. The opposing segments were represented, mostly, by medical corporations, such as the Regional Council of Medicine – *Conselho Regional de Medicina (CREMERJ)*, the Physician's Union – *Sindicato dos Médicos* and societies of obstetric and perinatal physicians in Rio de Janeiro.

The struggle among all groups involved during the implantation of the CP reached the courts. This disagreement took debates about this service beyond the professional, institutional and academic spheres of the healthcare area. On the other hand, the occurrence of conflicts was common in obstetric centers before the implantation of the CP. These were caused by the incorporation of the nurse-midwife as the professional in charge of childbirth care. Physicians and nurse-midwives diverged on healthcare practices, responsibilities and professional competences in obstetric care in the maternities of Rio de Janeiro[3].

The establishment of the CP in the municipal healthcare network of Rio de Janeiro made the conflicts related to concepts and perspectives on women's healthcare more visible, as well as the healthcare culture in the services and professional roles in childbirth care[4]. Therefore, this research decided to analyze the process of establishing the CP in the SUS of Rio de Janeiro and attempted to answer the following guiding question: Which were the events and consequences of the disputes between the social actors in the process of establishing the CP in the healthcare system of Rio de Janeiro?

GOALS

With this question in mind, the study attempted to identify the determiners of the establishment of the CP and analyze the influence of the hegemonic and counter-hegemonic segments in this process.

THEORETICAL REFERENCE: THE CONCEPT OF HEGEMONY

Hegemony is the capacity of being in command and making a social class or segment capable of exerting political and ideological direction, building a staunch system of beliefs and values that directs the world conception of other social segments. Hegemony can be established without the need to obtain government power[5].

There are two large super-structural levels – civil society and political society. The civil society is formed by the group of organizations that are responsible for the elaboration and dissemination of ideologies, encompassing the educational system, political parties, unions, professional organizations, material organization of culture (magazines,

newspapers, publishers, mass communication means), among others[6].

The civil society and political society form a unit, whose functions are differentiated in the organization of social life. One of the classes reaches hegemony when it is able to establish a consensus among the remaining social segments by means of political, ideological and cultural direction in the civil society. When the hegemonic class achieves supremacy, it dominates the coercion devices of the political society – bureaucratic, legal, police and military systems[7].

The hegemony crisis emerges from contradictions that exist in the social fabric. This crisis is a consequence of the conflicts that exist in different world conceptions. These conceptions are propagated by ideologies – groups of ideas that determine the manifestations of life, either individually or collectively – and they make a given social group think and act in the same way. Ideology is decisive for the practical orientation of men. It is the highest meaning of a conception of the world, expressed in the law, in the economic activity, in all individual and collective manifestations of life, forming an ideological unit in every social block that is cemented and unified exactly by that ideology[7].

The battle of ideas – dialogue and cultural confrontation – is decisive in the struggle for hegemony. Ideological criticism – the cultural battle – becomes a decisive moment to aggregate a collective desire, overcome an old hegemonic relationship and replace it with a new one. The struggle for hegemony implies an action that, being focused on having an objective result at the social level, assumes the construction of an intersubjective universe of beliefs and values[8].

In the construction of a new moral and intellectual order, the counter-hegemonic segments need to build their own group of intellectuals. Every man is an intellectual, but not all men play this role within society. Those who act out this role contribute to maintain or change a given conception of the world. The intellectual role is related with the ability to formulate and disseminate a perspective of the world that may make the ideological direction of a given social segment feasible. Counter-hegemony emerges from this in the process[7].

Gramsci's ideas, therefore, provide support for the comprehension of the process of establishing the CP in the city healthcare network, as its historic-cultural context is related to the debate between different healthcare proposals for SUS-assisted childbirth care.

METHOD

The problem of this study fits within a complex, transforming, dynamic social context. Therefore, we chose a dialectic qualitative research. The dialectic method has the following basic categories: *contradiction*, represented by opposites; *totality*, which assumes the union of these opposites; and *historicity*, which has human practice as its main condition[9].

The study setting was the CP David Capistrano Filho, in the city of Rio de Janeiro, located in the West of the city, in the Realengo area. Data collection occurred from January to June 2007, after the study was approved by the Review Boards of Escola de EEAN/HESFA at UFRJ, files # 012/06, and SMS/RJ , file #72 A/2006.

The study subjects were divided in two groups of respondents. The first group was composed by the four managers of SMS/RJ: The City Secretary of Health, the Collective Health Superintendent, the Coordinator of Integral Healthcare Programs and the Women's Care Program Manager. The second group consisted of eleven technical-administrative professionals, nominated by the Secretary of Health to integrate the Implantation and Implementation Group of the CP – *Grupo de Implantação e Implementação da CP (GICP)*, as per Regulation SMS/RJ #1040/2004. The data were collected through individual semi-structured interviews and recorded on cassettes.

The raw data were submitted to the following operational phases: a) transcription, ordering, organization of the reports and production of a horizontal map; b) data sorting and identification of relevant structures in the central ideas; c) constitution of the units of meaning, thematic grouping and elaboration of raw categories; d) cross-sectional reading within the perspective of the dialectic method categories and constitution of the empiric categories; e) final analysis according to Gramsci's theoretical reference[10].

RESULTS AND DISCUSSION

After the analytic route had been defined, two central categories emerged: *Counter-hegemony in the cultural debate for the implantation of the Childbirth House* and *Conflicts and contradictions during the implantation of the Childbirth House*. Each of these categories is discussed next.

Counter-hegemony in the cultural debate for the establishment of the Childbirth House

The establishment process of the CP in Rio de Janeiro took rather long. The initiative appeared, especially, after the conception and opening of the CP in Sapopemba, São Paulo, by the public health physician David Capistrano. In 1999, he coordinated the actions to regulate and set up this modality in the services belonging to the SUS. At that time, Capistrano encouraged and provided the managers of the SMS/RJ with information to elaborate the proposal for opening three CPs in Rio de Janeiro.

In the same period, the SMS/RJ already had a certain reputation among the social circles that defended reforms in obstetric practices. This visibility was due to the actions performed especially at Maternity Leila Diniz, which opened in 1994. Ideas like recovering women's autonomy, childbirth as a physiological event, utilization of appropriate technology and an affectionate birth environment, similar to the home, influenced the functional and architectural concep-

tion of this maternity. On the other hand, the Superintendent, the Program Coordinator and the Women's Healthcare Program Manager were sensitive to the feministic ideas and the humanization of childbirth. These ideas include the valuation of the feminine aspects in childbirth care, both regarding the woman as a protagonist and the encouragement of midwives and nurses to provide care. As such, these ideas influenced the institution of the CP in the SUS. This influence can be observed in the following testimonies:

> Actually, when I was hired to work at the Secretariat in 1991, a group of women was already pushing the feminist issue. […] We understood that delivery should be as physiological as possible so that it could happen without any problems. […] So, when David Capistrano came over to talk to us, about having CPs in Rio, that was something we had already discussed in the City Healthcare Council (Manager D.1).

> Then, as the nurse-midwives approved the humanization proposal and we saw the chance of having professionals from other categories provide care, just like the foreign models that had good results, this also exerted influence (Manager D.2).

At first, nurse-midwives direct care during deliveries was not part of healthcare and organizational strategies at Maternity Leila Diniz. This professional practice was initially disputed by a trio of nurses who started it according to the perspective of humanization of childbirth, in line with the normative discourse of the institution. The achievement of this space added new concepts and skills to obstetric nursing in Rio de Janeiro. The nurses then started to discuss the proposals for humanized practices. This fact is described in the final report of the discussion forum for nurse-midwives held in 1997 and 1998[11]. It should be noted that there already were nurses working in delivery rooms in the Women's Institute Fernando Magalhães, a result of the institutional initiative agreed upon by medical and nursing management teams.

In addition to this critical view, both the Ministry of Health and the SMS/RJ officially supported the work of the nurse midwife in normal childbirth situations from 1998 onwards. The actions of this Secretary corresponded to the qualification and encouraging of the work of nurse midwifes in the obstetric centers of maternities Herculano Pinheiro and Alexander Fleming, and in the prenatal services offered in the basic healthcare network. In 1999, the nurses were responsible for 30-40% of the amount of deliveries in four maternities in the city[12].

In this period, the federal initiatives were directed both at the establishment of regulatory norms for obstetric nursing care in childbirth in the SUS and the funding of specialization courses in obstetric nursing in the college network. These norms correspond to regulations #2815/98 and #169/98. The first regulation established the inclusion of the procedure named *normal childbirth without dystocia, performed by a nurse-midwife* in the charts of the Hospital Information System – *Sistema de Informações Hospitalares (SIH)* of the SUS. The second regulation describes the duties of nurse-midwives in this type of care and regulates the nursing hospitalization report for the issuing of the hospital admission authorization – *Autorização de Internação Hospitalar (AIH)* for women who had normal deliveries[13].

It should be noted that the management context in the Ministry of Health had changed, maybe favoring the proposition of such measures. The coordination of women's healthcare had remained under the responsibility of a gynecologist physician for a long time, from 1987 to 1997. Later, technicians identified with feminism, nominated by the women's movement[14], occupied the technical coordination in women's healthcare.

The Ministry of Health established strategies for coping with the contradiction existing between the cruel reality of maternal mortality and the precarious care women were submitted to. Also, the discourse that acknowledged citizenship, the sexual and reproductive rights of women as defined by the Women's Movement, the World Health Organization and the Ministry of Health itself, through the Women's Integral Healthcare Program[15]. A similar situation was verbalized by the manager of the SMS/RJ, regarding difficulties to provide care:

> In 1998, the city of Rio [de Janeiro] had a serious crisis of baby deaths. The Secretary [of Health] summoned us and asked: *What do you propose to improve care?* We said: *Let's have nurses provide care*. That's when the program for the qualification of nurses for childbirth started, especially those who already had such a background but were not focused on that area, or prenatal care. (Manager D.1).

Historically relevant facts occurred in the year 2000, stirring up the ideas of humanization in the country. In the governmental area, the Prenatal and Childbirth Humanization Program was created in order to improve access, coverage and quality of prenatal, delivery, puerperal and newborn care, according to the perspective of rights to citizenship and humanization of care.

At the time, the International Conference on Childbirth and Delivery Humanization was held. Nearly 2000 people attended this event, coming from over 23 countries, in the Brazilian city of Fortaleza. This conference promoted the debate about the global situation of maternal and perinatal health, proposing the concept of humanization as a strategy to strengthen the healthcare model for deliveries and childbirth in the 21st century[16].

As such, a favorable political conjuncture and a cultural atmosphere was built for the implantation of the CP in the SUS, putting obstetric nursing on the healthcare policy agenda as one of the strategies to encourage normal deliveries. On the other hand, the SMS/RJ managers already shared the idea that the CP should be a community service, isolated from the hospital. About this issue, they took the following stance:

> At that time, we were already discussing childbirth healthcare models, thinking about the hierarchization of this service, the issue of low-risk deliveries. We also had the ap-

> proval of the Ministry of Health […] We thought it would be easier to do it outside the hospital due to institutional resistance (Manager D. 3).

As such, the institution of the CP in the public healthcare network was motivated by three interdependent and complementary factors, representing the dialectic movement between the general (the state), the private (the organized civilian society) and the singular (Nursing) aspects of this phenomenon. The first factor was the constitution of an ideological and cultural context opposed to the hegemonic healthcare moment practiced in Brazilian public maternities. This is a consequence of the counter-hegemonic movement in the organized civil society, which built reforming ideas and influenced the governmental spheres to promote women's healthcare policies.

The second factor was the ideological compliance of public healthcare managers, especially those in the SMS/RJ, with the ideas of humanized childbirth as an effective action proposal to improve maternal and perinatal healthcare. With the government power inherent to management, political actions of qualitative change in the architectural spaces and healthcare protocols of public maternities were established, even though professionals who disagreed with those actions resisted. Regarding the Ministry of Health, this compliance established the legal, political, regulatory and financial bases that made the local initiatives feasible for the establishment of Normal Childbirth Centers within the scope of the SUS.

Finally, the last factor was the quantitative increase in nurse-midwives providing care to physiological deliveries and pregnancies, encouraged by the public policies of childbirth humanization. This quantitative change occurred concomitantly with qualitative changes observed in the development of obstetric nursing, especially regarding the political competences focused on the defense and consolidation of their professional practice.

Conflicts and contradictions during the implantation of the Childbirth House

The great political, ideological and cultural battle was fought with the medical corporation, represented mainly by the CREMERJ. It was a legal battle, represented by the Public Ministry, in print and broadcast media, and even in virtual communities on the Internet.

The medical corporation's manifestation of disapproval regarding the CP started with the activation of the Childbirth House Sapopemba, in 1998, and increased with the approval of Decree #985/99 by the Ministry of Health, when Normal Childbirth Centers were officially instituted in the SUS. Concomitantly, the medical category discussed the medical act, attempting to fight off the *interferences* of other professionals in physicians' exclusive activities.

Due to this stand, taken before the public action of implanting the first CP in the West of the city of Rio de Janeiro, the medical corporation alerts the population of Realengo and its neighboring areas about the risks it would incur at this service. Among other initiatives, the physicians' representatives had a meeting with the health district council members of program area (AP) 5.1. We should clarify that the city of Rio de Janeiro is divided in 10 administrative program areas. AP 5.1 covers eight neighborhoods: Deodoro, Vila Militar, Campo dos Afonsos, Jardim Sulacap, Padre Miguel, Realengo, Bangu and Senador Câmara.

In 2002, when the CP was under construction, the CREMERJ and the City Secretary of Health held several meetings. The purpose of these meetings was to dissuade the Secretary from the initiative. Being unsuccessful, that Council and the Physicians' Union filed a public lawsuit before the Public Ministry, file #1676/2003. They denounced the illegality of the service due to the absence of physicians[17]. Faced with this situation, the manager stated the following:

> There was terrorism, such as saying that there would be deaths, that it would take too long to take them to the hospital and that the project should be rejected. However, it was a project by the Ministry of Health, it wasn't something we had invented. But we fought a good fight. The women's movement favored us. The natural delivery movement favored us. I mean, all the women, all these movements supported us […] So, we opened the childbirth house, and it has been an extraordinary success (Manager D. 4.).

The support from the women's social moment was decisive throughout the establishment process of the CP. Initially, the neighborhood association requested the building of a basic healthcare station in the available area. When the association was inquired about the possibility of using the area for the construction of the CP, there were manifestations of displeasure. However, the organized movement of women in the region favored the community's acceptance. The importance of this participation is quoted below:

> We sat down and talked about how important a CP is. This lady [president of the Women's Association] is very open-minded, and she mobilized the community quickly. We had a meeting where the CP was proposed. With that, we were able to insert the community, to the extent that the CP is held dearly, treated with respect. It's not even a target for graffiti. (GIPC professional D. 11).

The debate over the CP became visible in print and broadcast media as the legal audience drew nearer. The CREMERJ activated communication means in order to voice its opposing opinions towards this service. In mid-January 2004, the council released a note to several newspapers for two consecutive days, with warnings to the population, reiterating its position that the CP would bring risks to the population, as it lacked physicians.

The medical pitch was built around two arguments: the (lack of) medical security and degradation of Medicine. The first argument is directly related to the concept of risk supported by the ideology of medicalized deliveries, which allowed modern obstetrics to outline childbirth as an act of medical healthcare. These concepts were fundamental in

the history of childbirth institutionalization, represented as modernity and progress in obstetric care[18].

The second argument supporting the medical pitch is based on the statement that the true intentions of the Ministry of Health, regarding the CP, would be to reduce the costs of maternal-infant care by means of a *poor medicine for the poor* strategy[18]. With this argument, the State is portrayed as the promoter of differentiated service quality and access strategies due to the rationalization of expenses and technological reduction of public healthcare actions, resulting in a division between the central and peripheral zones of a city in the distribution and provision of professional and healthcare resources. In a way, this reasoning emerged in the following statement:

> First, because we believe in the [CP] program. In a country of midwives, you cannot ignore this instrument. Of course, if everyone could have a maternity with an adult ICU, a maternal ICU… But this is not the Brazilian reality, a country of midwives. So, we have to take advantage of the specialization of the nurse-midwife, the specialization courses, the high specialization, the successful experiences that we have here and now (Manager D.4).

Therefore, the city management is also under the influence of the hegemonic production logic in healthcare. In the structures of the state, contradictions and conflicts are manifested between hegemony and counter-hegemony, and they can clarify the reasons why the public policies, although supported on programmatic precepts with a significant social and democratic base, have faced difficulties and resistance to put its recommendations in practice at the services.

Throughout the lawsuit, the managers of the SMS/RJ activated the representative of nursing organizations, the Federal Nursing Council, The Regional Nursing Council of Rio de Janeiro, the Nurses' Union of Rio de Janeiro and the Brazilian Association of Obstetricians and Nurse-midwifes, national and sectional in Rio de Janeiro, to support the defense of the SMS/RJ regarding the inquiries of the Public Ministry about the legality of the actions of nurse-midwives. Nurse-midwives who were active in the social microspaces, within their own local social networks, developed political actions. Nurses working at maternity Leila Diniz were able to summon women whose children had been born by their hands. Those who would become responsible for the coordination of the future CP contacted the Women's Association of Realengo, who fiercely supported the social movement. Other nurses strengthened the articulation with the Network for Humanization of Delivery and Childbirth – *Rede pela Humanização do Parto e Nascimento (REHUNA)* and nurses working for the CPs in São Paulo and Juiz de Fora, and promoted a petition on the Internet in favor of the establishment of the service.

Other conflicts arose during the discussion of the conceptual, organizational and operational aspects of the CP by the employees of the SMS/RJ central management. Debates were held among the professionals managing the Hospital Area and the Collective Health services. The technicians involved in the management of hospital services believed that humanization actions should be prioritized in municipal maternities, and that the reasons of the CP proposal expressed ideologies of the Collective Health managers related to a public healthcare management action. This debate is evidenced below:

> So, these discussions started at the core level, from what is dispensable, what is superfluous and what is necessary. The birth of this project [of CP] started with the internal discussion. Then, we started to speak the same language. Actually, the intensive care and public health physicians had to make their discourse uniform first (GICP professional D. 3).

As an innovative healthcare service proposal, the SMS/RJ technical-administrative staff visited the CP in Juiz de Fora in order to know how it worked and its healthcare model. In spite of this previous visit, the nutrition, architecture and engineering professionals had difficulties to conceive the architectural and functional projects of the CP in Rio de Janeiro, because the guidelines and regulations traditionally covered the operation of hospitals. The situation was voiced as follows:

> But they [architects and engineers] always focused on how they built and thought about maternities. […] Another great struggle happened with the nutritionists, because of all those protocols they have to use when they handle food. Therefore, they wanted an exclusive set of tableware for the staff, another for the patients, and different types of sinks (GICP professional D.7).

This testimony shows the relationship between rationality, technique and space. Rationality is not only the expression of objectivity, the mental operations of logical reasoning that are indispensable to obtain results. It also includes human subjectivity, which is determined by desire, intention and purpose. Thereby, the paradigmatic change implies not only changes in healthcare techniques, as they are usually known, but in a whole set of knowledge and practices that determine healthcare work.

Another conflicting moment involved the reference maternity, Maternity Hospital Alexander Fleming. Meetings were held with the managers, technical-administrative staff of SMS/RJ and medical and nursing managers to build the structure of medical support for cases with maternal or perinatal complications. In these meetings, the local medical staff expressed disagreements about the CP, especially regarding its community structure and due to being away from a hospital. However, the power of the government managers prevailed over the local managers, with the determination that cases forwarded by the CP would be received regardless of the occupation rates of the maternity. The reference was established, and, over time, the bonds between both institutions were strengthened. Such situations were mentioned as follows:

> Many things happened from top to bottom […] Today, we're doing another revision in the protocol [of transference]. Because, if something happens, we'll sit down and discuss: *This has to be taken to the [Maternity Alexander] Fleming*. Over time, the heat of the emotions (laughter) is reduced. […] So, I think it gets easier for everybody (GIPC professional D.5).

In spite of these conflicts and disputes that emerged during the establishment process of the CP David Capistrano Filho, the SMS/RJ obtained a favorable decision from the Public Ministry, being opened to the public in March/2004. However, a while later, a security warrant was filed by the Physicians' Union/RJ, forcing the SMS/RJ to hire physicians in the service and acquire hospital equipment. In August, the judge of the 5th Public Court decided in favor of the SMS/RJ, and the CP was finally granted the right to work according to the precepts defined by the Ministry of Health and the City Hall.

CONCLUSION: A SYNTHESYS

The implantation of the CP was determined by the counter-hegemony in childbirth care, which influenced the state to institute public policies for women's healthcare, transforming the medicalized culture by means of the ethical-political project of delivery humanization.

During the establishment process, conservative and transformative forces of the hegemonic childbirth care model clashed in the governmental and civil spheres. However, corporate issues, aimed at maintaining the medical hegemony over physiological pregnancy and delivery, monopolized the debate. The moment was not used for reflection about childbirth healthcare models, governmental actions and possibilities to improve healthcare indicators and the satisfaction of healthcare system users.

The legal and political dispute in the establishment process of the CP highlighted the importance of organized social movements, especially the women's movement, for the execution of emancipating and affirmative group projects of action and citizenship. Therefore, obstetric nursing should strengthen its alliances with social segments to defend the ideas inscribed in the SUS, the democratization of human relations in healthcare services and the quality of care focused on the satisfaction of the clientele, guaranteeing the rights of Brazilian women to choose childbirth experiences away from the hospital.

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