



Journal of Nursing

Revista de Enfermagem

UFPE On Line

ISSN: 1981-8963

ORIGINAL ARTICLE

SUSCEPTIBILITIES AND HEALTH PROBLEMS OF PREGNANT WOMEN: CARE ADOPTED IN THE FAMILY HEALTH STRATEGY

SUSCETIBILIDADES E PROBLEMAS DE SAÚDE DE MULHERES GRÁVIDAS: CUIDADOS ADOTADOS NA ESTRATÉGIA SAÚDE DA FAMÍLIA

SUCEPTIBILIDADES Y PROBLEMAS DE SALUD DE MUJERES EMBARAZADAS: CUIDADOS ADOPTADOS EN NA ESTRATEGIA SALUD DE LA FAMILIA

Daniela do Carmo Oliveira¹, Edir Nei Teixeira Mandú²

ABSTRACT

Objective: to analyze prenatal procedures of the Family Health Strategy (ESF) adopted in situations with possible negative repercussions for the woman and/or the baby. **Method:** this study is descriptive with a qualitative approach, carried out in five ESF, from an open interview with doctors and nurses, consultation with prenatal records, participant observation of consultations. The analysis of the information was performed by the Content Analysis Technique in the Thematic Analysis modality. **Results:** the behaviors are consistent with the perspective of privileged risk in prenatal care. There is the bond with the women to specialized prenatal care and guidance on the classification of higher risk and referral. The joint monitoring of the referenced woman and the offer of actions to support the family are non-systematic, transferring the responsibility of care to the referral service and the woman. **Conclusion:** Behaviors are limited from the perspective of the social determinants of reproductive health and the production of women's autonomy. **Descriptors:** Prenatal Care; Pregnancy, High-Risk; Health Vulnerability; Reproductive Health; Family Health Strategy.

RESUMO

Objetivo: analisar condutas pré-natais da Estratégia Saúde da Família (ESF) adotadas em situações com possíveis repercussões negativas para a mulher e/ou o conceito. **Método:** estudo descritivo, de abordagem qualitativa, realizado em cinco ESF, a partir de entrevista aberta com médicos e enfermeiros, consulta a registros pré-natais e observação participante de consultas. A análise das informações foi realizada pela Técnica de Análise de conteúdo na modalidade Análise Temática. **Resultados:** as condutas coadunam-se com a perspectiva de risco privilegiada no pré-natal; abrangem a vinculação da mulher ao pré-natal especializado e orientações sobre a classificação de maior risco e o encaminhamento feito. O acompanhamento conjunto da mulher referenciada e a oferta de ações de apoio à família são assistemáticos, transferindo-se a responsabilidade do cuidado ao serviço de referência e à própria mulher. **Conclusão:** as condutas revelam-se limitadas na perspectiva dos determinantes sociais da saúde reprodutiva e da produção da autonomia das mulheres. **Descritores:** Cuidado Pré-Natal; Gravidez de Alto Risco; Vulnerabilidade em Saúde; Saúde Reprodutiva; Estratégia Saúde da Família.

RESUMEN

Objetivo: analizar conductas prenatales de la Estrategia Salud de la Familia (ESF) adoptadas en situaciones con posibles repercusiones negativas para la mujer y/o el bebé. **Método:** estudio descriptivo, de enfoque cualitativo, realizado en cinco ESF, a partir de entrevista abierta con médicos y enfermeros, consulta a registros prenatales, observación participante de consultas. El análisis de las informaciones fue realizado por la Técnica de Análisis de contenido en la modalidad Análisis Temática. **Resultados:** las conductas están en línea con la perspectiva de riesgo privilegiada en el prenatal. Enfocan la vinculación de la mujer al prenatal especializado y orientaciones sobre la clasificación de mayor riesgo y las indicaciones hechas. O acompanhamento conjunto da mulher referenciada e a oferta de ações de apoio à família são assistemáticos, transferindo-se a responsabilidade do cuidado ao serviço de referência e à própria mulher. **Conclusão:** as condutas revelam-se limitadas da perspectiva dos determinantes sociais da saúde reprodutiva e da produção da autonomia das mulheres. **Descritores:** Atención Prenatal; Embarazo de Alto Riesgo; Vulnerabilidad en Salud; Salud Reprodutiva; Estrategia de Salud Familiar.

¹Nurse, Master's degree in Nursing, Professor of the Nursing Undergraduation at the University of Mato Grosso State/UNEMAT. Tangará da Serra (MT), Brazil. E-mail: danielacarmoliveira@gmail.com; ²Nurse, Ph.D. in Nursing, Professor of the Undergraduate and Post-Graduation in Nursing of the Federal University of Mato Grosso/UFMT. Cuiabá (MT), Brazil. E-mail: enmandu@gmail.com

INTRODUCTION

Although healthy, pregnancy puts the woman in a group of greater vulnerabilities, requiring special care. However, susceptibilities and consequent occurrences, in many of them, reaching higher levels of concern. These **special situations** cause or can cause negative repercussions to the woman's health and/or the baby, of different severities, and requiring **special care actions** by the health services, in principle of the basic network, responsible for diagnosing the situation and to carry out and articulate the necessary care, in the service, in other health services and with the social network.

These special care actions are part of the **care actions** directed at pregnant women, in which certain health needs are considered, based on privileged social purposes for prenatal care and other proposals and possible to be adopted by professionals in their daily lives.

This socio-historical and intersubjective production¹ has been specially guided by the current biomedical model, in which the approach to the susceptibilities and health problems arising from pregnant women is privileged from a risk perspective. This occurs both in the direct care of the woman and the family and in the indirect care provided through management, especially in the articulation of necessary health actions.

The risk perspective is based on knowledge of classical or risk epidemiology, identifying by cause-and-effect studies, the probability of occurrence of an unfavorable outcome, of a biological damage or a non-desired phenomenon.² Thus, in the clinic, the susceptibilities are interpreted as resulting from factors that increase the chances of illness when present, recognized from this reading. Thus, reproductive health care identifies and controls individual, social, and environmental factors that classical epidemiology indicates to increase the likelihood of illness, injury, or harm to women's reproductive health and/or the health of the developing baby. Likewise, care identifies health problems as early as possible and performs preventive and clinical-obstetric care of interurrences, giving priority to possible or occurring morbidities through care behaviors that emphasize, above all, medical and individual aspects.

In the Family Health Strategy (ESF), prenatal care has incorporated this important purpose, constituting a strategic action prioritized in these terms.³⁻⁴ This orientation, in its developments in clinical practice, has contributed greatly to the preventive and clinical-obstetric control of maternal, fetal and neonatal morbidity and mortality.⁵

Despite this importance, this perspective is neglected by the correlation of reproductive health

with the overall life process of the woman, and by the sociocultural, relational and intersubjective character of the woman. That is, the reading of the susceptibilities and health problems of pregnant women disregards both the causes of the problems and several of them, distancing them from the integrality of women's lives and the complexity of the interrelation between reproductive health and multiple intertwined aspects - environmental, social, cultural, institutional, community, family, individual.

The pragmatic and probabilistic nature of the epidemiological approach to risk allows for a potentially permanent expansion of the investigation of the causal association between any events of interest. However, its epistemological characteristics compromise the objectification of the social dimensions of health and disease.⁶

Thus, the risk tool migrates from the macro level of the socio-demographic context to the micro level of personal characteristics, subjectivities, behaviors. This reduction is also characterized by the fact that only certain risks are privileged by the health services, as well as certain ways of dealing with them.

The notion of vulnerabilities, under construction in the social epidemiology area, is intended to offer new elements to the broader understanding of risk, although it does not deny the importance of this and prevention practices. This notion aspires to give meaning to the interweaving between individual and contextual conditions in the production of fragilities and the exposure of people not only to diseases but also to suffering and limitations in the development of existing own and environment potentials.⁷

When professionals approach the susceptibilities and problems from the perspective of the vulnerabilities of pregnant women, considering them in their clinical actions, they extend not only the health diagnosis, but also the care behaviors, based on the comprehensiveness and concret of the health needs of those women and through theoretical-methodological and practical contributions that deal equally with the web of causality of health and reproductive disease.

From this point of view, prenatal actions of both prevention and health promotion are relevant. The health promotion is stated as one of the strategic areas of the ESF, to be worked in a way that is both outstanding and transversal to other assistance actions⁸, such as prenatal care.

Prenatal care at ESF is the subject of many studies. However, in them, as workers make diagnoses and conduct behaviors in special situations (vulnerabilities and/or risks) they have not been treated in their specificities and movements. Both perspectives are not addressed in

their care unfolding, and there is a gap in the academic literature in this regard.

Thus, the study presented here analyzes the professional care behaviors adopted and affirmed against special situations in the prenatal ESF and reveals if there are advances towards the approach to the social determinants of women's reproductive health. It is expected to contribute to the improvement of prenatal care, considering the importance of both the appropriate risk approach and its extension to the approach of vulnerabilities, providing elements to the construction of integrality in the health care of pregnant women in the ESF.

MÉTODO

This work is part of a qualitative research carried out in five Family Health Units (USF) and a reference hospital for high-risk gestation, located in Cuiabá, Mato Grosso, Brazil. It addressed care by professionals and pregnant women in situations in which their health and/or the baby's health were susceptible to problems or compromised by them, called in the biomedical model as higher risk pregnancies. The theoretical tools of analysis used were extracted from classical epidemiology and social epidemiology and a reading considered the social and intersubjective nature of health work.

Here, there are the results regarding the professional care of physicians and nurses who work in ESFs, because they participated in the care and referral of the participating women (twelve), selected in a referral hospital. Five nurses and five physicians (identified respectively with the letter "N" and with the letter "D" followed by an identifier number of 1 to 5), five USFs (identified from "A" to "E"), corresponding to all available individuals.⁹ Although nine ESFs were identified, four were excluded because in two of them the nurses were away from the activities, and in the other two, these professionals did not accept to participate in the research.

In the ESFs, which were composed of a minimal team, prenatal care consisted basically of pre-consultation, medical consultation, nursing consultation, a routine home visit by Community Health Agents and, eventually, by doctors and nurses, as well as health education. The first consultation was done by the nurse, and the subsequent consultations were done with the doctor. Referral to specialized prenatal care was performed by both, with some complementarity of action between nurses and physicians.

The empirical construction of the research in the USF space occurred in 2013, from the previous integration with the teams. An analysis of prenatal records (card and chart of the twelve referenced pregnant women included in the study and control book of the professional's activities) was

performed using a tested instrument, with questions about the number of consultations made by the woman, classification of vulnerabilities and/or risk, and the proposed and actual behaviors. In the 32-hour period, as a participant observer, we observed 16 medical consultations and 11 nursing consultations (three in USF A, six in B, four in C, ten in D and four in E), made with women in different pregnancy phases, and in none of the consultations it was necessary to classify gestation as being at greater risk by the professional who performed the care. A tested script was used, also guided to the apprehension of the diagnostic actions and the prescribed and offered care. Individuals and physicians were interviewed within 30 minutes, using a script with open questions about how they performed and interpreted the care actions regarding the susceptibilities and the health problems of pregnant women, and particularly to capture reports about how they proceeded in diagnosing a gestation at greater risk.

In the definition of the number of consultations observed, the limits of the observation resource were considered in the apprehension of specific care actions based on the diagnosis of special situations, of greater susceptibility or occurrence of problems. Thus, in the application of the saturation criterion⁹, the information that allowed a more general characterization of the consultations in the units as a whole were considered of interest. For this, the apprehension, analysis, and categorization of the empirical material were concomitant.

The recording of the observation was done in a field diary and through audio recording, authorized by the participants. The interviews were also recorded and the data of the documents were stored by a portable scanner.

The findings were submitted to content analysis of thematic type¹⁰, including thematic reading - identification of the topics of interest and corresponding statements, initially grouped - interpretative reading, with the apprehension of the sense nuclei, and a categorical classification of the findings, supported by the reasoning inductive and theoretical reference. The construction presented in this work was guided by the question: what actions were proposed and carried out? How were they carried out? This process resulted in two central categories: 1) transfer of the responsibility by the ESF, for the care of the pregnant woman, the specialized prenatal service and the woman; And 2) vulnerabilities such as interference from social into the organic.

The study had approved the research project by the Research Ethics Committee of Júlio Muller University Hospital (HUJM), Opinion 206,916, and respected Resolution 196 of the National Health Council, in force at the time. It was requested the signing of the Free and Informed Consent Term.

RESULTS AND DISCUSSION

Next, the actions or behaviors integrating the care repertoire of the ESF workers participating in the research and how they are conceived are presented and discussed in the perspective of the risks and vulnerabilities and the assistance model they report.

♦ Transfer of the responsibility by the ESF, for the care of the pregnant woman, the specialized prenatal service, and the woman.

In the five services studied, clinical health diagnoses of pregnant women, their susceptibilities, health problems, and causes were emphasizing medical and individual aspects, through evaluation of manifest morbidities and classification of risk. That is, the pregnant women were primarily classified as having a normal or higher risk pregnancy, based on certain risk factors, due to the possibility of resulting in medical problems or their occurrence. In contrast, their susceptibilities were not exploited, evaluated and interpreted from the perspective of vulnerabilities, although eventually recognized.

Given that gestation is a higher risk, the prioritized care behaviors or actions involved: 1) referral of women to specialized prenatal care; And (2) guidelines related to risk and behavior. Contradictions are expressed about the participation of the ESF in the continuity of the follow-up of the woman referred and a vision of the vulnerabilities that binds her, mainly, to the organic aspects.

♦ Behavior: referral of women to specialized prenatal care

In Cuiabá - MT, prenatal care at the highest risk in the Unified Health System, is done through institutions of tertiary care and secondary to health. The polyclinics are part of the secondary care of the municipal network and, among several visits, they perform the prenatal care of higher risk pregnancies, assisting pregnant women of free demand and those referenced by USF doctors and nurses. Hospitals are tertiary referrals and are configured as specialized units for the follow-up of high-risk pregnancies. Among the actions offered, there are prenatal visits of greater risk; birth assistance; and admission to obstetric interurrences.

For linking women to institutions of reference for the highest risk, by the USF, there is central of vacancies in the municipality, called Regulation Center. It regulates vacancies for prenatal care of a higher risk, especially in specialized hospitals, as well as obstetric examinations (ultrasound, Doppler ultrasound, and transvaginal examination) at hospital and outpatient level, and for delivery in tertiary care institutions.

Once the situation of greater gestational risk is diagnosed, the ESF professional decides to refer the woman to a specialized service. This is done, as a priority, for the specialized prenatal outpatient clinic of a tertiary reference public service, for the continuity of follow-up. Eventually the same occurs for the emergency department of the hospital unit, with immediate interventions being foreseen, or for a secondary public service (polyclinic) of the municipal health network, whose organization, as it is said, provides this level also monitor women with diagnosed pregnancies of greater risk.

The referral of the woman to the referral service occurs through the contact of the professional of the ESF with the central of vacancies of the municipality and through the orientation of the woman for the direct search of the service of reference, secondary or tertiary, by decision of the professional nurse and/or by the primary care physician.

Thus, the way in which the referral of women to referral services occurred was diversified among ESFs. Some of them received an orientation from waiting for a vacancy in the specialized institution, to be regulated by the central of vacancies municipal. Others were guided to seek directly at the referral service, with a referral form in hand, especially when there was a concern of the professional, or the woman, with the possible delay in access because of the health situation presented.

In the latter case, it is assumed that the direct referral of the woman is an attempt of the professional to give an agile response to it, judging that the woman needs or due to negative experiences that had previous referrals. This form of referral can also be suggested by a possible request of the woman, who is assisted by the professional.

This fact can be related to the organization of the municipal obstetric network, which admits that the referral of the woman to the referral service is done through the contact with the central vacancies of the municipality or the direct search by the woman of the referral service whether secondary or tertiary.

The referral of women with a higher risk pregnancy to specialized services has been considered of great impact in the control of maternal, fetal and neonatal morbidity and mortality, and it is recommended by the World Health Organization¹¹ and by the Ministry of Health⁵, for women's immediate access to certain equipment, laboratory resources, and diagnostics, procedures, which are particularly available in the tertiary service.

Thus, the referral of the woman is important, so a specific and specialized plan of health care of the

woman and her baby¹² is established and executed in the required time.

It is fundamental that basic care should be in dialogue with other health services and the prenatal care support network to implement this referral process. These articulations, when carried out, provide the guarantee, promptly, not only of laboratory tests and diagnostics, medicines and supplies but also the transportation of women to specialized services when necessary. Deficiencies of this order may result in impairments to the quality of women's follow-up.¹³

Therefore, it is necessary that the service network be organized through a regulatory complex at the state and municipal level for the necessary integration between health services at different levels of complexity, which must be responsible for managing the demands of primary care to health, according to the needs of the community, with the availability of medium and high complexity services¹⁴, enabling the interaction of all levels of health care.

In this sense, the more structured the organization of primary health care services and their articulation with health services of greater complexity, the more qualified will be the health care provided, as will be ensured the integrality in the care provided to women in gestation of greater risk.¹⁵

It is also necessary for professionals to recognize the importance of building the active role of women in their gestational health care. The work of health teams and organizations should support them to broaden their capacity to think in a social and cultural context and to take care of their health in the reproductive cycle, and beyond. In this way, they also enable them to seek other ways to access or dispose of what they deem necessary for their health, while professionals often fit into the predominant work organization, trajectories and using standardized care resources.

It is also important to meet the health needs expressed and recognized by these patients, through the commitment of health professionals to establish communication between the different levels of health care going through when referenced. The local organization of the service should consider the health needs expressed by the service user population, identified based on the epidemiological diagnosis, and daily information from the units.¹⁵

Therefore, the process of referencing pregnant women at various levels of complexity and specialty should favor their access to health services, according to their needs, susceptibilities and health problems.

One aspect to ensure this access is that the health professional understands the way in which he is positioned both favoring and hindering this

access.¹⁵ In this perspective, the health worker has the power to decide on the trajectory to be implemented by the patient, because in the techno-assistance model, he judges and decides the work based on his subjectivity, defining the patients' health needs. It should be emphasized that this "power" of decision directly interferes with the guarantee of access to all levels of care that the patient needs and how it is received by the health service since the reception and the bond must be established among them aiming at promoting the integrality and humanization of care.¹⁶

Ensuring the access of pregnant women at greater risk, it can potentially favor the attendance to the health needs of this group of women. Failure to implement access to health services of the various levels of complexity is a problem that can aggravate their gestational situation of greater risk, as well as provoke new susceptibilities and health problems to women who perform prenatal care.

♦ Behavior: guidance to women related to risk and referral to specialized prenatal care

Another behavior adopted by the workers, related in particular to the purpose of effecting the referral made, that is, to the attachment of women to the specialized service for which it was referenced, is the provision of guidelines or information to the woman, the specialized prenatal site, and its importance.

In this sense, they highlight possible problems that women may have if they do not seek specialized care:

When I identify the risk, I rather mentor her (woman). I make a referral to the high risk, explaining it will be a high risk prenatal, where it will be, the importance of going, how will be followed, what problems can occur if it is not at high risk, and it can aggravate both for her and for the child during prenatal care. So, it comes out well oriented from the importance of monitoring both (D1 - USF A).

For the provision of quality assistance and the access to health services, it is essential to respect the right of people to be informed about the services available, their schedules, the preconditions required for access to them, actions they carry out, among other information.¹³

As the search for specialized service depends on women, through information, professionals seek to increase their awareness of the risks and the importance of safe behaviors:

I start guiding; I personally like to clarify very well what she (woman) has, to take away the yearnings and, at the same time, to leave her worried to know that it is not simple. I like to put it apart from what is going to happen to her, what treatment, explaining where she goes, what our high-risk references are (N5 - USF E).

However, this is a practice based on the traditional informational model, since in the prenatal consultations observed, the educational actions are carried out individually. In general, the professional speaks about healthy eating, immunization, preparation for childbirth, care for the newborn, family planning, among others. For example: [N5 - USF E, investigates the complaints and symptoms of a primigravida woman, 16 years old, with 27 weeks of gestation, in her 6th prenatal visit].

N5: And the silly things you have been eating, have you stopped? You have to eat well, eat breakfast, to prefer fruit, healthier foods.

Woman: Just today I ate a cookie and "toddinho"; I got two reais with my husband and bought it.

N5: And why did not you buy a banana?

Woman: Because my aunt kept giving it to me. She said she would bring some fruit for me.

[Then, N5 asks about the woman's dwelling and their family relationships; Verifies the ultrasound brought by the woman, calculates the GA, the Probable Date of Childbirth (PDC) and continues the consultation, performing the physical examination].

The informational model is where the communication flow is established between the sender and the receiver, in a vertical and linear manner. In this model, the communicative process is constituted in a fragmented way, because the power of the word is conferred to the emitter pole, considered the holder of knowledge and information to be transmitted to the receiving pole, aiming at its behavior change. In approaching communication as a mere process of message transmission, with previously established meanings, this model neglects the intervention of subjects in social life and omits the complexity of the symbolic dimension present in every communicative act.¹⁷

In these cases, the message or information transmitted during educational actions is not established as effective, since it must be taken as symbolic content, that is when it represents something to someone.¹⁸

Furthermore, although the professionals emphasize the importance of women's participation in self-care, stimulated by health education, they do not express a critical understanding of health education to foster their autonomy. However, it is important that professionals recognize the need for the education that manages it.

[...] In general, I try to empower them with knowledge, from what they already know and sometimes deconstructing some harmful things. I like to explain well the whys of things [...], So I do not simply say that she cannot. So, I realize, in practice, that when I do this, detailing, they adhere more (N5 - USF E).

This way of effecting educational aspects creates barriers to the construction of knowledge by women, providing tranquility and autonomy.

In the first sense, it is important for the professional to consider that the experience of increased gestational risk by women is accompanied by new tensions, concerns, and fears. These feelings tend to remain when, among other things, they do not understand or have no access to new references to understand what happens to them. Equally, if they do not have access to the professional care they need or feel they need. When informed by the woman, the diagnosis of greater risk can generate an important reaction of suffering related to the impact that the problem will bring to her life and the health of the child, in front of the one projected. This reaction may or may not be aggravated if there is no understanding of what the higher risk diagnosis means.

Research on high-risk pregnancy experiences, developed in Divinópolis, Minas Gerais, indicates that in the prenatal care of the woman in a situation of greater risk, the attention and availability offered by the professionals to clarify doubts and give detailed guidelines and anguish. With the dialogue around risk diagnosis and the reasons for referral, women often feel more secure.¹⁹

As to produce autonomy, women must emerge in the care space in a way that is not restricted to only a supporting element of the decision of how to do it, that is, they must also actively participate in the choices of what to do⁷ in their reproductive process.

To this end, women and their caregivers should be encouraged and supported to broaden their knowledge, to recognize the resources available to the community, and to learn about reproductive and sexual rights and about laws that involve gestation, childbirth and the puerperium to participate in claiming rights and proposing changes in care. Thus, the participatory educational process favors women and family protagonism contributing to their choices, strengthening their individual and collective capacities, broadening the vision of available resources and encouraging them to pursue new strategies to understand their problems to minimize or solve them and to strengthen them to face the challenges.²⁰

The intensification of health education actions among women in special situations is a fundamental strategy. However, it is necessary to promote the autonomy of women and their families in its implementation, based on the social approach to health. Health education is an important strategy for the promotion of reproductive health by stimulating women's capacity for analysis and intervention in the susceptibilities and health problems to which they are exposed.

For this, the workers need to know the women, their capacities, and potentialities, and consider their experiences and their needs from their perspectives. Proper prenatal care at ESF requires the women's approach and how they feel, and how they make sense and take care of the experience of raising a child, especially when they are in a situation of greater susceptibility.

♦ Contradictions about the participation of the ESF in the continuity of the monitoring of the woman referred

Besides the two highlighted behaviors, prioritized by the professionals, they affirm to control the permanence of the connection of the woman in the service of reference. In this sense, they emphasize the home care of the ACS, verifying this connection, and the use of a confirmatory approach by the prenatal professional when the woman attends the USF, to access a given procedure or even to continue it:

[...] It sometimes happens, the pregnant woman, after the referral, having a consultation scheduled here (USF) and come without having taken the referral. Here, people guide [...]. They are separated in my report, how many pregnant women do I have by micro-area, then I can get control with the health agent: - "Are your pregnant women going to prenatal? Who is not going, do you seek to know why it is not going", so I try to keep control (N3 - USF C).

From the perspective of traditional surveillance, this has been considered an important practice, since the absence of prenatal control by the professional can increase the risk for pregnant women or the baby.⁵ In this sense, benefiting the woman's contact with the local service and referral services and their resources, to some extent, allows her to be better accompanied in her reproductive health condition and having a continuity of care.⁴

There are several actions advocated in the prenatal technical manual²¹ that compose the monitoring of reproductive health in the scope of basic care. Among them, it is recommended the active search for the lack of systematic actions offered. Another axis of reproductive health surveillance is the promotion of health, with the guarantee of access to health services and actions, focused on comprehensive and recognized problems/needs, including the causes of reproductive health/disease. Therefore, when looking at reproductive health surveillance with a broad sense, actions are expected to occur in different directions, in a solid, articulated way, involving different strategies and subjects.⁴

Maintaining the link between the woman and the USF is part of the recommendations made for local services. It is present in the national health policy for the highest risk gestation care, which proposes that the local team has information about

the evolution of the woman's health conditions, the treatments administered and, if necessary, in their territory, through the home visit. The joint follow-up is considered necessary to ensure the quality of care at the highest risk of pregnancy.⁵

Thus, the local service should organize its work process to achieve this goal establishing what actions will be taken, by whom and in what way. In this sense, the woman should be guided and encouraged not to lose the bond with the basic care that began her follow-up. Home visits, ACSs, nurses, and doctors, if necessary, should be planned and carried out.

It is expected that the service of greater complexity, including the counter-reference for the ESF team, for better monitoring of its process, being a practice that favors the continuity of care and promotes greater resolution and longitudinally of care.²² The establishment of a dynamic communication between the health services allows pregnant women to access basic care services more easily, given their proximity to their home.⁵

Doctors and nurses consider it important to maintain the prenatal appointments of the woman referred in the USF. They affirm that the joint monitoring helps to maintain the bond with the USF, the faster and at no cost financial access to the care that women need, as well as the monitoring of women's health history and the provision of guidelines throughout the reproductive cycle.

I believe that it would be right for her (woman) to be monitored in both units, both in the reference center and in ours (USF). In ours, because we are close to the patient, it is an easy access that she has here. But she is going to the referral center, being consulted, having a record, also important in the case of an emergency, when she needs it because she will be attended there in a very easy way, without needing that bureaucracy, waiting, to have a vacancy. So, it is important because of the proximity of the patient's home, because people are controlling something more quickly, because the pregnant woman, any little thing, any minute, anytime, makes a difference, especially because the patient is a poor community, we see the difficulty of her going there (specialized service). So, it would be important to be following in a partner way, the reference center and the PSF, so that we can be following and guiding the best way (D3 - USF C).

We need to know her history, to have this bond to take care of the child, the spouse. So, you do need to have a link in the Family Health, even if it is at high risk (N5 - USF D).

This view is important for local monitoring not only of the medical process that has generated the greatest risk but also for the wide acceptance and support of the woman, consistent with the vulnerability perspective.

Professionals not only attach value to women's prenatal care, by the specialized service, and by the USF but also affirm to carry it out:

She (woman) continues to be monitored here (in USF). She has the consultations there in the reference, but they have the monthly consultations here, which we appoint them, and have the follow-up of the community agents. So, she continues the follow-up in the same way; we only advise that it will be a broader follow-up, because it will not be restricted, here with us. They will also be followed up by the hospital (N2 - USF B).

However, although the workers affirm that there is continuity of the local prenatal care of women referred, this does not occur routinely. Some women, in fact, continue to be followed up by USF, through the consultation and/or ACS, particularly those with some physical factor considered more significant by the team (microcephaly, visual impairment, hyperthyroidism, gestational diabetes, high blood pressure), while others do not. The latter establish eventual contact with the ESF, only for care such as immunization, obtaining medication, blood pressure measurement, among others.

A study that analyzed the perspective of puerperal women on prenatal care, performed in Rio Grande do Sul, also showed this discontinuity in prenatal care and the breakdown of the woman's bond with the ESF professionals, from their referral to the reference.²³

When prenatal consultations are performed, the basic routine of care is maintained, repeating many of the actions performed in the referral service. In this routine, risk control is central, which is done by investigating factors pre-existing gestation (individual, socio-demographic, reproductive history and clinical conditions) and pathological manifestations during its course (exposure to teratogenic, obstetric disease and clinic intercurrents). The object of the work action, for which the control turns in place of the person and his history, falls on data of interest, worked as a clinical history and physical examination, and results in medical diagnoses of the situation. Even if root causes in the person's life are investigated, it virtually disappears.

In this way, the local teams do not act with specificity and in a complementary way to the referral service, for example, using resources to approach women's living conditions, activating the family and social support network, to support them continuously and to the family in their participation in care.

Besides the local health service referring the woman to the highest risk to a specialized service, it must accompany and support it, assuming the coordination of the care directed to it. The coordination of care by the ESF is important to

strengthen the attachment of the woman to the referenced service, to follow the care defined there and to support her in what she needs.^{5,24} The continuity of the contact leads to actions promoting health and emotional and family care. To that end, prenatal care must be based on diverse social services and resources, aiming to break with the fragmented approach to health and the transfer of responsibility from the ESF to the specialized service and the pregnant woman.

♦ Vulnerabilities as social interference in the organic

When effecting prenatal care, workers claim to constantly deal with social, family and behavioral aspects of pregnant women. They are translated as vulnerabilities faced by them. That is, vulnerabilities are non-organic issues for them. In this sense, they show: lack of interest or knowledge of women to adopt "adequate" reproductive and health care behaviors; Deficiencies in access to formal education and income; Lack of social support for the care of the children in situations where it is necessary for women to go to services; Difficulties in the acceptance of gestation, by the family and the partner; And lack of support for women.

[...] There is a vulnerability in the social sense, to have the condition to go (to the specialized service): sometimes the place is very far, she has other children that she does not have to leave with to do the examinations [...] So, all this we have to be seeing, and find a way to be welcoming this pregnant woman [...] (D3 - USF C).

Generally, in these lower classes, there is a lot of vulnerability, their lack of interest in prenatal care, lack of information, 14 and 15-year-old girls who do not know the importance of prenatal care, having problems in the family, with the boyfriend, they do not know who the father is, those kinds of things [...] So, these are the types of vulnerabilities (D4 - USF D).

The understanding of workers that these aspects compromise the reproductive health of women is important to the approach to reproductive risks prioritized in the ESF, through preventive actions.

Vulnerable contexts reinforce the importance of the social dimension in understanding the complexity of risks because even in situations where risks are known, and preventive measures can be applied, several factors prevent both the recognition of problems and the implementation of preventive and control measures more effective.²⁵ However, from a risk perspective, aspects such as those evidenced by the workers are taken as isolated factors in the care action, considering the susceptibilities and the health problems of recognized pregnant women.

Vulnerability analysis, taken as an integrative conceptual and methodological reference, seeks to

understand health by articulating it with multiple aspects and processes of the social, environmental, institutional context and ways of living, acting and thinking of individuals and groups.

A picture such as vulnerability seeks to rescue the relationships between contextual and individual aspects and implicate them in diagnoses and an effective health action.⁷ Therefore, these aspects of clinical practice must be identified and analyzed in their articulations and become diagnostic of the vulnerabilities faced by women, as well as the potential they have. More than that, they should result in health promotion actions, in their broad sense.

Therefore, it is essential to understand and articulate the set of individual, economic, cultural, political, and biomedical processes in their repercussions for the health of the pregnant woman to give meaning to the pregnant women's vulnerability promoters, and to recognize how much are the weakening or strengthening of women in the face of the situations experienced.

Thus, the question to ask is how these aspects are interrelated by the workers of the units studied, in the daily care, when assessing women's health conditions, and if they imply the definition, accomplishment or articulation of actions to promote the health. That is if they represent some openness to overcoming the predominant prenatal clinical practice, based exclusively on biomedical knowledge and risk epidemiology.

What can be understood from the discourse of workers is that they somehow differentiate risks and vulnerabilities by associating them with degrees of severity of women's health and the actions required, while admitting a certain association between the two, when reporting to interference from social to the organic.

The risk is understood as something more serious than vulnerability, resulting in illness, organic impairment or death of the woman and/or her child. The idea of risk appears to be linked to diseases, to the urgency of care and the use of technologies from other levels of care. Gestation is "risky" when it requires immediate follow-up in a specialized medical service since USF does not have the technologies to deal with it.

The risk is a greater severity since it represents socially the one that has a greater chance of aggravation of the clinical-organic picture, with possibly harmful consequences to health. The more critical the risk, the greater the importance given to it, the adoption of preventive measures, its monitoring by indicators and the presumption of corrective measures applied when it materializes.

26

The vulnerability is less serious, and as a task to be carried out by the local health unit, with the use of care resources differentiated from those of

action on risks - among which health education and partnerships with corporate bodies. The vulnerability is related to social and behavioral issues or aspects not clearly identified ("these things"), and secondarily admitting their relation to disease.

In the vulnerability, we intervene in a different way than a risk, because the vulnerability is the items: low education, pregnant women who already have several children. The risk refers more to even diseases, toxoplasmosis, pre-eclampsia, gestational diabetes. It has this difference, and there the approach is different, because the patients that I classify as vulnerable, the majority I monitor in the unit, and the ones that I classify as a risk I refer most (D2 - USF B).

Sometimes the pregnant woman is vulnerable, but she does not present the risk in pregnancy, the risk in pregnancy we consider when the mother can enter in suffering and the baby too. Often, being vulnerable we managed to get around, we partnered with other Ministry actions. We can get around that case; you can help. Now, high-risk pregnancy, we often cannot interfere and then we need to refer this pregnant woman (N2 - USF B).

Although it is relevant to understand the ESF dealing with vulnerabilities, the risk approach has been given greater value; and the resources to be used to address vulnerabilities are simplified or viewed as less complex.

They express the idea that the vulnerability approach provides conditions for women's physical health and quality of life and the birth of a healthy baby:

It is very important to be monitoring vulnerabilities because, based on this, we do or do not have a well-formed fetus, a healthy fetus, and even the question of a pregnant woman's quality of life during pregnancy, delivery and postpartum. So, evaluating the vulnerability of pregnant women is something very important, we must always be close to the pregnant woman (D5 - USF E).

However, they dichotomize vulnerabilities, risks, and diseases or vulnerabilities and health in the broad sense. Thus, in the analysis of the health problems of pregnant women, other dimensions, other than biological ones, are not valued, contributing to limited behaviors that overestimate organic issues, to the detriment of their socio-political, economic, cultural and intersubjective contextualization.

The risk cannot be translated as vulnerability, but there are close relationships between them, for example, the behavior of subjects in situations of risk depends on their vulnerability. Thus, both should be analyzed in an integrated and contextualized way, allowing the confrontation and complementation of the two approaches. That is, assessing and understanding the risks and, beyond them, the existing vulnerabilities also provide a

more comprehensive view of the pregnant woman's health situation and the care practices she needs.

Professionals recognized the importance of assessing and intervening in women's prenatal vulnerabilities. But for them, intervening is revealed as understanding what of their living conditions interferes with the evolution of the medical problems that pregnant women present; and use the professional knowledge and the conversation to confront them. Also, action on vulnerabilities includes obtaining family participation in care; The articulation of intersectoral partnerships; The accomplishment of the reception (such as listening and support); And adaptation of the guidelines to the living conditions of women.

It is very important to evaluate vulnerability, because it is no use talking to her (woman) to eat this, to eat that, to have to eat every three hours, to eat six meals a day, since she cannot do any. Sometimes she cannot even have lunch, breakfast, and you keep talking. So, if you do not research, how will you know what she needs? You can make a list of food for her, guide her, guide and guide, and the next month she comes back, she will be hypocritical in the same way, with low weight; The exams will continue to change, and you will not understand why. It is because you have not seen the "behind" her. So, here we see not only the pregnant woman but the "behind" the pregnant woman as well. So it is important to know (N2 - USF B).

Working with vulnerability is not something simple. Vulnerabilities do not manifest in the same way to everyone. They require specialized professional action and analysis for their apprehension, understanding and coping.²⁸ Also, they require intersectoral responses²⁹ and integration with social support network alternatives.

Although workers identified some vulnerabilities of pregnant women in prenatal clinical practice and considered their evaluation in this space important, this is not a systematic practice. Therefore, related information is not recorded in the medical records and other accompanying instruments. Likewise, their approach to vulnerabilities is not to provide for comprehensive actions to promote the health of women, their children and the family, concentrating on traditional educational actions and/or eventual referrals to available social services.

We (professionals) try (diagnose degrees of vulnerability), because it is a peripheral neighborhood, with enough lack. We see social, cultural, all that. So, we were able to identify vulnerabilities but to interfere, provide support and follow-up, we were a little deficient, but we tried to work with health education (N3 - USF C).

In the second sense, an effective action is the referencing of women to the Social Assistance Referral Center (CRAS), and the articulation of local actions with social resources to support women, including the family is fragile. Although workers recognize intersectoral actions as important measures to address the vulnerabilities of pregnant women, they are not organized in the municipality. In this sense, important actions are: support for education and physical, leisure and socialization activities; Promotion and defense of rights; Integration of health practices into community development and political participation actions, among others.⁷

The non-assessment and recognition of women's vulnerabilities and their possible implications for professionals, as well as the difficulties in articulating and providing health promotion actions are related to the historical and predominant biomedical model in health, with the resulting health policies, prioritized for basic care, as well as with the ways in which the work process in this space is effective day-to-day.

This is reflected in a certain lack of preparation of doctors and nurses to address vulnerabilities in the clinic and collective actions, as pointed out by them.

I believe that I can identify the risks, the vulnerabilities I take a while to realize, mainly, social, economic vulnerability, which, often, we do not understand [...] We make the biological identification, that we know how to do well, but it also has to improve other looks. There is training for us, and that is good; Because there are some things that fall into oblivion [...] (N3 - USF C).

This perception represents a certain criticism of the fact and openness to new incorporations. In this sense, it is important to invest in the preparation of professionals, regarding the limits of what they do and the knowledge that guide them daily, so they can play a leading role in the construction of new alternatives for care, unfolded in proposition and use, in clinical work of new technologies.

CONCLUSION

In the context studied, overcoming the exclusivity of the risk perspective adopted in the prenatal ESF remains challenged by the necessary incorporation of the social approach to reproductive health and attention to its determinants and conditioning factors.

Although intersubjective, family and sociocultural aspects are recognized by professionals as promoters of vulnerabilities of pregnant women, with repercussions on their physical health and quality of life, they have a restricted view of the issue and difficulties in articulating and providing health promotion

actions. Then, this is a topic to be the subject of joint debate and reconstruction, by local workers, sector managers, and other social actors.

There is a need to deepen the study of the approach to vulnerabilities of pregnant women, particularly the need to creatively build, with the support of research, operational ways to apprehend and interpret the social determinants of women's health in the prenatal clinic, as well as acting on them.

REFERENCES

1. Carvalho BG, Peduzzi M, Mandu ENT, Ayres JRCM. Trabalho e intersubjetividade: reflexão teórica sobre sua dialética no campo da saúde e enfermagem. Rev. Latino-am Enfermagem [Internet]. 2012 [cited 2012 Dec 05];20(1):19-26. Available from: http://www.scielo.br/pdf/rlae/v20n1/pt_04.pdf
2. Castiel LD, Guilam MCR, Ferreira MS. Correndo o risco: uma introdução aos riscos em saúde. Rio de Janeiro (RJ): Fiocruz; 2010.
3. Jabra KL. Consulta de enfermagem de pré-natal na Saúde da Família em Cuiabá: reflexo burocrático e normalizador do social [dissertação]. Mato Grosso (MT): Universidade Federal de Mato Grosso. Programa de Pós-Graduação em Enfermagem; 2013.
4. Elias NA, Mandú ENT, Araújo LMA. Vigilância à saúde reprodutiva na Estratégia Saúde da Família. Esc Anna Nery Rev Enferm [Internet]. 2014 [cited 2015 Jan 05];18(3):456-63. Available from: <http://www.scielo.br/pdf/ean/v18n3/1414-8145-ean-18-03-0456.pdf>
5. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Manual Técnico: gestação de alto risco. Série A - Normas e Manuais Técnicos [Internet]. 2012 [cited 2013 June 12];5:1-304. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/gestacao_alto_risco.pdf
6. Ayres JRCM. Desenvolvimento histórico-epistemológico da Epidemiologia e do conceito de risco. Cad saúde pública [Internet]. 2011 July [cited 2013 Oct 15];27(7):1301-11. Available from: <http://www.scielosp.org/pdf/csp/v27n7/06.pdf>
7. Ayres JRCM. Cuidado: trabalho e interação nas práticas de saúde. Rio de Janeiro (RJ): Abrasco; 2011.
8. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política Nacional de Atenção Básica. Série E - Legislação em Saúde [Internet]. 2012 [cited 2013 June 12];1:1-114. Available from: <http://189.28.128.100/dab/docs/publicacoes/geral/pnab.pdf>
9. Fontanella BJB, Luchesi BM, Saidel MGB, Ricas J, Turato ER, Melo DG. Amostragem em pesquisas qualitativas: proposta de procedimentos para constatar saturação teórica. Cad saúde pública [Internet]. 2011 Feb [cited 2014 Mar 12]; 27(2):389-94. Available from: <http://www.scielosp.org/pdf/csp/v27n2/20.pdf>
10. Minayo MCS. Análise qualitativa: teoria, passos e fidedignidade. Ciênc Saúde Coletiva [Internet]. 2012 [cited 2013 Oct 15];17 (3):621-6. Available from: <http://www.scielosp.org/pdf/csc/v17n3/v17n3a07>
11. World Health Organization. Programme to map best reproductive health practices [Internet]. 2002 [cited 2014 Jan 24]. Available from: http://whqlibdoc.who.int/hq/2001/WHO_RHR_01_30.pdf
12. Feitosa ACR, Queiroz AM, Vianna AM, Schleu M. Aplicação de programa educativo multidisciplinar em gestações de alto risco devido a doenças endócrinas. Rev bras ginecol obstet [Internet]. 2010 [cited 2013 Sept 10];32(10):504-9. Available from: <http://www.scielo.br/pdf/rbgo/v32n10/v32n10a06.pdf>
13. Serra CG, Rodrigues PHA. Avaliação da referência e contrarreferência no Programa Saúde da Família na Região Metropolitana do Rio de Janeiro (RJ, Brasil). Ciênc saúde coletiva [Internet]. 2010 [cited 2013 May 14];15(3): 3579-586. Available from: <http://www.scielo.br/pdf/csc/v15s3/v15s3a33.pdf>
14. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Regulação, Avaliação e Controle de Sistemas. Diretrizes para a implantação de complexos reguladores [Internet]. 2010 [cited 2013 June 12];6(2):1-57. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/pacto_saude_volume6.pdf
15. Correa ACP, Goi HY. Contrarreferência de mulheres que vivenciaram gestação de risco a unidades de Saúde da Família em Cuiabá. Cienc Cuid Saude [Internet]. 2014 [cited 2014 May 14]; 13(1):104-10. Available from: http://www.periodicos.uem.br/ojs/index.php/CiencCuidSaude/article/viewFile/19916/pdf_119
16. Merhy EE. Em busca do tempo perdido: a micropolítica do trabalho vivo em saúde. In: Merhy EE, Onocko R. (Org.). Agir em saúde: um desafio para o público. São Paulo (SP): Hucitec; 1997.
17. Simões PG. Para uma abordagem das interações comunicativas. Verso Reverso [Internet]. 2007 [cited 2014 July 31];21(46):[about 5 p.] Available from: <http://www.revistas.univerciencia.org/index.php/versoereverso/article/view/5776/5234>
18. Silva LB, Soares SM. Comunicação nas práticas de coordenação de grupos socioeducativos na saúde da família. Rev Esc Enferm USP [Internet]. 2013 [cited 2013 Oct 15];47(3):640-7. Available

from:

<http://www.scielo.br/pdf/reeusp/v47n3/0080-6234-reeusp-47-3-00640.pdf>

19. Oliveira VJ, Madeira AMF. Interagindo com a equipe multiprofissional: as interfaces da assistência na gestação de alto risco. Esc anna nery rev enferm [Internet]. 2011 Jan/Mar [cited 2013 Oct 15];15(1):103-9. Available from: <http://www.scielo.br/pdf/ean/v15n1/15.pdf>

20. Zampieri MFM, Gregório VRP, Custódio ZAO, Regis MI, Brasil C. Processo educativo com gestantes e casais grávidos: possibilidade para transformação e reflexão da realidade. Texto Contexto Enferm [Internet]. 2010 [cited 2014 May 14];19(4):719-27. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-07072010000400015

21. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Atenção ao pré-natal de baixo risco. Série A - Normas e Manuais Técnicos [Internet]. 2012 [cited 2013 June 12];32:1-320. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/cader_nos_atencao_basica_32_prenatal.pdf

22. Baratieri T, Marcon SS. Longitudinalidade no trabalho do enfermeiro: identificando dificuldades e perspectivas de transformação. Texto Contexto Enferm [Internet]. 2012 [cited 2014 May 14];21(3):549-57. Available from: http://www.scielo.br/scielo.php?pid=S0104-07072012000300009&script=sci_arttext

23. Cabral FB, Hirt LM, Van der Sand ICP. Atendimento pré-natal na ótica de puérperas: da medicalização à fragmentação do cuidado. Rev Esc Enferm USP [Internet]. 2013 [cited 2014 Oct 15];47(2):281-7. Available from: http://www.scielo.br/scielo.php?pid=S0080-62342013000200002&script=sci_arttext

24. Brasil. Ministério da Saúde. Portaria nº 1.020, de 29 de maio de 2013. Institui as diretrizes para a organização da Atenção à Saúde na Gestação de Alto Risco e define os critérios para a implantação e habilitação dos serviços de referência à Atenção à Saúde na Gestação de Alto Risco, incluída a Casa de Gestante, Bebê e Puérpera (CGBP), em conformidade com a Rede Cegonha [Internet]. 2013 [cited 2014 June 12]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2013/prt1020_29_05_2013.html

25. Porto MFS. Uma ecologia política dos riscos: princípios para integrarmos o local e o global na promoção da saúde e da justiça ambiental. Rio de Janeiro (RJ): Fiocruz; 2007.

26. Areosa J. O risco no âmbito da teoria social. In: VI Congresso Português de Sociologia. Mundos sociais: saberes e práticas [Internet]. 2008 June [cited 2013 Sept 24]. Available from: <http://www.aps.pt/vicongresso/pdfs/323.pdf>

27. Janczura R. Risco ou vulnerabilidade social? Textos Contextos [Internet]. 2012 [cited 2014 Oct 15];11(2):301-8. Available from: <http://revistaseletronicas.pucrs.br/fo/ojs/index.php/fass/article/view/12173/8639>

28. Luciano MP, Silva EF, Cecchetto FH. Orientações de enfermagem na gestação de alto risco: percepções e perfil de gestantes. J Nurs UFPE on line [Internet]. 2011 July [cited 2014 May 15];5(5):1261-266. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/viewFile/1727/pdf_559

29. Ministério da Saúde (BR). Departamento de Informática do SUS. Sis prenatal [Internet]. 2012 [cited 2013 Sept 24]. Available from: <http://www.datasus.gov.br/SISPRENATAL/index.php?area=01>

Submission: 2015/12/09

Accepted: 2017/04/03

Publishing: 2017/05/01

Corresponding Address

Daniela do Carmo Oliveira
Rua João Batista S. de Oliveira, 244, Ap. 706 C
Bairro Vista Alegre
CEP: 78085-712 – Cuiabá (MT), Brazil