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# Women's perspective in the evaluation of the Program for the Humanization of Antenatal Care and Childbirth

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## ABSTRACT

**OBJECTIVE:** To analyze the importance of inclusion, from women's perspective, in the evaluation of the Program for the Humanization of Antenatal Care and Childbirth, carried out by the Brazilian Ministry of Health.

**METHODOLOGICAL PROCEDURES:** This qualitative study was based on primary data collected in 2003 in an evaluation of the Program conducted in seven towns spread out among Brazil's five geographic regions. These sites were selected from a Federal Government data base utilized for quantitative analysis. Women attended by the Program were considered key informants when primary data was collected. Sixteen focal groups were performed in the primary care units. The Collective Subject Speech (CSS) method was used for qualitative analysis. The theoretical concepts of accessibility and Paideia Health within the framework of public health were used to interpret the findings.

**ANALYSIS OF RESULTS:** The Program standardizes procedures to be taken in antenatal care and childbirth for all health services in the country, including the flow among these services. However, analysis of women's discourse in the focal groups elucidated the existence of dissonances between their needs and desires and many of the program's recommendations. Pregnant women thus choose among available services and professionals and try to set up their own schedules which, in turn, do not correspond to those set up by the program. This discrepancy damages the bond women establish with the health services and creates obstacles for the control of the activities actually provided by the health services to the women.

**CONCLUSIONS:** Analysis of the Program based on women's perspective identified aspects that might result in more humanized and effective antenatal care, if they are taken into account in the redefinition or correction of the Program schedule. *Miolo abstract Miolo abstract Miolo abstract.*

**DESCRIPTORS:** Pregnant Women, psychology. Prenatal Care. Humanizing Delivery. Program Evaluation. Qualitative Research.

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## INTRODUCTION

In the evaluation of public health programs, in parallel to the external evaluations, executed exclusively by specialists, a strong tendency of considering the beneficiaries as key actors in the process has been observed.<sup>12,14,15</sup> Participant evaluations<sup>1,7</sup> presuppose the presence of all those involved from the stage in which the planning of the design of the evaluation occurs to that in which its conclusions are discussed so that the evaluation itself also becomes an opportunity for learning.<sup>2,13</sup>

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The Program for the Humanization of Antenatal Care and Childbirth – PHPN (Ministry of Health, Brazil)<sup>a</sup> was created in order to perfect the *Programa de Assistência Integral à Saúde da Mulher* (PAISM) Women's Integral Health Care Program. The PAISM, although it had integral health actions in the field of women's health as its objectives, was still questioned with respect to the quality of care it delivered and to its impact on maternal mortality.<sup>14</sup> The PHPN was instituted in 2000 and emphasized the affirmation of women's rights, proposing humanization as a strategy to improve the quality of care. Its principal actions were the reduction of maternal mortality, as defined by the Pact for Life (2006),<sup>b</sup> the object of which are to guarantee access to respectful/dignified quality care during pregnancy, birth and the puerperal period.

The objectives of this study were to: 1 – describe the evaluation conducted by women who were the beneficiaries of the PHPN; 2 – analyze the relevance of the inclusion of women beneficiaries' perspective in the evaluation of the Program for the Humanization of Antenatal Care and Childbirth.

## METHODOLOGICAL PROCEDURES

Data collected in 2003, referring to the national evaluation of the PHPN promoted by the Ministry of Health<sup>c</sup> and conducted by a team from the Faculdade de Saúde Pública (School of Public Health) of the Universidade de São Paulo were analyzed.<sup>d</sup>

The methodological design of the project included the use of quantitative and qualitative approaches. Data-banks (DATASUS, SINASC, SIM e SISPRENATAL) were utilized in the quantitative analysis. The qualitative analysis, object of the present study, evaluated Brazilian municipalities. These were arranged according to geographic region, population size, SUS-dependent population, presence of the *Programa Saúde da Família* (PSF) [Family Health Program] and community health agents, hospital and ambulatory resources, period of adherence to PHPN and services delivered.

This analysis made it possible to identify supply and production of services indicators such as the expressive increase/decrease of productivity of the PHPN, presence of PSF, lack of hospital beds, that is, variables that could be related to significant alterations in antenatal, birth and puerperal care. These indicators were considered were considered “markers/signs” utilized in choosing the seven municipalities where case studies were conducted: Cascavel and Morada Nova (Northeastern

Brazil), Goiânia and Abadiânia (Central-West), Porto Velho (Northern), Paissandu (Southern) and Monte Azul (Southeastern).

The method utilized in the qualitative study was the case study approach and each municipality corresponded to one case.<sup>16</sup> For each municipality, two or three health care units were selected, based on their geographic location and productivity within the PHPN. In all, 18 health care units were included in the study.

Sixteen focal groups were conducted, composed of six to eleven beneficiaries that had utilized the health care services in the last 12 months. A free and detailed description of the care they received was solicited of participants in these focus groups.

The groups were heterogeneous with respect to age, educational and socioeconomic level.

Primary data was analyzed according to the “Collective Subject Discourse” methodology<sup>8</sup> and were grouped together along six axis of central ideas: captivation of pregnant women by the service choice of the location for conducting antenatal care; exams undertaken; choice of the location for childbirth; moment of childbirth; and puerperal consultation.

The Project was approved by the Committee on research Ethics of the School of Public Health of the University of São Paulo, in conformity with Resolution N° 196/1996 of the National Council of Health. All participants signed an Informed Consent Form.

## ANALYSIS AND DISCUSSION OF THE RESULTS

The results shall be presented according to the above mentioned axis of analysis. Seeking to attain a more in-depth comprehension of the care received by women within the program, the entire set of discourses that emerged in the focal groups with respect to each particular axis are discussed in conjunction.

### Captivation of pregnant women by the service

Captivation corresponded to the beneficiary's first approximation to the health care service and to her means of assimilating the news of her pregnancy, her expectations and necessities, as well as the way in which the supply of care was structured.

Five kinds of experiences were identified among the women:

<sup>a</sup> Ministério da Saúde. Secretaria de Políticas de Saúde. Programa de Humanização do Pré-Natal e Nascimento. Brasília; 2000.

<sup>b</sup> Ministério da Saúde. Secretaria Executiva. Departamento de Apoio à Descentralização. Coordenação-Geral de Apoio à Gestão Descentralizada. Diretrizes operacionais do pacto pela vida, em defesa do SUS e de gestão. Brasília; 2006.

<sup>c</sup> Publication of data from the evaluation, authorized by the Departamento de Ciência e Tecnologia (Decit) of Brazilian Ministry of Health (ofício 46 from 14/8/2007).

<sup>d</sup> Report published by Decit/MS, at *Rev Saude Publica*. 2008;42(2):383-7.

1. she sought out the public health care service as soon as she suspected she was pregnant and was attended according to her expectations;
2. she sought the service, but her expectations were not met;
3. she utilized a private service to conduct exams to confirm her pregnancy for she supposed that the public service would not attend her promptly;
4. she was certain that she was pregnant and did not feel that confirming this with an exam or initiating antenatal care were urgent matters;
5. she did not feel an urgent need to confirm pregnancy because she had difficulty in assimilating the possibility of pregnancy – adolescents or women that believed they had no chance of becoming pregnant.

*“I paid eleven reais to do the exam (confirmation exam) at a private laboratory...I didn’t do the exam at the health care center, this didn’t even cross my mind. I wanted to know right away and at the health care center everything takes so long....”* (DSC 1C)

*“It was three months late. I felt no pain, nothing, there was no sign I was pregnant. I didn’t believe I was pregnant when my period was late. I came when I was five months pregnant.”* (DSC 1E)

The PHPN establishes that captivation by the service should occur within up to 120 days of pregnancy. The great variation in the time period transpired until women seek public health care services is associated to the availability of access to the service – supply of confirmation exams and of first antenatal consultation – however it is also influence by women’s perceptions as to their need for antenatal care and the quality of the service provided.

It was observed that psychological factors interfere with the pregnant woman’s promptness or delay in seeking the health service to begin antenatal care, portraying the strength of utilizing the beneficiary as a source for attaining accessibility (Frenk 1985).<sup>6</sup>

### **Choice of the location for conducting antenatal care**

The principal reasons for choosing the location for conducting antenatal care were:

1. experience reported by a family member attended at that location;
2. the possibility that antenatal care at this location guarantees that childbirth will take place in the same institution;
3. geographical proximity to the residence;
4. lack of options because there is only one public antenatal service in the municipality;

5. empathy with the professional team;
6. loss of a private health plan.

The statements that follow illustrate the experience:

*“Since I wanted to have my baby in that hospital, I came there to have my antenatal care when I was seven months pregnant.”* (DSC 2B)

*“...you can’t trust the health care center... I didn’t want to be seen by this doctor. He attends people very badly. So I decided to go to another center for care.”* (DSC 2E)

The PHPN recommends geographical proximity to the pregnant woman’s residence as the only criteria of reference for the location of conducting antenatal care. The results of this study indicate that subjective factors, such as the need to feel secure during labor and birth, were more important to the women.

Upon visualizing this axis through the “Paideia Health”<sup>3</sup> model, emphasis is placed on the creation of a bond between the needs of the beneficiary and the health team’s potential for welcoming and channeling this demand. When this subjective variable is not taken into consideration, the possibility of creating a bond decreases and the fluxes established may become simply bureaucratic and not very functional.

### **Exams undertaken**

The central ideas/experiences identified portrayed mainly the way in which the supply of procedures is organized and how women:

1. were able to undertake all the exams solicited by their physicians, according to their expectations, in function of the organization of the service;
2. with a huge personal effort, were able to do all the exams solicited;
3. were not able to undertake exams in general because these were not provided by the services;
4. were not able to do ultrasounds because these were not offered by the services;
5. were only able to do ultrasounds because they had the financial resources and paid for them.

*“I did many exams around here. A while back no one did testing for Aids, VDRL. If you wanted to do them, you had to pay for them. Exams were very expensive and it took a long time to receive results. I was able to do everything he (the physician) asked for.”* (DSC 3A)

*“I had the ticket for the ultrasound but I wasn’t able to schedule it. We really can’t schedule it. You have to arrive at dawn. The health center looks like an ant hill at these times. It’s suffocating, people feel discomfort. I didn’t get an ultrasound, just wasn’t able to.”* (DSC 3D)

The limitation was imposed primarily by the service, since women were predisposed to do all the exams solicited of them. There were moments in the organization of care in which the supply of exams decreased due to the depletion of the quota of exams provided to primary care services. A greater effort was then observed by beneficiaries – their “utilization power” increased – in order to get their exams done, they resorted to several laboratories or even arranged to pay for them.

Pregnant women who are beneficiaries of public health care want to rely on resources that can diminish their lack of knowledge with respect to their babies' health status and propitiate more tranquility to them during pregnancy. Ultrasounds provide this possibility and are highly valued by them for this reason. However, this exam is not foreseen by the PHPN.

The model “Paideia Health” proposes that the organization of health care should not occupy itself solely with issues representing high mortality risks, but also with aspects of health care that attend to people's desires, stressing the importance of creating a bond with beneficiaries.<sup>5</sup>

### Choice of the location for childbirth

The central ideas revealed alternative forms that women utilized to make their personal choices with respect to the location of childbirth viable:

1. agreements with their physicians so as to occupy a bed in a maternity where he/she attends;
2. choice of a specific hospital due to the positive experience of a family member;
3. there was no choice – it was the only hospital in the city.

*“I made an agreement with my physician that, during the last week, I would consult with him in the hospital where he works (it also attends patients through the Unified Health System), and so he got me a bed for there when it was time (for childbirth). If it's a cesarean, there are no vacancies and people remain there in pain. I didn't want to go to hospital X, no way! I used to pray every night (that I wouldn't end up there).” (DSC 4A)*

*“I'm familiar with the hospital because my mother had children there and its near her house. I would prefer to give birth there.” (DSC 4B)*

Bypasses from the reference/ counter-reference flux established by the PHPN, were observed. It foresees criteria which limit the number of beds available in the hospitals indicated by the primary health care centers. Given the importance of continuity between antenatal and birth care, the program must consider these bypasses as evidence in decision-making processes. Furthermore, even when the pregnant woman seeks the hospitals indicated to her, the binomial antenatal care/

birth care is not, in the majority of cases, contemplated by the services, since the primary care centers undertake formal referrals to the so-called reference hospitals that are not followed through concretely.

The system continues to face the challenge of no longer considering the practice of birth assistance as an isolated procedure, detached from antenatal care, and creating strategies for articulating these different levels of care.

### Moment of childbirth

Women emphasized the experience of the attention they received in the maternities, particularly the quality of the procedures:

1. satisfaction for having their needs attended to during antenatal care;
2. difficulties in finding vacancies in the hospitals and the negative consequences for both mothers and babies;
3. pain during prolonged labor due to lack of medications or delays in the decision to conduct a c-section in the maternities;
4. lack of attention from the professionals during labor.

*“For me it was good. The nurse told me about all the steps of labor, any doubts I had I cleared them up with her or the health agent. When I went to the hospital, I had no problem getting a vacancy. The care I received was fine, I suffered a lot. I stayed in a room with six other women and the nurse came in all the time to see, to hear the baby. Care at the hospital has improved a lot, the nurses are more attentive, they even provide the women with modesses.” (DSC 5A)*

*“There was no vacancy at the maternity. They told me to go to hospital X, Y or Z. I first went to hospital X, but since it was going to be a c-section, they sent me to the medical school hospital. There was no vacancy there so they sent me by ambulance to hospital W. I had a lot of problems during childbirth.” (DSC 5B)*

*“Childbirth was not good. The doctor had no patience, the hospital was bad... Didn't give orientations, didn't say anything. They took a long time to attend me. I didn't like the hospital, revision was lacking. The nurses only appear when the baby is already being born. Then she tells you to close your legs so you can get to the delivery room...” (DSC 5D)*

It is possible to identify in many of the statements concerning labor that assistance was precarious according to the expectations of the women giving birth, either in terms of the interpersonal relations established with the professionals, or because of the delay in adopting technical procedures that minimize discomfort or suffering.

Even before they arrive at the maternity, the pregnant women experiences insecurity due to the prospect of not finding a vacancy, which is enhanced by the uncertainty as to the quality of care she will receive.

News concerning the experience of other pregnant women circulates in the community. When these are negative, pregnant women become apprehensive with respect to some hospitals, and tend to avoid them if they can. When information is positive, it provokes a movement in search of some means to guarantee a vacancy in that specific service. Communication established in this manner also assumes a role in organizing the local health system.

### **Puerperal consultation**

The central ideas revealed the importance attributed to the puerperal consultation. Consequently the fact that this consultation is not undertaken at another moment represents a great loss of opportunities:

1. the mother did not need to go to a consultation after childbirth: only the child should be taken to the doctor for follow-ups;
2. the consultation was not a priority for the puerperal woman and if she could not make it to the appointment, it would not be re-scheduled;
3. the consultation after birth is important for the mother;
4. a follow-up was indispensable because the woman need medical treatment after childbirth.

*“During the appointment, she (the physician) looked at the baby, explained about breastfeeding, that I must breastfeed... I came back for him to take his vaccine... I didn't consult with the doctor after that.” (DSC 6A)*

*“The doctor asks us to come to find out how the mother and the baby are doing. I went back for the baby's follow-up after sixteen days. I had a follow-up too.” (DSC 6C)*

During the puerperal period, the woman is placed at the crossroads between the program of care during the gestational-puerperal cycle and program of care for the child. The puerperal consultation, that should take place 40 days after birth according to the PHPN, is at risk of loosing space to the first appointment for the baby, as has also been described by Serruya et al<sup>11</sup> (2004). This is due both to the lack of significance attributed to this follow-up by puerperal women and to the fact that the dynamics of the child care program is much more well structured than the antenatal/birth/puerperal program.

If the beneficiary returns to the primary care center for a personal consultation, she generally noticed some health problem or was interested in seeking family planning.<sup>11</sup> Important opportunities for conducting puerperal care are squandered due to the lack of articulation between

health programs. Other moments when women seek the service could propitiate the opportunity to conduct a puerperal follow-up, in a period distinct from the one recommended by the PHPN, but that could lend itself to the opportunity of accompanying women's process of recomposing their biological conditions.

### **FINAL CONSIDERATIONS**

The inclusion of women's perspective may make it possible to flexibilize certain of the program's norms, adapting them to the peculiarities of different groups of pregnant women in different communities. Women respond to the attention provided to them according to their thoughts regarding their health needs. Creating the opportunity for this information to emerge in processes of evaluation leads to the inclusion of different actors of a program as “subjects of self-evaluation” and not only as “analytical goals” (Minayo et al<sup>9</sup> 1999). This results in both a more realistic approximation to the health necessities of the population and an opportunity of reflection for this actor and for him/her to strengthen him/herself.

Thus, when a health team is not sensitized with respect to the importance of creating a bond with the pregnant woman, the risk of her desisting or of diminishing the frequency with which she comes for her follow-ups increases. It was observed that even if the system offers her few options as to the places where she can seek care, the pregnant woman makes an effort to go to those which transmit a greater sense of security to her, in a natural movement geared towards obtaining the best possible conditions for accompanying the growth and development of her child.

Challenges with respect to early captivation and evasion of follow-ups were also detected in a similar study conducted by Carvalho & Novaes<sup>4</sup> (2004), that utilized the quanti-qualitative approach in evaluating antenatal care. If local management of the health system could gather information on the motives why certain fluxes are not observed, as this study did, perhaps it would be possible to allow the requirements for access to become more flexible in favor of greater support. In this manner, the flow among services determined by the pregnant woman could be accompanied and adjustments in planning could be promoted.

This beneficiary should be considered as an integral subject in her necessities, desires and interests; not only in terms of the satisfaction/insatisfaction with the care she receives, but also in terms of her ability to unleash a critical reflection with respect to the objectives and the format of assistance. She should not be regarded only as an object of action, but as a person Who detains a proactive potential with respect to the control of determinant variables of the health-illness process for herself and her community.

As to the conduction of the evaluation process, it is fundamental to register and process the speech of beneficiaries and key informants in the decision making process, so as to flexibilize planning.<sup>10</sup> Valorizing the listening process in focal groups may be a management instrument that is so effective as the analysis of epidemiological indicators of results or else production/productivity of the process of care.

In the present stage of scientific development, it is no longer possible to avoid the use of a qualitative approach due to methodological limitations: the need for

a more in-depth understanding of the object of study leads researchers to make these evolve continually. One of the alternatives found has been the systematic integration of quantitative and qualitative approaches. Creswell<sup>5</sup> (2003) presents the method of the “sequential explicative drawing”, reinforcing the possibility of understanding the relations found in analysis of the quantitative data by utilizing primary qualitative data. This study intends to have contributed as an alternative for developing this approach, in this case, targeting the process of adjustment of health programs.

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