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NOTE PREVIEW ARTICLE

HUMANIZATION OF CARE TO HIGH RISK PREGNANT WOMEN*

HUMANIZAÇÃO DO CUIDADO À GESTANTE DE ALTO RISCO

HUMANIZACIÓN DE LA ATENCIÓN A EMBARAZADAS DE ALTO RIESGO

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ABSTRACT

Objective: to analyze the humanization of care for high-risk pregnant women. ***Method:*** this is a qualitative, descriptive, exploratory study. The population will comprise high-risk pregnant women and health professionals from the obstetric inpatient unit. Semi-structured and focus group interviews will be applied for information collection, guided by instruments composed of guiding questions and a self-administered multiple choice questionnaire. In the analysis of the information, the Thematic Analysis technique will be used. ***Expected outcomes:*** it is expected to recognize the production of care for pregnant women during the hospitalization process, stimulate critical reflection among managers and professionals about the humanization of care, direct the praxis in health care of hospitalized high-risk pregnant women and offer elements to production of scientific knowledge on the subject in question. ***Descriptors***: Pregnancy, High-Risk; Hospitals, Maternity; Humanization of Assistance; Patient Care Team; Quality of Health Care; Salud de la Mujer.

RESUMO

***Objetivo*: analisar a humanização do cuidado à gestante de alto risco. *Método*: trata-se de um estudo qualitativo, descritivo, exploratório. Constituir-se-ão, como população, as gestantes de alto risco e os profissionais da saúde da unidade de internação obstétrica. Aplicar-se-ão, para a coleta de informações, entrevistas semiestruturadas e em grupo focal guiadas por instrumentos compostos por questões norteadoras e um questionário autoaplicável de múltipla escolha. Utilizar-se-á, na análise das informações, a técnica de Análise Temática. *Resultados esperados*: espera-se reconhecer a produção do cuidado à gestante durante o processo de hospitalização, estimular a crítica-reflexão entre gestores e profissionais sobre humanização da assistência, direcionar a *práxis* na atenção à saúde das gestantes de alto risco hospitalizadas e oferecer elementos à produção do conhecimento científico sobre a temática em questão. *Descritores*: Gravidez de Alto Risco; Maternidades; Humanização da Assistência; Equipe de Assistência ao Paciente; Qualidade da Assistência à Saúde; Saúde da Mulher.**

RESUMEN

Objetivo: analizar la humanización de la atención a embarazadas de alto riesgo. ***Método:*** este es un estudio cualitativo, descriptivo, exploratorio. La población estará compuesta por mujeres embarazadas de alto riesgo y profesionales de la salud de la unidad de hospitalización obstétrica. Se aplicarán entrevistas semiestructuradas y de grupos focales para la recopilación de información, guiadas por instrumentos compuestos de preguntas orientadoras y un cuestionario de opción múltiple autoadministrado. En el análisis de la información, se utilizará la técnica de Análisis Temático. ***Resultados esperados:*** se espera reconocer la producción de atención para mujeres embarazadas durante el proceso de hospitalización, estimular la reflexión crítica entre los gerentes y profesionales sobre la humanización de la atención, dirigir la praxis en la atención de la salud de las mujeres embarazadas de alto riesgo hospitalizadas y ofrecer elementos para producción de conocimiento científico sobre el tema en cuestión. ***Descriptores***: Embarazo de Alto Riesgo; Maternidades; Humanización de la Atención; Grupo de Atención al Paciente; Calidad de la Atención de Salud; Women's Health.

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INTRODUCTION

It is known that the humanization of health care and attention has been the scope of research, reflections, discussions and debates in the health area remotely, although intensified in recent years after the elaboration of a public policy that is part of the Unified Health System (SUS).

The National Humanization Policy, launched in 2003 by the Ministry of Health, is characterized as a strategy for qualifying comprehensive care with accountability and bonding, valuing users and advancing the democratization of management and participatory social control.[1]

It brings with it the concept of humanization related to the right to health, moving away from the concept of charity and philanthropy that was long linked and still linked to care practices, even those formally occurred in health services.[2]

The valorization of the autonomy and the protagonism of all participants involved in the health-disease process are highlighted, establishing co-responsibility, solidarity bonds and collective participation; enabling the understanding of collective social and subjective health needs and promoting mutual exchange and the construction of knowledge among the actors involved in the process.[3]

In addition, with regard to women's health care, the picture is no different, especially when analyzing the quality of obstetric care based on the humanization of care during pregnancy, childbirth and the puerperium.[4]

When a pregnancy is classified as high risk, it is recommended that hospitals and maternity hospitals should be properly structured in the face of the needs of the mother-fetus binomial, preventing complications, assisting complications and preserving human life. More than just techno scientific competence, it is expected that, in this care space, the health team will move around the obstetric care of non-technical aspects capable of producing practical meaning to its application.

However, it should be noted that, although the policy has emerged to direct an improvement in management, care and relationships between professionals and users, the humanization and quality of this attention to women during their stay in the obstetric unit are still a challenge that health services, and especially health professionals, must assume and conquer.[4]

In Brazil, attention to women's health in the context of maternity remains a problem for care, both in terms of quality and philosophical principles of care, which is still centered on a medicalizing, interventionist and hospital-centric[5] and sometimes arbitrary and abusive. It is detailed that, in this sense, the pregnant woman is separated from the protagonism that should belong to her by constitutional law and the current political proposals.[6]

It was identified, in a study developed in a maternity hospital of the University Hospital of the Fluminense Federal University, in the city of Niterói, State of Rio de Janeiro, with ten pregnant women hospitalized in the high-risk ward, that health professionals understood the high-risk pregnant woman in her process, however, did not privilege her condition as a woman during pregnancy; they did not give women the opportunity to become active subjects of their self-care and did not promote care focused on the emotional / psychological aspects of the pregnant woman during the hospitalization process.[7]

However, considering the complexity that involves high-risk pregnancy, care should not be directed only to the biological aspects and treatment of complications, focusing only on the risks and survival of the fetus. This should be expanded, recognizing that, above all, the woman herself is also experiencing the process of pregnancy and its related crises with the family, requiring specialized monitoring focusing on self-care.[8]

It is evident, when dealing with studies on this subject, that the scientific literature has emphasized humanization during prenatal care in Primary Health Care[9-15] and at the time of labor, delivery[12-3,16-22] and birth[12, 22] in the maternity ward. However, it is emphasized that adequate attention during the hospitalization process, based on technical and scientific competence, on the valuation of the individuality of the human being and on current public policies, is an important aspect to ensure the quality of maternal and child health, women's rights advocated by the institutional guidelines and, above all, the minimization of ambivalent feelings, odd feelings and negative experiences that may have a direct effect on the health of the mother-fetus binomial.

Based on these reflections, the following question is asked: “How has the humanization of care for high-risk pregnant women been produced in maternity?”.

This study is justified by the social importance that this theme reveals, both for the State and for the hospital institutions, especially with regard to the health team, which should understand the woman in the pregnancy period while staying in the obstetric unit, changing paradigms and acting under a care model that values needs and particularities, with innovative and effective actions that contribute to the quality and humanization of care.

OBJECTIVE

- To analyze the humanization of care for high-risk pregnant women.

METHOD

This is a qualitative, exploratory and descriptive research, which will be developed during November and December 2019, in a maternity hospital of a philanthropic hospital in the state of Ceará, Brazil.

It is emphasized that this is a regional and state reference in highly complex health care and serves more than 60 municipalities in the region and a population of approximately two million inhabitants.[23]

The research population will comprise high-risk pregnant women and health professionals from the obstetric inpatient unit.

The following inclusion criteria will be adopted for high-risk pregnant women: 18 years of age or older and 24-hour stay in the obstetric unit, which is considered essential for the hospitalization experience and opinion on the proposed theme. Pregnant women who are not oriented in time and space, with mental and / or cognitive disabilities and who have any difficulty in participating in the interview will be excluded.

Health professionals will be given the perspective of two groups directly or indirectly involved in perinatal care, namely: health professionals (doctors, nurses, technicians and / or nursing assistants) and health unit managers (coordinators) of the obstetric unit and Nursing managers). Hired professionals who do not belong to the effective maternity unit or those who have a health certificate or leave work during the period of data production will be excluded.

Due to the nature of the study, it is emphasized that the number of participants is not the most relevant, but the way in which the representativeness of the elements and the quality of the data that are unveiled are conceived.[24] Thus, the sample closure of pregnant women will occur when the information obtained will present some redundancy or repetition, in the evaluation of the researcher. As for the health team, a minimum of six and a maximum of eight professionals will participate, so that everyone can express themselves and defend their ideas.

Semi-structured and focus group interviews will be applied for information collection, guided by instruments composed of guiding questions and a self-administered multiple choice questionnaire.

The instrument will be addressed to high-risk pregnant women organized in two parts with closed and open questions: the first, with questions about the socio-demographic and economic profile of the participants, while the second, with subjective questions related to the purpose of the study.

For health professionals, the self-administered multiple-choice questionnaire with closed questions about the socio-demographic, economic and professional characterization, and the open-ended question regarding the humanization of care for hospitalized high-risk pregnant women will be composed.

Therefore, information collection will start with the first group of research subjects, consisting of high-risk pregnant women. Thus, information will be collected through medical and nursing records regarding high-risk pregnant women admitted to the obstetric unit of the study scenario and who fit the inclusion and exclusion criteria established in this investigation.

Subsequently, the research will be presented regarding the objective, methods and procedures and the benefits and risks to the selected pregnant women, inviting them to participate voluntarily in the study and, after acceptance, will present themselves and request The Free and Informed Consent Term (FICT) will be signed.

Therefore, the interview will be held in a space reserved for the health service to ensure the confidentiality and anonymity of pregnant women. This will be recorded in audio through electronic recorder, with the permission of the participants, to maximize the reliability of the information obtained and facilitate the literal transcription of the full statements.

At the end of this moment, data will be collected with the second group of research subjects, composed by the health team. To this end, the focus group methodology will be applied, characterized as a research technique for collecting information through group interactions when discussing a special topic suggested by the researcher.

Thus, the group sessions will be planned according to the Composition, Tools and Operationalization criteria, [25] as reported below.

The focus group will be composed of health professionals and coordinator, also called moderator, and, alongside you, will be the reporter (advisor / researcher), who will take note of all the details record or film with the consent of the participants.

Group sessions will be held as needed by health professionals, lasting a maximum of 50 minutes, with dates and times agreed during the recruitment of potential participants.

The tools for the implementation of the group sessions will include: setting in the study sites for the recruitment of participants; subject guide focused on the main objectives, each being the main focus of a session and evaluation guide.

In the setting, a visit will be promoted in the research setting to verify the possibility of carrying out the study in that location and will talk with the maternity coordinator about the selection of participants and the development of the

research, with the identification of the best place, the day and time for the first group session.

The research will be made available after this visit to potential participants. The researcher will visit the field of research in order to bring the printed invitation to the service and thus obtain an estimate of how many professionals are interested in participating in this research.

This will present the research regarding the objective, methods and procedures and the benefits and risks to health professionals, inviting them to participate voluntarily in the study and, after acceptance, will present themselves and the signing of the Free and Informed Consent Form (FICT) will be requested.

With regard to the theme guide, a roadmap for the operationalization of the meeting will be prepared. It relates to your organization closely with the purpose of the study and the research question. It will contain a schema of the key moments of each session, which will guide the discussion, promoting a more productive investigation.[26]

As for operationalization, the key moments will be developed, namely: opening of the session; presentation of participants to each other; clarifications about the dynamics of participatory discussion; setting of setting; debate; Synthesis and Closure of the Session.[26]

For this moment, the group intervention will be adopted, operatively developed by Enrique Pichon Rivière, Swiss psychiatrist, whose epistemological pillars were psychoanalysis and social psychology.[27]

The group process will be constituted by an intense movement of *structuring*, *unstructuring and restructuring*. We express what is explicit and implicit in the group, its manifest and latent contents, and such movement happens in round trips called dialectical spiral.[28]

Finally, the evaluation guide will be used at the end of the last session to identify how the focus group was guided by participants. This instrument will be composed of questions related to place and time, operationalization, role of the moderator and the rapporteur.

Thematic analysis will be used in the analysis of the information, which aims to discover the meaning cores that make up a communication, with presence or frequency of significant elements for the analytical object, operationally divided into three stages: Pre-Analysis; Material Exploration and Treatment of Results Obtained and Interpretation.[29]

To ensure anonymity of deponents, high-risk pregnant women will be identified by the letter "G" followed by an alphanumeric code according to the sequence of the interview (Ex: G01, G02, G03, ...), while The health team will be identified by the letter "P" followed by a random alphanumeric code (Ex: P01, P02, P03, ...).

The research will respect the ethical principles in their stages, according to Resolution 466 of December 12, 2012, of the National Health Council, which regulates research involving human beings.[30]

This research is integrated into a broader research, submitted to the Research Ethics Committee for the consideration of the scientific committee, obtaining favorable opinion no. 2,674,358 and CAAE 89578718.0.0000.8133.

EXPECTED RESULTS

It is conjectured that the empirical information, extracted from the statements of pregnant women, will enable to recognize the production of care during the hospitalization process, stimulate critical reflection between managers and professionals about the humanization of care and direct praxis in health care of high-risk hospitalized pregnant women, expanding the possibilities of care production beyond medicating, unnecessary interventions and the hospital-centric model still present in health services.

Based on the operating group Pichonian assumptions, it is expected to articulate, as an explicit task, discussion with health professionals about the health care of high-risk pregnant women and, as an implicit task, the management of their health opinions and feelings about the social construction of this theme and the limits and possibilities of their daily care. Through the use of this framework, in-depth discussion and group logic will be provided, as well as clarifying aspects inherent to reality, which may be useful in the search for the quality of health care for high-risk pregnant women.

It is believed that the research will offer relevant elements for the production of scientific knowledge on the subject in question, since, in a quick search for the subject in some electronic databases, few studies were found that addressed the humanization of care of high risk hospitalized pregnant women.

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