Prenatal care from puerperal women's point of view: frommedicalization to the fragmentation of care*

ATENDIMENTO PRÉ-NATAL NA ÓTICA DE PUÉRPERAS: DA MEDICALIZAÇÃO À FRAGMENTAÇÃO DO CUIDADO

ATENCIÓN PRENATAL EN LA VISIÓN DE LAS PUÉRPERAS: DE LA MEDICALIZACIÓN A LA FRAGMENTACIÓN DEL CUIDADO

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ABSTRACT

This qualitative and exploratory-descriptive study aimed to reveal the perceptions of puerperal women about prenatal service care. The data collected through semi-structured interviews were submitted to thematic analysis and consisted of the opinions of eight puerperal women. The access, booking of consultations and provision of priority services in case of complications were highlighted as qualifiers of the prenatal care. The study revealed limitations concerning the comprehensive care, humanization, sheltering, bond absence, indiscriminate use of technologies and unnecessary interventions, which can produce or enhance vulnerabilities. The results indicate the necessity of refocusing attention to the prenatal period and birth, under the longitudinality of care aspect, both in public and private services; pact of actions between the related sectors to promote women's health is necessary to support the formulation of more equitable and positive public policies for comprehensive care perspective.

DESCRIPTORS

Obstetrical nursing
Prenatal care
Comprehensive Health Care
Health vulnerability

RESUMO

Este estudo qualitativo e exploratório-descritivo objetivou conhecer a percepção de puerpéras sobre atendimento em serviço de pré-natal. Os dados coletados mediante entrevista semiestruturada foram submetidos à análise temática, tendo por sujeitos oito puérperas. O acesso, agendamento das consultas e atendimento prioritário em caso de intercorrências foram destacados como qualificadores da atenção pré-natal. O estudo apontou fragilidades no que tange à integralidade, humanização, acolhimento, ausência de vínculo, uso indiscriminado de tecnologias e intervenções desnecessárias, as quais podem produzir e/ou potencializar situações de vulnerabilidade. Os resultados sinalizam a necessidade de reorganização da atenção no pré-natal e nascimento, sob a lógica da longitudinalidade do cuidado, tanto nos serviços públicos como privados e de pactuação de ações intersetoriais nos modos de promoção da saúde das mulheres e de fomento à formulação de políticas públicas mais equânimes e positivas na perspectiva da integralidade da atenção.

DESCRITORES

Enfermagem obstétrica
Cuidado pré-natal
Assistência Integral à Saúde
Vulnerabilidade em saúde

RESUMEN

Estudio cualitativo, exploratorio-descriptivo, objetivando conocer la percepción de puérperas acerca de la atención en servicio de prenatal. Datos recolectados mediante entrevista semiestructurada y sometidos a análisis temático, siendo los sujetos ocho puérperas. El acceso, marcado de las consultas y atención prioritaria en caso de emergencias fueron destacados como calificadores de la atención prenatal. El estudio determinó fragilidades vinculadas a la integralidad, humanización, recibimiento, ausencia de vínculo, uso indiscriminado de tecnologías e intervenciones innecesarias, las cuales pueden generar y/o potenciar situaciones de vulnerabilidad. Los resultados expresan la necesidad de reorganización de la atención en el prenatal y el nacimiento, en la lógica de la longitudinalidad del cuidado, tanto en servicios públicos como privados; y de acuerdo de acciones intersectoriales en los modos de promoción de salud de la mujer y de fomento a la formulación de políticas públicas más ecuánimes y positivas en la perspectiva de la integralidad de la atención.

DESCRIPTORES

Enfermería obstétrica
Atención prenatal
Atención Integral de Salud
Vulnerabilidad en salud

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INTRODUCTION

The process of birth, which is understood to involve the period from gestation through parturition, puerperium and certain aspects of parenting, is a complex experience that may produce vulnerabilities in women[1]. The complexity stems from the intertwining of biological, psychological, emotional, relational, sociocultural aspects and gender issues that are inherent in this process. Vulnerability, which is a notion that goes beyond the idea of susceptibility or fragility, unites the exposure and protective factors of this process, which may be individual, collective (or social) and related to government policies and programs (e.g., large or focal, sectoral or intersectoral)[1-2]. From this perspective, the high rates of caesarean and maternal and perinatal mortalities represent some of the vulnerable situations to which women are exposed during the pregnancy-puerperium period.

In recognition of these characteristics of the birth process, the Ministry of Health (MH) has in recent years assumed, as one of its commitments, the promotion of safe motherhood. Accordingly, it has adopted strategies such as increasing the remuneration for natural parturition, limiting the payment for caesareans by the Unified Health System (SUS), promoting safe motherhood, and expanding humanized prenatal care[3-4]. Under this logic, the Family Health Strategy (FHS) was implemented, and this policy prioritizes actions to promote the health of families, with an emphasis on responsibility for primary health care and co-responsibility for promoting comprehensive care. Thus, the restructuring of the country's health care model and the strengthening of primary health care through FHS has resulted in the prioritization of promotional activities, including those specific to the pregnancy-puerperal period[5]. To this end, the MH recently launched the Stork Network (SN) to implement a network of care that ensures women the right to reproductive planning and humanized attention to pregnancy, parturition and the puerperium period; in addition, children are ensured the right to a safe birth and healthy growth and development. The ultimate goal is to structure and organize the attention to maternal and child health in the country[6].

However, studies indicate that the expansion of primary care and the amplification of care during the pregnancy-puerperium period have not yet altered the picture of maternal and perinatal morbidity and mortality [7-8].

Notably, in addition to the SUS, health care in Brazil comprises a state-owned sub-sector, which is composed of SUS services and complementary actions (i.e., contractor, private sector and nongovernmental) services, but not of the state, and a supplemental sub-sector of private enterprise was formed to provide actions and services such as health plans and health insurance, which are controlled by the state[9].

In the context of the present study, which was conducted at a municipality in the state of Rio Grande do Sul, women constitute 51% of the total population of 34,328 inhabitants; 61% of these women are of childbearing age[10]. The municipality has five health units linked to the FHS, and maternal care and childcare are centralized in a Basic Health Unit (BHU), which is located at the city center. According to data from the Information System of Live Birth (SINASC)[11], the percentage of cesarean parturition in this city was 81.3% in 2007 and 82.7% in 2008, which possibly indicates the progressive process of medicalization of parturition. Based on this scenario, the data presented are emblematic of deficiencies in the health care of women during the pregnancy-puerperium period, allowing for the argument that this factor is one of the critical nodes within primary care in this county and does not differ from the national scene[7-8].

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Given these considerations, the aim of the present study was *to reveal the perceptions of puerperal women regarding prenatal care in a city in the interior of Rio Grande do Sul/RS.*

METHOD

The present investigation was a qualitative[12] and descriptive study. The subjects were eight puerperal women, who met the following inclusion criteria: women who were up to the forty-fifth day postpartum, were living in the city, and had used public health services and the Supplemental Health Network (SS). The initial contact with the potential subjects, the purpose of which was to invite them to participate in the study, occurred in the vaccine room of a BHU that specialized in maternal and child care. At this location, procedures such the Guthrie Test and immunizations are performed, as a rule, in the presence of the mothers.

Of the individuals who agreed to participate, two subjects were enrolled at FHS A, two subjects were enrolled at FHS B, two subjects were enrolled at a BHU that specialized in maternal and child health and two subjects sought prenatal care within the SS. The data were collected at the homes of the participants, using semi-structured interviews that were conducted by the same interviewer, with an average duration of 45 minutes, during September and October 2010.

The interview was guided by the following questions: Where have you undergone prenatal care? Tell me about your prenatal monitoring. During pregnancy, have you participated in any educational activity? If yes, tell me

about it. Whom did you normally seek for advice when in doubt about your health state during pregnancy? Talk to me about this. Prior to the interviews, the respondents signed the Informed Consent Term (ICT), their responses were recorded and transcribed, and the data were submitted to thematic analysis[12]. To identify the participants, the letter S followed by ordinal numbers from one to eight was used at the end of the excerpts from the verbal responses. The study was approved by the Ethics Committee of the Santa Maria Federal University under No. 23081.011803/2010/12, respecting the ethical and legal issues of Resolution 196/96.

RESULTS

At the time of the present study, five of the eight puerperal women were married, and the other women were single. The subjects were between 19 and 38 years old. As for occupation, two individuals were students, one was a secretary, one was a teacher, one was a Christian minister, and three did not have professional activities. Regarding pregnancy and parturition, five subjects were primiparous, and the others were multiparous; six subjects gave birth by caesarean section, and two gave birth by vaginal parturition.

The data revealed the focusing of attention to pregnancy and puerperium cycle in a specialized BHU.

> If the obstetric care was located here in the neighborhood, it would have been better. And the person who does not have a car to go {to the specializes unit}? Here are buses, but only every half an hour (S3).

All of the participants reported attending, on average, ten prenatal consultations, although the MH guidelines[3-4] recommend six prenatal consultations and one puerperal consultation. There was consensus among the puerperal women that the appointment facilitated the continuity of prenatal care because by the end of each consultation, the patient was already scheduled to return the following month.

> The schedule also works well. I thought it was great (...). Every month had a consultation. Scheduled the time, you would arrive there and were attended (S3).

The easy accessibility, in cases of medical complications before the scheduled consultation for the following month, was highlighted as positive by the puerperal women, who reported having priority in attending to their demands.

> (...) If we got sick, with some pain, or if we needed to go there {to the basic health unit}, they would receive us (S8).

When mentioning the reasons for accessing prenatal care within the SS two puerperal women who received this care mainly reported accessibility issues.

> I did not have time to schedule the consultation through SUS. There, the office is very good. The location is central. I always scheduled {the consultations} quickly. (...) It was very good! (S1).

Most of the study participants (except for two subjects), did not participate in health education activities. This finding was an emblematic example of disagreement with the MH guidelines[4-5] and with the policies developed by the city, which has not always prioritized the educational component as a strategy for promoting health care in the context of prenatal care, as reported by the participants:

> Would {have attended the activities in health education} if it had, but it hasn't (...); so then, we have to fight with the things we have (S4).

> Here at the health unit {FHS} was a group of pregnant women, in which I participated, where there were lectures {and} guidance on the postpartum {period}, all very interesting (S3).

In the SS, such actions are not practiced, as expressed by a participant:

> Unfortunately, I was not in any group, but I would have gone. I could have learned more things (S1).

Regarding the information/guidance regarding prenatal care that was received by the women who accessed the supplemental sub-sector, the statements substantiate the fragility of the attention regarding the (im)possibility of the choices offered for health care, to the extent that their actions are driven by biomedical logic that often ignores the role of women as subjects of this process.

> The consultations were good, although I think they were fast. Sometimes, I needed to take a list of questions I had to ask because he {the doctor} is very fast, and I ended up forgetting to ask things (S1).

> I had no information, hence, only the consultations as a source. The doctor did not clarify any doubts. Things I did not ask him he did not mention, only what was asked to him(S2).

The information received on prenatal care was notably focused on promoting a healthy pregnancy and preparing for the maternal role. The guidance focused on the baby's health and neither on the mother herself nor on the intimate, subtle, diffuse or objective concerns of the mother, as expressed by one of the puerperal women, as follows:

> (...) They talked and taught how to give a bath, give the breast, about feeding the baby, applying rash ointment, a lot of stuff about the baby (S5).

Analysis of the data revealed that family members and other women with previous experiences related to the pregnancy-puerperal cycle were the main references consulted by the participants in the present study when they required information during the puerperal period. Indeed,

most of the subjects cited support from their family and social networks support as an important benchmark in health care.

> Information, readings, magazines, books and the Internet - a lot of reading. We talk with other pregnant women: my mother, my sister, and my relatives (S1).

The study also revealed excessive solicitation of laboratory exams and prenatal scans, both for those women who received care in the public system and for those patients using the SS. Regarding the women who received prenatal care within the SUS, one possible explanation is that the same tests were repeated monthly under the established routine service because every month, the pregnant women consulted with a different doctor, as reported by the interviewee:

> Each one of them requested a review, so I was always submitted to the same exams every month (S4).

The data analysis revealed that the prioritization of diagnostic technologies appeared to focus much more in medical claims than those that could have been brought by pregnant women if they were offered opportunities to be listened to, which would have facilitated the emergence of other demands (i.e., not noticeable from the clinician's point of view but extended to other aspects involved in the production of health). These additional elements are critical for a high-quality obstetric evaluation. A similar situation was reported by six women who sought prenatal care within the public network, which required them to undergo several ultrasounds and to submit, on average, to at least five exams and, in some cases, even more:

> We did two ultrasounds when I was there in the first weeks. Then, we did another two when I was five and six months, so, one more when closed the seventh, to see if it had already turned {to cephalic presentation} and the last was just before the birth (S4).

In the context of the study, all of the pregnant women should have held consultations with the three obstetricians who provided prenatal care, being justified by the fact that their parturition would be assisted by one of these professionals, once the assistance to the parturient in the hospital occurs as part of its planning.

> Prenatal care was good, I just do not like that it is now obligatory, one must consult with the three {physicians} because there {in the hospital}, at the time, we give {birth} with a SUS physician who was there. Like me, I had not consulted even once with the doctor that did my surgery (S5).

There was a consensus among the participants that the possibility of choosing a professional to perform the parturition would occur only upon the payment of fees.

> Only if we pay, if we do not pay it is by SUS, so it is the doctor who are on duty (S6).

As for the type of parturition, of the eight puerperal women interviewed, six underwent a cesarean section, which confirms the high percentage of surgical parturition in the municipality of the study[11].

> He could not make natural parturition, just cesarean because he [baby] was generated sat, after twist and then turned back, there he was with the umbilical cord wrapped around his neck (S8).

DISCUSSION

Based on the presented results, it is worth noting that the present study revealed the perspective that care[13] is more than an act, but it is an attitude and comprises more than a moment of zeal, attention and devotion. Caring implies an attitude of occupation, concern, responsibility and emotional involvement with the other. These elements are ratified by procedures such as sensitive listening, embracement of demands, bonding and co-responsibility for the social production of health, which are grounded in assumptions of the humanization of care and of comprehensive care.

The data revealed a contradiction concerning the MH propositions, which advocate decentralization, humanization, comprehensive health care and equity, corroborated by the guidelines of the Program for Humanization of Prenatal and Birth (PHPB), the National Humanization Policy and the Pact for Life to Defense the SUS. Possibly, this contradiction is justified by the incipient process of organizing and structuring some of the FHS teams in the city under study. This situation is problematic because it causes certain difficulties in the access of pregnant women who need to move from its health unit of reference (territory which are ascribed) to the city center for prenatal care, in that geographical proximity to the residence of the pregnant woman is a criterion for the location of this monitoring, according to PHPB guidelines[3].

Healthcare researchers[14-15] have aggregated their findings on access, characterizing it as the pursuit of the satisfaction of health needs and the possibility of achieving care, which is guided by the logic of solving problems. Accessibility to health services goes beyond the geographical dimension, the difficulties faced in obtaining care (e.g., queues and the waiting time) and the treatment received by the user. By this logic, inclusion and connection are powerful devices for the reorganization of current practices in health services, aiming at comprehensiveness, humanization and qualification of attention during the pregnancy-puerperium period[14-15].

In addition to the implications arising from the difficulty of access reported by the participants, there is discontinuity of care and fragmentation of the bond with the FHS professionals who have formerly been a reference for health care, which imposes upon the SUS patients the requirement to transfer to a new team, which will also be soon interrupted during the puerperal period.

The World Health Organization (WHO)[16] proposes a model of care for pregnant women, consisting of four prenatal consultations and one postnatal consultation using procedures that are based on scientific evidence. However, in the present study, all of the participants reported having, on average, ten prenatal consultations.

Despite the participants' significant number of prenatal consultations, none of them exhibited gestational risks that justified the requirement for this number of medical consultations. A study published in the Cochrane Review[17] did not demonstrate, in low-risk pregnancies, any differences in maternal and perinatal results with four versus six visits. Moreover, a prenatal consultation, by itself, does not always provide quality service, nor does it guarantee a reduction in the rates of maternal and perinatal morbidity and mortality[3-4,7-8].

During the prenatal period, educative practices that are rooted in emancipatory approaches (namely, more problematizing behaviors than informative behaviors) enable the pregnant woman and her family to understand the gestational process and birth; to express concerns and feelings; to clarify questions; and to provide listening spaces and dialogue between professionals and the users of health services, with emphasis on individual and collective mobilizations that are directed to healthy living and happiness[2]. Such activities should be prioritized because they constitute qualifying elements that contributing to female empowerment; thus, in exercising their sexual and reproductive rights, women may redeem their autonomy and leadership regarding healthcare choices and may achieve their therapeutic goals during the process of pregnancy and birth[4].

In the SS, educational practices were not available, which reinforces the understanding that, in this sub-sector, attention to prenatal care and birth tends to remain vertical, medicalized and interventionist, devaluing the potentiality of the educational component as a qualifying element of care and health promoter.

Although not found in puerperal women, it is possible to infer from their statements that, on the dynamics of prenatal consultations, the informative component was not a prioritized aspect in both, the SS and primary care. By giving visibility to the need to produce more privileged spaces for listening in the professional-user relations, this problem also signals the urgency of investment in the relational component of care[13]. From this perspective, it is for managers, health care providers and professionals to incorporate the educational dimension in the process of care in health, thereby permeating every plan and proposition of the health-related programs of teams/services or of sectoral/intersectoral public policies.

Despite the unlikelihood that the study participants remembered all of the guidance received during the prenatal period, the interest in knowing the content of the information provided was due to the excessive number of consultations performed by these women, both in public service and in the additional health sub-sector.

The emphasis on child health that was revealed in the data could be problematic because many of the health education activities do not include the woman as the subject of this process and appear to be permeated, to some extent, by regulatory interventions, hygienist characteristics and idealistic and disciplinarian models in certain wayd to exercise maternity[1.18]. In the present study, it is possible that other issues were addressed during the prenatal care, but possibly, the most significant were recorded for the participants and were therefore the most remembered.

The recommendation is that attention during the prenatal and puerperium periods be provided by multidisciplinary health care team, organized to meet the needs of women in their family and social context[3-4]. One strategy that may ultimately transform the scenario under study and contribute on the qualification of this attention refers to the inclusion of nurses in prenatal care for low-risk pregnancies because its humanistic formation is anchored in frameworks of education and promoting health as inseparable axes of nursing care.

Regarding the request for exams, research about prenatal care in the supplemental health sub-sector indicated that providing assistance is, *predominantly, synonymous of medical care and of biomedicine logic of care, namely, clinical-laboratory evaluation and monitoring in birth process*[19].

The fact that many of these exams, in the context of the study, were evaluated by a doctor who requested them in the previous months, or by a professional of a subsequent consultation, who, in turn, also requested new exams, signifies the abuse of diagnostic technologies, producing a vicious process that, besides burdening health spending, brand hegemony of the current medicalization of health. This process enables the removal of such problems from the contexts and social processes in which they are generated to link its articulation to certain investments of biomedicine, which seek to appropriate everyday problems and coat them with meanings, explanations and solutions that can, solely be handled, via the hegemony of certain types of knowledge[20].

According to the MH guidelines, there is no scientific evidence that the performance of routine ultrasonography during pregnancy has any effectiveness in reducing the maternal and perinatal morbidity and mortality[4].

This trend towards medicalization during the prenatal period and parturition is reinforced by the indiscriminate use of biomedical technologies, as if cesarean parturition was natural and always superior and safer for parturition. This assumption was shown to condition women to choose operative parturition, to the detriment of which would be *per se* a preparation for natural childbirth and, logically, from undergoing normal parturition[19-21].

Although the surgical parturition, when properly indicated, reduce maternal and perinatal morbidity and mortality, it should be noted that their risks are greater than those of natural parturition and that their indiscriminate practice, besides consuming resources of the health system, violates the exercise of the sexual and reproductive rights of women, who find themselves unable to become pregnant and to give birth free of interventions.

Generally, it is possible to infer that prenatal care appears dissociated from parturition and birth care, in this case study. This situation, besides violating the assumptions for attention to prenatal care and qualified and humanized birth, does not produce a bond due to the absence of a professional, which is recognized by users of the SUS as a reference for self care. This fact also implies the fragmentation of care practices and non-accountability of these health professionals in the women's health, which can produce and/or increase situations of vulnerability.

The humanization of care during parturition and birth assumes a political-relational dimension and implies a recognition by the user as being someone who is proactive in the production of their own health. Thus, an effective therapeutic relationship during this period requires the production of the bond, the ability to listen to the woman and her family's demands and to identify care needs and co-responsibility for the production of health, which goes beyond simple attendance.

Compared to the investigated scenario, which does not differ from other studies in the country[7-8], the results indicate that *it remains the challenge of the system of not taking the practice of parturition care as an isolated procedure, unrelated to prenatal care, and develop strategies for linking the different levels of complexity of care*[8]. This problem, by its nature and complexity, requires the mobilization and conjugation of actors that are involved in the social production of health; thus, collectively, efforts will be demanded in the manner that this practice effectively integrates the attention given to the pregnancy-puerperium period.

The appreciation of practices related and subjectivities involved in the care of women during the pregnancy-puerperium period constitutes a powerful device that brings more quality to attention and, most importantly, renders health services more receptive and resolute. This process requires monitoring by qualified professionals beyond the realm of clinical knowledge, namely, that the process of care involves soft skills, such as listening, bonding and inclusion, which are responsible for promoting the construction of individualized therapeutic projects. Thus, even if such elements ratify the assumptions of humanization and comprehensiveness of qualified health care, one must consider not only that the professional models in the health field are restricted to the prospects of unfolding process of work management, as that derives its materialization, but also that these models should include technical, relational, ethical, and above all, political conduct.

CONCLUSION

Once the perceptions of puerperal women are acknowledged, issues relative to access were highlighted as defining the quality of this care, both in the primary care and within the supplementary network. Possibly, this factor is due to attendance to the more immediate demands and health needs.

Generally, the understanding of how these puerperal women perceived the service received in prenatal reveals various situations of vulnerability, with implications for the organizational design of health services in focus, evidenced by poor articulation of care at pregnancy-puerperium period, materialized by fragmentation of care. This situation is problematic in that, before any clinical complications presented by a woman during this period, possibly, none among many and every professional who assisted her would recognize and consider the health of the woman and, more specifically, about the development of her pregnancy, parturition and puerperium, which can produce and/or potentiate situations of vulnerability.

The study notes weaknesses regarding the comprehensiveness of health care and the humanization of this attention, especially regarding the embracement and bond, indiscriminate use of unnecessary interventions and technologies and, above all, the current notion, legitimized by the language and the biomedical discourse, that the surgical parturition would be the outcome and appropriate *natural* for the birth.

The results of this study are not depicted in evaluating the prenatal care *per se*, which is beyond the scope of this approach. However, the observance of the elements discussed here, from the perspective of puerperal women who use the service of prenatal care, reveals the vulnerability of the same program, to contribute to managers, professionals, teachers and students of the health field coordinating efforts to rethink the actions addressed to the pregnancy-puerperium period in primary care, adding more resoluteness.

These reflections are intended to contribute to the production of subsidies for planning, implementation and monitoring the program goals, as well as the reorganization of healthcare within the context of longitudinal care, both in public and private services. These goals would provide intersectoral answers promoting the health of women and the promotion of public policies that are more equitable and positive from the perspective of comprehensive health care.

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