EXPERIENCES OF PREGNANT WOMEN ASSISTED IN SECONDARY HEALTH CARE

ABSTRACT

Objective: to describe the experiences of pregnant women attended in a Secondary Health Care Unit.

Method: exploratory-descriptive study, with a qualitative approach, performed at an outpatient clinic with 11 pregnant women in prenatal care. The information were produced from a semi-structured interview and analyzed through the technique of content analysis.

Results: the assistance was restricted to the medical consultation, highlighting the lack of actions of other professionals and the absence of interdisciplinary work.

Conclusion: the participation of the multiprofessional team in the gestational period is essential, in order to promote integral care and intervene in complications.

Descriptors: High-Risk Pregnancy; Secondary Health Care; Comprehensive Health Care.

RESUMO

Objetivo: descrever as vivências de gestantes atendidas em uma Unidade de Atendimento Secundário à Saúde.

Método: estudo exploratório-descritivo, com abordagem qualitativa, realizado em um ambulatório com 11 gestantes em acompanhamento de pré-natal. As informações foram produzidas a partir de entrevista semiestruturada e analisadas por meio da técnica Análise de conteúdo.

Resultados: constatou-se que a assistência ficou restrita à consulta médica com destaque para inexistência de ações de outros profissionais e ausência de trabalho interdisciplinar.

Conclusão: é essencial a participação da equipe multiprofissional no período gestacional, de modo a promover um cuidado integral e intervir em complicações.

Descritores: Gestação de Alto Risco; Atenção Secundária à Saúde; Assistência Integral à Saúde.

RESUMEN

Objetivo: describir las experiencias de las mujeres embarazadas atendidas en una Unidad de Atención Secundaria a la Salud.

Método: estudio exploratorio-descritivo, con un enfoque cualitativo, realizado en un ambulatorio con 11 mujeres embarazadas en control prenatal. Las informaciones fueron producidas a partir de entrevistas semiestructuradas y analizadas mediante la técnica de análisis de contenido.

Resultados: la asistencia se limita a la consulta médica, destacándose la falta de actuación de otros profesionales y la falta de trabajo interdisciplinar.

Conclusión: es esencial la participación de un equipo multidisciplinario durante el embarazo, con el fin de promover una atención integral e intervenir en las complicaciones.

Descritores: Embarazo de Alto Riesgo; Atención Secundaria a la Salud; Atención Integral a la Salud.
EXPERIENCES OF HIGH RISK PREGNANT WOMEN ATTENDED AT A SECONDARY HEALTH CARE UNIT.

INTRODUCTION

Pregnancy is a magical and delicate moment for women, because their bodies need to prepare to shelter and form a new being; however, there are people who are prone to develop complications, either for genetic reasons or for the influence of factors linked to their environment. Those complications during pregnancy, childbirth and puerperium are capable of culminating in maternal death, which may still be a consequence of iatrogenic conducts, which makes the investigation of all maternal deaths and women at reproductive age compulsory to identify the reasons that led to the deaths, for it is not an expected outcome in a pregnancy.¹

Prenatal care is a means to monitor the evolution of pregnancy and the baby development, in which professionals perform researches to ensure the necessary measures to preserve the health of the mother and child so that they experience a uneventfully childbirth. Among the benefits of skilled prenatal care is the prior preparation, through educational activities and attention to the psychosocial aspects of the pregnant woman.²

The pregnant woman classified as high risk should be referred to a secondary health service, where there is specialized assistance. According to the National Humanization and Birth Policy (PNHPN), that level shall ensure consultations to the pregnant woman, with special attention to her clinical condition, guarantee her reference and counter reference to Primary Health Care (PHC), offer a humanized reception and health practices based on scientific evidence that respects the individuality of each person, to the detriment of the cultural diversity of the individuals given their choices.³

The secondary level of health care has specialized assistance in outpatient clinics with technological resources to streamline diagnoses and direct therapeutic behaviors, and is part of the Health Care Network (RAS). The APS is linked to the secondary care, which gives users better results in health care, in which the performance depends on a work based on the integral care of the individual and on the organization of the referral flow in the Unified Health System (SUS).⁴

The Health Care Network consists of a set of services of different complexity levels, organized in technical, logistical and management support systems, whose implementation aims to add efficiency and effectiveness to health by creating health regions.⁵

OBJECTIVE

- To describe the experiences of pregnant women attended at a Secondary Health Care Unit.

METHOD

Study extracted from the Completion of Course Work << The care of high-risk pregnant women in a Secondary Health Care Unit >>, presented to the Federal University of Juiz de Fora, College of Nursing, 2014.

Exploratory-descriptive study, with a qualitative approach, developed at the outpatient clinic of an institution dedicated to the care of Women's Health, which is a reference in secondary care services in the SUS service network and covers more than 90 municipalities in the Zona da Mata region, in Minas Gerais, and some cities of Rio de Janeiro/RJ, Brazil. The health team of the mentioned Service consists of gynecologists and obstetricians, mastologists, nursing assistants, and nurses. In addition, it receives trainees from private institutions and the Federal University of the place, which also has links through extension and research projects.

In order to carry out the research, the Health Department of the municipality and of the service in which the study took place needed to authorize it. Next, it was submitted to the Research Ethics Committee, where it received the authorization, CAAE 20740113.0.0000.5147, for being in agreement with Resolution 466/2012 of the National Health Council.

Eleven pregnant women aged between 22 and 44 years who underwent prenatal follow-up in the secondary care participated in this...
study and were awaiting medical visits during the months of October to December 2013. The inclusion occurred by signing the Informed Consent Form (ICF). Five pregnant women were excluded: four of them refused to participate in the study and one was an adolescent. The exclusion criteria applied consisted of being 18 years old or less, being in the institution for the first consultation and not presenting cognitive conditions to answer the questions.

In order to produce the information, the interview used a guide with semi-structured questions. Pregnant women who was waiting for the consultation in the mentioned service were approached, invited to participate in the study after exposing the objectives of the research and attentive reading of the ICF. In order to meet the inclusion criteria, one verified the pregnant woman’s provenance at the delivery of the prenatal card to the reception staff.

After fully transcribing the recorded interviews, the researchers read them exhaustively in order to delimit units of meanings. Thus, it was possible to group the information, in which the women's statements were correlated with the theoretical basis of the research and with the reflections of the researcher. The content analysis technique was used in the information analysis for it is able to explore the material obtained in the interviews, seeking to establish units of records with clipping, enumeration, classification and aggregation in categories of information.6

RESULTS AND DISCUSSION

The interviewed pregnant women reported having one to six children, only one self-reported single regarding the marital status and the others were married or in a stable union. One woman reported a degree in pedagogy, another six reported complete or incomplete high school, and the others had complete elementary school.

From the analysis of the interviews, four categories of discussion emerged: Lack of Primary Health Care: demand for the specialized service; The experiences of the women attended at the secondary level of attention; The difficulties and facilities of the pregnant women assisted in secondary health care; and Evidence of integrality and interdisciplinarity in women’s speeches.

♦ Lack of Primary Health Care: demand for specialized service

Among the 11 participants transferred to the Secondary Level, five did not belong to the high risk classification, which shows a problem situation from the UAPS and the management of the place, since the professionals that work in the assistance must be able to identify the moment to refer the pregnant woman to a specialized level or to intercalate the consultations with other professionals according to the prenatal care protocol.1

Among the reasons that led women to the secondary level, there is, or not, the health service in the area where they live or the presence of some complication in the pregnancy, being the lack of the medical professional in the health team one of the justifications for the referral, showing a difficulty faced by several municipalities due to the high turnover of professionals. The following information enables verifying such situation:

[...] Sometimes it is necessary that you o have a more in-depth service not offered by the unit. (E9)

[...] When you are in your neighborhood and you are not attended there, they send you out. (E10)

When asked about the transfer to the secondary level of attention, some women claimed reasons associated with their health status. Others related to the fact that those professional services were more qualified in relation to where they came from, where they did not have similar professionals. Regarding the specificities of care at the secondary level, all were unaware of the name and characteristics of care organized by the health care networks.

Limited knowledge on the characteristics of each level of health care leads to population discontent, which may lead users to blame primary health care professionals for not being able to schedule specialized consultations and examinations.7

They do not care that much at the health center, as when I needed the exam, they do not care at all. Here, you get to be already attended, pass in to the next room, schedule and that’s it. (E6)

Such situation can lead to several conflicts, since users, unaware of the flow of the SUS, tend to display their fury at the units that are the gateway to the system, since some people do not understand that the difficulty to schedule consultations and examinations is due to the small number of professionals in the municipality and that the available vacancies are divided among all the contracted municipalities in the Zona da Mata region of Minas Gerais and some cities in the state of Rio de Janeiro.8

The entrance doors of the system are responsible for referring to the services
pertaining to hospital and outpatient care, and to those of a higher degree of complexity that require greater technological devices, thus guaranteeing the user the sequence of health care.  

Furthermore, the current context shows the displacement of patients from their coverage area to the Tertiary Care Units searching for medical consultations, overloading the hospitals with demands that should be assisted in the PHC, and proves the population’s lack of knowledge about the types of services that each level is responsible for granting users, as one participant states when saying:  

[…] I live in Neighborhood I, but most of them, like me, when they need it, go to the UPA (Unidades de Pronto Atendimento) of Neighborhood II. (E10)  

The system has difficulties to follow what the law determines, because the existing disinformation in the society interferes in the correct flow of users within the SUS, since “universal and equal access to health actions and services will be ordered by primary care and should be based on the assessment of individual and collective risk severity and chronological criteria”.  

Considering that the transfers must have a known cause justified by the presence of comorbidities, an adequate and illuminating language is necessary to communicate the referral to the pregnant woman, since the association with definitions that relate risk or danger can give them a feeling of fear capable of interfering in the gestational phase by raising physical and mental stress, which may affect family relationships and trigger changes in the clinical condition.  

The experiences of pregnant women at this level of health were concentrated in the medical consultations, with little or no participation of other professional categories. According to the reports, the consultations followed the doctor’s appointment and pregnancy-related intercurrences were attended in other levels, where the pregnant woman mentions:  

Then I look for another hospital, just as it already happened I looked for maternity, that’s how I do it. (E11)  

Regarding the continuity of care in PHC, only one pregnant woman maintained the bond in both units because she was satisfied with the consultation of the PHC nurse, characterized as attentive and present. However, the speeches show that, when they are transferred, they cease to be assisted in the UAPS, which differs from the PHPN that proposes the concomitant follow-up of the pregnant woman in the PHC and at the level to which she was transferred, in order to ensure her complete prenatal care in the late puerperium.  

The SHC nurses were not different from the members of the team, referenced by pregnant women as professionals responsible for performing reception activities related to the scheduling of consultations, examinations and medication delivery. Nevertheless, in APS, the nurse is recognized for other activities, such as consultations with women for screening for cervical and breast cancer, prenatal care, childcare, educational groups, among others.  

Such fact allows inferring that the nurse in the SHC presents low visibility and has presented difficulties to exercise the exclusive competences of the nursing, being, in some cases, overwhelmed by demands related to other professional categories. Yet, the institution receives pregnant women who nurses could accompany, either in the consultations or in operative groups, not mentioned by the professionals who attended them, revealing the absence of interdisciplinary and multiprofessional assistance, a situation incoherent with the description present in the literature for SHC, which is known to hold the necessary resources to assist the risk conditions.  

Although the participants are unaware that the nurse is a member of the team with the technical and scientific knowledge to carry out the consultation, Law No. 7,498 of June 25, 1986, and Decree 94,406/87 regulate it. Resolution COFEN 159/1993 defines that the Nursing consultation should include a broad interview, including the findings in the physical examination, followed by the systematized stages of Nursing care with the Nursing diagnosis, prescription and implementation of care and nursing evolution, being the consultation one of the nursing duties to be performed in public and private institutions. Nevertheless, the research revealed that the care received by the pregnant women in the institution remained restricted to medical consultations, characterized as:  

Look, I attended several consultations, both regarding medical consultation, as examinations, which are Ultrasonography examination, urinal examination, complementary exams. (E8)  

I’m not very happy with my doctor, because I’m not a doctor and at the beginning I had to keep asking, “Aren’t you going to measure my uterine height, are you?” I mean, some
things he should prescribe, I had to keep asking. And I’m not a doctor, I do not know everything that I have to ask for and I have to know (...). (E11)

The professional who attends pregnant women determines their position regarding the care, but, although some users are aware that the consultation does not correspond to the expected, they are grateful, since they left a reality where there was no professional to accompany them and that was the service where they got a vacancy to undergo the prenatal, as the user says:

It favored a lot, I could hear my baby’s heart, I could not do that nor anything. It’s much better here. (E3)

Other service users demonstrated expressions of revolt and discontent, given the attitudes of professionals who did not correspond to their expectations. They reported feeling depressed and insecure, with a tendency to originate phrases that designate the SUS as an inoperative system. Even though the SUS is a structured policy and with many therapeutic resources, it still faces difficulties for its effectiveness.

Comprehensive and humanized care encompasses the rights of all users, since units must implement it, both as a way to apply the recommendations of the law, as to ensure active social and family participation, regarding their health care and the therapeutic plans used in the treatments.¹⁷

♦ The difficulties and facilities of the pregnant women assisted in secondary health care

The transfer to the Secondary Level of Health Care consists of a need of the women who present the risk classification. However, the change can bring benefits as well as difficulties for the pregnant women, which can affect their emotional state and bring changes in their health state.¹⁸

Some of the mentioned difficulties are the doctor’s delay and the consultation with insufficient time to clarify doubts and exchange information, intolerance to the pregnant woman’s delay, even with a plausible justification, they are subject to lose the vacancy and have to wait for the next consultation. The same happens with the exams, if the pregnant woman does not take them on the day of the consultation, she has to wait for the next consultation to present them, which can configure a risk situation within a service that exists to attend the high risk.

Sometimes, scheduling the examinations that we need, perhaps with urgency, is very time consuming (...) we have to put it off, postponing, it is something that we could get the result before so we can treat before and we do not have that possibility. The consultation time is fast, it takes time for the doctor to arrive, after we go in, it’s a matter of 2 minutes to go out. (E11)

When you are 10 or 15 minutes late they do not attend you any more, so they tell you to re-schedule, but they can arrive late. (E6)

The Ministry of Health, in order to ensure a full and humanized care, determines that the professional responsible for high-risk prenatal care should perform a detailed care following the steps of “anamnesis with the general physical examination and gynecological obstetrics”, because, in that way, he/she will be able to intervene in a timely manner and prevent morbidities that may arise during pregnancy.¹

♦ Evidence of integrality and interdisciplinarity in women’s speeches

The interaction of the professionals is reduced and the working time tends to be occupied with other procedures, among them the bureaucratic ones. Although they recognized the lack of spaces in the service to talk about the changes of the body during the gestational phase and the need to prepare for childbirth and breastfeeding, pregnant women reported that they were not invited to participate in educational practices at any time.

The communication in the consultations is limited and, consequently, the guidelines are incomplete, since only the doctor has a greater contact with the pregnant women, which is a lacuna in the prenatal follow-up, a crucial moment moment to solve doubts, to transmit orientations and to constitute bonds, being essential to reduce the anxiety in pregnancy and in preparation for labor and delivery.¹⁹

Group-based health education consists of a strategy to promote and disseminate knowledge among pregnant couples by humanized care and the use of resources to favor the interaction, such as dynamics and educational materials. The group allows a collective growth and sensitizes the participants so that they are able to develop self-care within their health context.²⁰

When asked about the recommended physical training to facilitate delivery, all pregnant women say they do not know how to prepare for it. The focus on the individual, curative and biologicist care may characterize the absence of integrality, hampering visualizing the user as a whole within his/her context, and reducing health care to a curative assistance, which does not work health promotion.²¹
CONCLUSION

The obtained surveys can help promoting health and preventing diseases in the period from pregnancy to childbirth, puerperium, and in the care of the newborn. The scenario of the research was an institution of secondary level of health care, little studied in researches related to the service of greater complexity to pregnant women classified as high risk, which hampers directing actions and knowing reality. Nevertheless, entering that system and researching it are of paramount importance, since it allows correlating the existing policies for gestational care in the country with the results of maternal and neonatal mortality, which may reflect poor attendance during prenatal care.

It was possible to hear from the pregnant women what they thought of the follow-up they received, given the crucial social participation of users in Public Health, being a right to express their opinions and demand improvements. Thus, the study sought to analyze the statements regarding what the Ministry of Health recommends to high-risk pregnant women, but the study revealed that, when there is no medical professional to attend them at their place of origin, the UAPS refer them to secondary care, even though it belongs to low risk.

Moreover, participants’ statements show the lack of knowledge about the flow of users in the SUS to access the primary, secondary and tertiary levels of care, which explains the demand for care at levels that do not correspond to clinical conditions and the consequent disorganization of the System in the current context of health care units, with a high number of users awaiting specialized care.

There is a need to provide guidance to SUS users, either through educational practices or even through the media, in order to collaborate with the organization of health care networks and reduce demand that should be monitored at UAPS.

The fact that the studied institution offers only medical consultations to pregnant women contravenes what policies propose and reinforces the curative biomedical model, since pregnant women described that the assistance is not integral, does not count on interdisciplinary work and there is no referral or counter-referral.

One expects that this study may contribute to reflections and reformulation in the care services for pregnant women, both at primary as secondary levels, and with the training and qualification of professionals, especially nursing professionals, aiming to promote the health of the users of the health service, through multiprofessional articulation, as well as in care settings, through effective referral and counter-referral, and interdisciplinary procedures, based on the integrity of actions directed at pregnant women at all levels of health care.

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Submission: 2016/01/10
Accepted: 2016/11/09
Publishing: 2016/12/01

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