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Solicitude in home visit of nurses in high-risk prenatal care: an experience report[a]

Solicitude em visita domiciliar de enfermeiras no cuidado pré-natal de alto risco: relato de experiência

Solicitud en visita domiciliara de enfermeras en la atencíon prenatale de alto riesgo: relato de experiencia

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Abstract

Objectives: to report the experience of producing high-risk prenatal care through home visits structured on request. **Method:** this is a descriptive study in the experience report modality, based on the experience of nurses in developing home visits under the solicitude framework for 17 women with high-risk pregnancies. **Results:** home visits allowed nurses to value the subjective aspects of care, with apprehension of women's needs and understanding of pregnancy in the lives of each one of them, determining aspects of comprehensive prenatal care. It promoted unique care and opposed to the insufficiencies and negatives experienced in the prenatal care received, anchored in the biomedical model. **Conclusion and implications for practice:** home visit by nurses under the auspices of solicitude has revealed itself as a high-risk prenatal care technology that produces reception of unique needs, as well as leads to care reconstruction in the context of high-risk pregnancy.

Keywords: Prenatal Care; Nurses; Pregnancy, High-Risk; Integrality in Health; House Calls.

Resumo

Objetivos: relatar a experiência de produção de cuidado no pré-natal de alto risco, por meio de visitas domiciliares estruturadas na solicitude. **Método:** estudo descritivo, na modalidade relato de experiência, pautado na vivência de enfermeiras em desenvolver visitas domiciliares, sob o referencial da solicitude para 17 mulheres com gravidez de alto risco. **Resultados:** as visitas domiciliares possibilitaram às enfermeiras a valoração dos aspectos subjetivos do cuidado, com apreensão de necessidades das mulheres e compreensão da gravidez na vida de cada uma delas, aspectos determinantes à atenção pré-natal integral. Promoveu cuidado singular e contraposição às insuficiências e negativas experienciadas na atenção pré-natal recebida, ancorada no modelo biomédico. **Conclusão e implicações para a prática:** a visita domiciliar por enfermeiras, sob os auspícios da solicitude, revelou-se como tecnologia de atenção pré-natal de alto risco que produz acolhimento de necessidades singulares, assim como conduz a reconstrução do cuidado no contexto da gravidez de alto risco.

Palavras-chave: Cuidado Pré-Natal; Enfermeiras; Gravidez de Alto Risco; Integralidade em Saúde; Visita domiciliar.

Resumen

Objetivo: relatar la experiencia de producción del cuidado en la atención prenatal de alto riesgo a través de visitas domiciliares estructuradas por la solicitud. **Método:** estudio descriptivo, en la modalidad de relato de experiencia, basado en la experiencia de enfermeras en el desarrollo de visitas domiciliaras a partir de la solicitud con 17 mujeres con embarazos de alto riesgo. **Resultados:** las visitas domiciliaras permitieron a las enfermeras apreciar los aspectos subjetivos del cuidado, comprender las necesidades de la mujer y comprender el embarazo en la vida de las mujeres, aspectos determinantes de las demandas de la atención prenatal. **Conclusión e implicaciones para la práctica:** la visita domiciliara de enfermeras bajo el auspicio de la solicitud se reveló como una tecnología de atención prenatal de alto riesgo que produce la acogida de necesidades únicas y capaz de conducir la reconstrucción de la atención prenatal en el contexto de embarazo de alto riesgo.

Palabras clave: Atención Prenatal; Enfermeras; Embarazo de Alto Riesgo; Integralidad en Salud; Visita Domiciliaria.

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INTRODUCTION

In Brazil, High-Risk Prenatal Care (HRPNC) can be developed comprehensively in Primary Care (PC) whenever there is a specialized team for these cases, and in their absence, specialized clinics are provided. In any case, PC is coordination, ordering and continuity of care, in the direction of guaranteeing rights and access to care technologies in a timely manner, with a view to meeting unique needs.[1,2]

In 2011, the Brazilian government established the *Rede Cegonha* (RC) with the prerogative that prenatal care, whether at usual risk or high risk, ensured quality of care, access, network articulation, and health promotion. It was guaranteed for pregnant women: embracement of complications during pregnancy; assessment and classification of gestational risk; timely access to high-risk prenatal care; conducting exams; and articulation of the maternal-infant care network towards effective comprehensive care.[3,4]

HRPNC demands qualification in the Brazilian context and the strengthening of this attention is signaled as urgent to guarantee rights and counteract maternal and neonatal morbidity and mortality rates in Brazil. By taking the Sustainable Development Goals, Brazil assumed for 2030 a reduction in the maternal mortality rate to 30 deaths per 100,000 live births.[5] In 2018, the Maternal Mortality Ratio (MMR) was 59.1 deaths for every 100,000 live births, with a predominance of maternal deaths due to direct obstetric causes.[5]

In this scenario, the relationship between the incidence of morbidity and mortality in high-risk pregnancy and insufficiency of information given to pregnant women[6] and family is also highlighted, with deleterious consequences for her and child's health, complications in pregnancy, childbirth and the puerperium, such as maternal mortality and increased neonatal mortality.[7]

Prenatal health care centered on and valuing the biomedical model tends to be limiting to meeting women's health needs other than the morphofunctional. The practice under this paradigm impacts the formation of the bond between pregnant women and professionals, reduces the clinic and leads to feelings of dissatisfaction and distrust for the care provided, even leading to situations of non-adherence to prenatal care.[8]

It is urgent to think about care for high-risk pregnant women, connecting the tangles of care production that involves the social, the technical, the non-technical, availability, affection, empathy. Therefore, thinking about care exclusively through protocol devices limits and makes prenatal care insufficient.[4]

In this sense, home visits (HV) stand out as an alternative of possible care articulation between professionals, pregnant women and their families and as a care practice that can overcome insufficiencies. First, by promoting the approximation of professionals in real-life contexts in which the subjects are immersed, with an impact on care production that few health practices have.[9] Second, because this approximation enables the appreciation of the subjective dimension of those involved in this relationship, building spaces for communication and dialogue, favoring the sharing of practices and knowledge[10] living and reflecting on the entirety of the entire pregnancy process.

In line with the previous paragraph, a solicitous attitude contributes to an attitudinal attitude that intends to understand the totality of the being and the gestation process in HRPNC, adopts availability for intersubjective and dialogical relationships, acting as a guide for care production in HV, in order to transcend the biomedical model. This attitude is based on the possibility of being open and welcoming to others, marked by the desire to "respond in the best way possible to any request, with commitment, interest, attention",[11:94] and the understanding is that it has the potential to guide the presence of nurses in home visiting practices, especially in the appreciation of subjective aspects.

Although HV is one of the tools suggested by the Ministry of Health (MoH) for monitoring pregnant women at usual risk and at high risk, there is a lack of scientific knowledge for a considerable number of nurses. Many understand that it is sufficient in terms of apprehension needs and care, directing pregnant women PC, or when HV take place through the Community Health Worker (CHW), even if its practice is recommended to other health professionals who are part of the network.[12]

Care for high-risk pregnant women is included in specialized services, sometimes a break in continuity of care in Primary Health Care.[1,8] Directing HV in prenatal care to high-risk pregnant women provides as a strategy for continuity of the bond of Primary Health Care professional team. It is essential to provide comprehensive care to women and their families in a longitudinal manner and should be used from the referral of pregnant women to the high-risk clinic, lasting until postpartum times, reaching the demanded health needs.[13]

Internationally, there are numerous investments in home visiting programs (HVP) with the purpose of promoting maternal and child care and development. These programs prioritize low-income families and communities in situations of social and economic vulnerability as an alternative to minimize vulnerabilities, an important mechanism for equity.[14-16]

In the same direction, Brazil has been encouraging and implementing programs. The Happy Child Program developed by the Ministry of Social Development provides for the care of children during early childhood through HV and, more recently, has published a manual to support HV for pregnant women.[13] Another HVP, entitled Young Care Mothers Program, aims to develop positive parenting in early childhood and in maternal and child health. It is offered through HV conducted by nurses to adolescent and first-time mothers.[17]

Practice in dialogued health has transforming potential in the balance between the subjective and the technical, and in the construction of therapeutic projects that rescue women's autonomy and empowerment.[18] Thus, in the understanding that women and families are the authors of their care, and it is

up to nurses to support them so that they have knowledge and claim the care that makes sense for them, this study aimed to report the experience of care production in high-risk prenatal care through structured HV in the application.

METHOD

This is an experience report on care production, through HV in high-risk prenatal care developed by nurses, under Paul Ricouer's[19] solicitude theoretical framework.[19] The French philosopher conceived the term solicitude for the statute of benevolence. Much more than a moral obligation of respect, the good comprises sharing, sometimes asymmetrical, between giving and receiving,[19-21] as a responsibility arising from the recognition of the other by oneself and the other as oneself.[20]

The report describes the experience of two nurses linked to a *strictu sensu* graduate program who, as part of research and extension activities, carried out HV to high-risk pregnant women. This report is anchored in the intervention (HV) of a project entitled "*Alcances de Programa de Visitação no Pré-natal de Alto Risco*", developed in a municipality in the countryside of the state of São Paulo, Brazil, whose high-risk prenatal care occurs through a specialized service.

The mentioned project followed Brazilian ethical-legal precepts for research with human beings. It was approved by the Ethics Committee and is registered under Opinion 2,467,733 and CAAE (*Certificado de Apresentação para Apreciação Ética* - Certificate of Presentation for Ethical Consideration) 81715317.7.0000.5504.

HV began in August 2018, from the gathering of first high-risk pregnant women in follow-up at specialized service and lasted until March 2021, with the end of HV with the last (17th) pregnant woman participating in the research. The visits were planned to occur every fortnight from the moment the pregnant woman was recruited until the first month of life of the child(ren) born. However, in light of what was experienced in each visit, the nurses decided to insert, when necessary, other visits.

High-risk pregnant women who participated in the research project were included after a high-risk pregnancy diagnosis and must be over 18 years of age, or, when adolescent, be emancipated. Those whose conditions interfered with women's abilities to get involved with the visitation, such as mental illness, severe cognitive and/or sensory deficit, were excluded.

The reflections in this report refer to visiting nurses' and support nurses' perceptions regarding the achievements in terms of care production arising from this HV. Support nurses are higher education professors who mediated dialogic spaces with visiting nurses and awakened reflection on the practice developed in the visits, clarifying and deliberating new behaviors considering the demand. This process took place on a monthly basis, starting from the meetings that were fully recorded in minutes. After the case discussions, the visiting nurses were instructed on how to proceed and intervene in the next HV. As a practical example of this support, we can cite the case of the birth of a child with a malformation in which the support nurses reflected on access, dynamics of Care Networks and bonding. After the reflections, the visiting nurses were able to clarify the women about their needs.

RESULTS

As part of presentation of results related to originated care production, a brief contextualization of the trajectory of construction and implementation of HV will be made.

A priori, the design of HV was aimed at adopting a visitation protocol for high-risk pregnant women, and three visits were carried out under this approach. However, care was sought that would promote genuine encounters between visiting nurses and high-risk pregnant women, aimed at understanding the entire phenomenon and women's and their families' real needs. Thus, team nurses' perception was that following the protocol was rigid and immobilized the meeting, depriving its dialogued nature and based on co-responsibility and collaborative construction of care. The protocol prevented the presentation of needs by women and families and tended to impose guidelines that were not those claimed by women.

Thus, given the concerns about the possibility of building singular care considering the adoption of a protocol guide and what to do with the guidelines considered there - gestational risk situation, issues related to childbirth and birth, rights, family and breastfeeding - the decision was taken to bet on the experienced interactions and on the subjectivities of each being that reveals itself in each interaction opportunity. In this sense, the protocol model was moved to a secondary place to be moved depending on what was exposed by each woman.

We then started to adopt a care practice through HV that would encourage pregnant women to participate in care production, when Paul Ricouer's[19] solicitude theoretical framework was deliberately incorporated into the ways we would walk in HV. The understanding was that it favored a professional attitude that was directed towards understanding the entire phenomenon and required availability for intersubjective relationships and dialogue, an aspect that was confirmed throughout the visits.

HOME VISIT AS A CARE PRACTICE

In all, 17 high-risk pregnant women accepted and received HV from diagnosis to the first month of life of the child(ren) born. A total of 130 visits were carried out, with an average time of one hour per visit. They were consulted by professionals from the outpatient clinic for monitoring high-risk pregnant women about the desire to integrate the intervention and, upon confirmation of interest, they were presented to the visiting nurses.

In the first HV to pregnant women, visiting nurses triggered the meeting through the following statements: "Tell me about you" and "Tell me about your life and pregnancy" as an incentive for

them to make a presentation of themselves and their lives, giving them freedom and an active space to speak. This fact proved to be relevant and powerful to promote the understanding of the phenomenon and a meeting, since the spaces provided for this in usual prenatal care were practically nil, since, according to their reports, a focus on the development of pregnancy prevailed. The women complained and denounced this way of being apprehended, thus, later on HV, the reports were discussed with the support nurses for reflection and targeting of interventions.

The subsequent visits were based on the bet on interaction, following the movements of each woman, the needs brought by them. However, under the understanding that we were also playing an important care role, child-mother context themes were addressed, always linked to what the women exposed, their revelations, for the construction of meanings. Theme planning and approach was prospected in a way that they transcended the biomedical order and did not build the interactions that were being built.

The construction of interactions based on visiting nurses' dialogue, reciprocity, compassion and availability to be with pregnant women was directly influenced by the theoretical framework. For the development of the visits, there was an understanding that the relationship with the other happens spontaneously, since there is recognition of the other by oneself and the other as oneself.[20] The context of solicitude calls for requirements that are not innate to individuals, requirements that, therefore, could be understood while HV was establishing itself as a practice of care.

A reflection of this, as HV was happening, pregnant women began to understand the home as a possibility of a space for care. Encouraged to dialogue, they developed trust, bonding with visiting nurses and felt free to exchange and dialogue. They revealed themselves authentically, participating in care production, sometimes sharing their doubts, sometimes raising issues to be explored, and so on in other visits.

Above all, in terms of time, pregnant women provided the opportunity for home care, as the space of the doctor's office did not explore their participation, another recurring complaint. A point to be highlighted in care production is that visiting nurses used the longitudinal care strategy. In other words, it was agreed to keep the same visiting nurse from the beginning of visits until the end of their development, in order to strengthen the bond and promote a more effective interaction, an aspect that was successfully achieved in care production. This aspect also favored the consolidation of the bond between nurses and pregnant women, in addition to trust, security and authenticity in interaction.

Finally, from the point of view of all nurses involved with the experience, it promoted professional and personal growth. As a common point, before the experience, we already believed in the possibility of care productions based on genuine encounters. Afterwards, we left even more strengthened to encourage care and practices that value respect, solicitude and, above all, focused on women's real health needs and leading role. In this direction, it is essential to reach availability and authentic encounter, which have in the items nurses' solicitous attitude and their going home, fruitful determinants and promoters of authentic encounter, moral promoter of welcoming needs, with unique care production.

DISCUSSION

The experience reported allowed us to reflect on the potential of HV under the solicitude framework as a promoter and edifier of singular and comprehensive care.

The practice of visiting alone, without anchoring professionals' attitudes, is not sufficient for dialogical and revealing needs. From the perspective of solicitude, understanding pregnant women as protagonists and valuing interactions at each meeting, HV, as reported here, allowed for relational involvement, strengthened the bond and favored care production.

The starting point for care reconstruction for high-risk pregnant women in this experience is the consideration that the care relationships that are built in a specialized service, or even in PC, they are located exclusively in the phenomenon of gestational diagnosis, in the imminent risk of maternal and child morbidity and mortality.[22] It is observed that the spaces forged to build care precarious the interaction of those involved and deny it to the background, because they look at the relational processes and the encounters produced by the subjects as obscurantism, to the detriment of valuing other knowledge, said to be more scientific.[23,24]

Thus, care production implies encounters.[23] For developing a relationship that adopts a reconstruction paradigm, the effective and active inclusion of users is necessary, in this case, to high-risk pregnant women as protagonists of their own lives, including in circumstances of emotional and biological fragility,[25] as the phenomenon of living at high risk refers.

It is necessary to deconstruct the place where pregnant women, and women in general, were placed as the object of health actions and practices. Only in this way and from there care production will be motivated from the perspective of a more comprehensive model.[23,25]

PC is added to its organization in delimited territories and for having HV in its set of praxis.[26] Placed in the Brazilian National Policy for Primary Care (PNAB - *Política Nacional de Atenção Básica*), since 2017, PC has been recommended to provide care to meet person-centered care. According to Moira,[27] this care takes place when the protagonists find a common field to address concerns and then exchanges are made possible for the decision-making power of health issues. Therefore, it is expected from health professionals, attitudes that value persons' autonomy and leading role, as well as the professional as a person.

In this sense, HV can be worked on and used as an alternative and starting point for new interactions with high-

risk pregnant women. The home space promoted greater safety, comfort and autonomy for women in care production. Above all, in recognition as a space that refers to memories of pregnancy, living and being now[23] made women express themselves freely with visiting nurses, sharing their lives, their anxieties and happiness, recognizing the prominent place of each one in living high risk.

In the meantime, in order for this self-recognition to be legitimate and continuous, it is inferred here that internationally disseminated HVP should reinforce information on how care is produced through visits. In the understanding that high-risk pregnant women, especially women in situations of vulnerability and poverty, need and have more positive outcomes when receiving HV,[16,27] such care must be disseminated by health professionals, aiming at the numerous benefits for women during pregnancy,[28] as well as the window of opportunity during the gestational period for other issues in life, such as coping with violence, parenting, mental health issues, among others.

Finally, it is noteworthy that care production, even through HV, a privileged space for building relationships, implies for nurses or other health professionals' attitudes that overcome the one-sidedness of biomedical paradigms, with investment in dialogical relationships, and broadening the view and listening to the complexity of pregnant women's lives.[29]

Believing that this attitude can indeed be developed while taking care, the concept of solicitude was pertinent in the experience of conducting HV in this study. The solicitude understands that not all intersubjective relationships are between equals. In other words, it includes relationships with oppressed people, in situations of vulnerability and suffering, for whatever reasons. Thus, starting from this assumption, it is necessary to understand and accept the existing differences, respecting the other, beyond the moral issues. The concept of solicitude is based on the possibility of opening and welcoming others and restores the balance of reciprocity between unequal relationships.[21]

For Ricouer,[19] the proposal of solicitude should not be confused with pity, as all relationships involve reciprocity, even if the person receiving care only shares their suffering with the other who is sharing compassion and sympathy.

Bringing to the present experience, the production involved meetings between pregnant women and nurses in the practice of HV. The results revealed and previously prospected only flourished in the face of favorable therapeutic environment that was created. Nursing and HV already have the potential for such a conception,[22] but it only materialized amidst the solicitude.

Nurses' choice as a visiting professional was intentional, when it was thought that, in addition to technical-scientific knowledge, it brings in its academic training foundations of humanization that favor reception and the creation of a bond. Thus, nurses' differential is built through care. When open to becoming, their knowledge and intentions are revealed and externalized, a process that takes place through human interaction in the recognition of nurses as a relationship being.[30]

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

The experience of developing and carrying out HV as a practice of care and under the auspices of solicitude proved to be a tool that promotes care production through established relationships. From the authors' perspective, the experience further enhanced the understanding that intersubjective interactions are necessary for care and are revealed through it. For pregnant women who received HV, it is assumed that the experience of producing care was transformative and significant in living the pregnancy under high gestational risk.

Considering that the phenomenon of pregnancy at high risk involves several aspects, it seems to us that care production exposed here is inconclusive. Thus, as limits, it is clear that there are other aspects that can be sought and strengthened in home visitation, from a perspective of rights, as well as care production for other subjects that involve high-risk pregnant women's lives, such as the partner, family and the network of services used by these pregnant women. So, in order that this work does not end here, we suggest further research with HV to high-risk pregnant women.

Elements such as access, equity, vulnerability and comprehensiveness in health were present in the present experience and enabled the construction of care that would overcome the exclusively technical and biomedical gaze insufficiencies that is usual in Brazilian health care. HV reflected and welcomed the real health needs of pregnant women, overcoming the gestational risk, but also in light of living conditions and family functioning, when nurses made themselves truly available to pregnant women, fighting with them to embrace the denied needs and rights.

We hope that this experience will sensitize health professionals, especially nurses, in care production and that they seek to reconstruct practices in the phenomenon of high-risk pregnancy, as it touched and motivated us to do so.

AUTHOR'S CONTRIBUTIONS

Experience report design. Bruna Felisberto de Souza. Monika Wernet.

Information collection. Bruna Felisberto de Souza. Bruna de Souza Lima Marski.

Exepience analysis. Bruna Felisberto de Souza. Bruna de Souza Lima Marski. Maria Aparecida Bonelli. Mariana Torreglosa Ruiz. Monika Wernet

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Responsibility for all aspects of content and integrity of the published article. Bruna Felisberto de Souza. Bruna de Souza Lima Marski. Maria Aparecida Bonelli. Mariana Torreglosa Ruiz. Monika Wernet

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