

ORIGINAL ARTICLE

PRENATAL HOME VISITS: EXPECTATIONS HIGH-RISK PREGNANT WOMEN

VISITA DOMICILIAR NO PRÉ-NATAL: EXPECTATIVAS DE GESTANTES DE RISCO

VISITA AL HOGAR EN PRENATAL: EXPECTATIVAS DE LAS MUJERES EMBARAZADAS POR EL RIESGO

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ABSTRACT

Objective: to analyze the expectations of high-risk pregnant women regarding home visits as part of prenatal care. **Method:** this is a qualitative, descriptive study, developed under the framework of Symbolic Interactionism. Data collection was carried out with ten high-risk pregnant women, through individual interviews recorded on a digital audio device, later transcribing them in their entirety. Due to the text derived from the transcription, the analytical processes of the Content Analysis technique under the Thematic Analysis modality were suffered. **Results:** it is clarified that the expectations are to be able to dialogue with health professionals about the unmet needs in prenatal practices. Two thematic categories were listed: << Continued dialogue with health professionals >> and << Informational reception >>, which present the details. **Conclusion:** it is inferred that the study gives visibility to relational insufficiencies in prenatal practices to high-risk pregnant women and reveals the prospect of these women to be the home visit counterpoint to this gap. **Descriptors:** Home Visit; High-Risk Pregnancy; Prenatal Care; Qualitative Research; Professional Patient Relationships; Comprehensive Health Care.

RESUMO

Objetivo: analisar as expectativas de gestantes de alto risco acerca da visita domiciliar enquanto parte do pré-natal. **Método:** trata-se de um estudo qualitativo, descritivo, desenvolvido sob o referencial do Interacionismo Simbólico. Realizou-se a coleta de dados com dez gestantes de alto risco, por meio de entrevistas individuais gravadas em dispositivo de áudio digital, transcrevendo-as posteriormente em sua íntegra. Sofreram-se, pelo texto derivado da transcrição, os processos analíticos da técnica de Análise de Conteúdo na modalidade Análise Temática. **Resultados:** elucida-se que as expectativas são de poder dialogar com profissionais de saúde as necessidades não correspondidas nas práticas de pré-natal. Elencaram-se duas categorias temáticas: << Diálogo continuado com profissional de saúde >> e << Acolhimento informacional >>, que apresentam os pormenores. **Conclusão:** infere-se que o estudo dá visibilidade às insuficiências relacionais nas práticas de pré-natal a gestantes de alto risco e revela-se a prospecção dessas mulheres em ser a visita domiciliar contraponto a tal lacuna. **Descritores:** Visita Domiciliar; Gravidez de Alto Risco; Cuidado Pré-Natal; Pesquisa Qualitativa; Relações Profissional-Paciente; Integralidade em Saúde.

RESUMEN

Objetivo: analizar las expectativas de las mujeres embarazadas de alto riesgo con respecto a las visitas domiciliarias como parte de la atención prenatal. **Método:** es un estudio cualitativo, descriptivo, desarrollado en el marco del Interaccionismo Simbólico. La recopilación de datos se realizó con diez mujeres embarazadas de alto riesgo, a través de entrevistas individuales grabadas en un dispositivo de audio digital, que luego se transcribieron en su totalidad. Debido al texto derivado de la transcripción, se sufrieron los procesos analíticos de la técnica de Análisis de Contenido bajo la modalidad de Análisis Temático. **Resultados:** se aclara que las expectativas son poder dialogar con profesionales de la salud sobre las necesidades no satisfechas en las prácticas prenatales. Se enumeraron dos categorías temáticas: << Diálogo continuo con profesionales de la salud >> y << Recepción informativa >>, que presentan los detalles. **Conclusión:** se infiere que el estudio da visibilidad a las insuficiencias relacionales en las prácticas prenatales para mujeres embarazadas de alto riesgo y revela la posibilidad de que estas mujeres sean el contrapunto de visitas domiciliarias a esta brecha. **Descritores:** Visita Domiciliaria; Embarazo de Alto Riesgo; Atención Prenatal; Investigación Cualitativa; Relaciones Profesional-Paciente; Integralidad en Salud.

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INTRODUCTION

It is inferred to be strategic prenatal care for the health of women and children,^{1,2} however, in Brazil, it is incipient in terms of access, coverage and quality.³ In the context of high-risk pregnancies, the biomedical approach prevails and there are gaps in the shared monitoring between specialized services and primary care,² an aspect that weakens the reception of needs.

In the direction of overcoming the weaknesses, bets on qualified listening and bonding are recommended,^{1,5} when the Home Visit (HV) is highlighted, given the chances of more intense interaction between health professionals and those demanding care.⁶ Care is qualified by the HV in prenatal care, as well as positive outcomes in terms of health indicators.⁷⁻⁸

It is intended to intensify discussions about the qualification of prenatal care in the context of high gestational risk, and this study directed attention to the expectations of women regarding receiving home visits as part of the prenatal care of a specialized service in pregnancy high risk. The question is: "What do pregnant women with high-risk pregnancies think about home visits? What expectations do you have?"

It is recognized that expectations are derived from social interaction and, in this way, Symbolic Interactionism (SI) presented itself as a potent reference, once it is understood in and from social interactions that meanings are established and transformed, with unfolding behaviors and actions.⁹

OBJECTIVE

- To analyze the expectations of high-risk pregnant women about home visits as part of prenatal care.

METHOD

This is a qualitative, descriptive study developed in a city in the interior of São Paulo with ten high-risk pregnant women who chose to receive HV in their prenatal care. The HV was offered as a doctoral study intervention entitled "Scope of a high-risk prenatal visitation program", with a positive opinion issued by the Research Ethics Committee of the Federal University of São Carlos, under opinion number 2,467,733, in 2018.

It is intended, in the municipality where this project was developed, prenatal care for high-risk pregnant women planned to be developed in partnership between Primary Care and the outpatient service. It is noteworthy that the latter's practices do not predict the HV.

The participation of women was regulated by the inclusion criteria: (1) being pregnant diagnosed as a high-risk pregnancy; (2) being 18

years of age or older or, as a teenager, being emancipated; (3) having your prenatal care with the outpatient service determined and (4) having accepted to participate in the aforementioned study. The following exclusion criteria were listed: (1) conditions that interfere with the woman's abilities to provide understandable narratives, such as, for example, mental illnesses, severe cognitive and sensory deficits and (2) pregnant women with pregnancies of children with already identified malformations.

Data collection was carried out prior to the beginning of the PhD research intervention, between the months of January to December 2019. The interview triggered by the placement was determined as a strategy for obtaining the data: "Tell me what you thought when you agreed to receive home visits developed by a nurse during your prenatal care". If necessary, the questions were asked: "What are your expectations?"; "What do you expect to receive on these visits?". Interviews were conducted by the first author and these took place at home during the visit called zero of the doctoral study. All of them were recorded on a digital audio device, later transcribing them in their entirety. For the text derived from the transcription, the Content Analysis technique underwent thematic analysis, which consists of three stages: (1) pre-analysis, with repeated and fluctuating readings of the transcribed material; (2) "exploration of the material", along which the search, extraction and first categorization of text units (excerpts and / or phrases) occurs from the inference of representation of manifest content; (3) "treatment of results and interpretation", when the material from the previous stage is interpreted to compose a reasoning about the phenomenon based on thematic categories, that is, thematic classification of elements according to their similarities and differentiation.¹⁰

It is pointed out that all the ethical precepts contained in the Brazilian resolutions for research with human beings were respected, with emphasis on having been the consented and voluntary participation, made official through the signing of the Free and Informed Consent Term (FICT). In order to preserve the anonymity of the participants, extracts were identified by the letter G followed by a number (one to ten) corresponding to the order of entry in this study.

RESULTS

It is revealed that, in all, ten women were interviewed, with an average age of 32.3 years old, varying between 23 years and 39 years. It is detailed that the diagnoses that determined the prevalent high risk pregnancy classification were: hypertensive syndromes of pregnancy and Gestational Diabetes Mellitus. It is added that, of

the ten women, two were primiparous; three had a live child and were pregnant with the second; three were in their third pregnancy; all had a history of abortion and two experienced their fourth pregnancy, all with three living children.

Two thematic categories were listed - Continued dialogue with health professionals and Informational reception - which describe expectations about the HV and reveal insufficiencies in prenatal care and the urgent need for informational and interactional reception.

◆ Continued dialogue with health professionals

It is noteworthy that the prenatal care offered was marked by shortcomings with a direct relationship with the option to receive VD. There are complaints about: the long waiting time for consultation, their short duration, as well as the lack of reception, including experiences of indifference and harshness by professionals. It is added that there was little verbalization of the attention received, with dissatisfaction.

[...]I go there at high risk and I already want to leave because you keep waiting a lot, which is already stressful, you wait, then, when you get there you already want to get rid of it, I myself want to leave, the professionals are very dry, not even looking directly at people. Go there for what? (G10)

I thought that, because I am at high risk, I would be much more accompanied. I even thought that I was going to be at high risk, but I'm not being, in general. (G9)

Consultations were characterized while focused on a morphofunctional approach, with access to diagnostic tests, but with relational weaknesses. Thus, in receiving HV, the complementation and qualification of this attention was deposited, especially in terms of 'speech space' and 'meeting with a health professional'.

If there is a home monitoring for all women who are at high risk, it would be great, because it is what is lacking. Because there [outpatient] there are tests, you know, tests and the laboratory. I think everything to add to my pregnancy is great, a space to be able to talk, tell my things. (G3)

[Receiving the HVs] it is good to follow, like, in the prenatal period, you cannot solve many doubts. The doctor over there is super, she was always super dry, like, there are things like that are silly things, but, like, you take questions. [...] I thought it was different to have a nurse here at home to talk, to know how it is, because, like, nobody was ever interested. [...] if my husband has any questions, he can ask the nurse. (G8)

It is strongly noted the need for them to be able to tell the health professional about their life, ask questions, enter into dialogue with them, however, they feel lack of comfort and freedom of interaction. It is understood that the home

environment and the fact that it is the same professional who will develop the HV will promote freedom of expression, with increased chances of offering information, presenting doubts and being welcomed, but they did not perceive the space of the ambulatory and the consultations as of potential for speech.

[...]if I have a visitor, until I have my baby, I will have the freedom to speak - look, I am in pain here, can you look?! Or - look, I have a spot here, can you look?! Because you create this freedom, right, but there at high risk, every week, you are a different person, so, something like that - will I speak, will I not speak? (G1)

We don't always remember all the doubts, right?! And when we are here [at home], we always remember or, at least, put it somewhere marked to remember what we are going to ask, so here, it is better than in the office to talk. (G4)

It is considered that, for a woman who already considered having a characteristic of being "locked in" in the interactions, the relational context found in the consultations did not encourage her to take initiatives, she only potentiated the closure, despite her need to talk to the professional.

I don't want to complain, but the two times I spent there, the doctor didn't even look me in the face. So, I don't even ask questions. Even more so, that I'm a bit of a "bitch" to talk to someone strange. Like, I'm inside my house, in my environment and I talk quietly [...]. (G8)

It is identified that another pregnant woman mentioned immense happiness with the opportunity to receive the HV in the hope of being able to count on a differentiated space, claiming that it was God who "presented it".

[...]I was fine, very scared with the high risk, with the service there. So, I went, I saw that the consultation was quick, then I said: "Wow, is there no other follow-up?". Then, the visiting nurse called and I said: "See! It was God!" (G9)

It is also understood that three women brought the possibility of experiencing warmth in the relationship with the visitor. It is pointed out that the situations were different, but kept a connection with the suffering, one faced with the professional mistrust placed on her regarding adherence to treatment, another due to the loneliness felt and another due to hopelessness in the face of pain due to the recent gestational loss of term fetus. Visits are presented as a possibility for transforming suffering.

Ah, it must be good to have someone there at my house to see what is happening because, sometimes, it gives the impression that the woman is not doing it right, right, for example, in my case, I was taking medicine and, even like that, my pressure didn't regulate, then, I

thought - well, if it's at my house, you'll see that I'm taking the right medicine. (G1)

[...]I expect nothing, without expectations. All the cards were sold out in 2018. So, whatever God wants [...] there were so many bad moments that I am even afraid to wish for something, but I will try the visits, who knows, I might be happy, if I was invited, it must be for God. (G5)

For me, I think the visits will be good because it will be a time to not be so alone at home. (G10)

◆ Informational reception

It is inferred that the HVs, as a possibility to expand understanding, especially from obtaining information and equalizing doubts, were present in the participants' statements. It is understood that having pregnancy classified as high risk is serious, requiring specialized and close professional monitoring. It is observed that their doubts were not being accepted, even for those who were experiencing, for the second time, the condition of high gestational risk, the feeling of being withdrawn was repeated.

And it's good, I think, because it will clear up doubts, right? (G1)

I want to clear my doubts. (G2)

[...]high risk is a very serious thing and as I had some doubts after B's birth [name of the first daughter], that I was very tense, nervous, I was worried about her birth, so I accepted. I want to understand the situation I live in. (G4)

I think, in fact, it is really the questions of doubts, [...] so, I think it will be cool to receive visitors, that's it, I want to, clear my doubts. (G7)

In general, I want to clarify doubts in the visits, what is to come, what I am experiencing now, whether it is normal or not, issues such as breastfeeding, childbirth, these things, so that we are in doubt. I think every pregnant woman, right?! (G9)

[...] because sometimes I feel bad, sometimes I get sick, sometimes there is so much that we want to clarify. As much as it is my second pregnancy, the third, because the second one I missed [...], but there are things that we go through during pregnancy and end up with no knowledge, experience for being in the second pregnancy, but no knowledge. So, the visit is great. (G10)

It should be noted that, despite the fact that the majority bring notes regarding doubts about the gestational condition and how it is conducted, there were women who mentioned doubts regarding motherhood and its work and organization process. A woman was concerned with the exposure of her diagnosis and the need to keep answering questions to other people, if she were to be placed in a collective room.

Ah, I hope you can clear my doubts, that you can help me with what I have doubts, that can really cease, you know?! Type of delivery, about the treatment you have at the maternity hospital,

how it works. When my other son was pregnant, I ended up staying in a room alone, so I'm afraid this one will have someone in the room with me and ask questions [regarding their diagnosis of retrovirus]. (G8)

It is emphasized that another woman is explicit in stating that information is right and needs to be more considered in health care.

And I'm super happy to think that maybe this can help, one day, to have these home visits in the public system, which we see is super necessary, it's right, guidance is right. (G3)

DISCUSSION

It is clarified that the expectations of the participants about the HV reveal deficiencies in prenatal care, especially in relation to the interest and consideration of their person and needs. It is projected, in the HVs, informational and relational reception, which is out of step with the doctrinal principles of the Unified Health System (UHS), in particular, that of integrality, which assumes itself to be opposed to reductionisms and technicalities, as well as favoring a response extended to health needs.¹¹

The quality of prenatal care in Brazil is debated, especially regarding the plastering of practices and the mechanistic and reductionist tendency when adopting an approach exclusively focused on biomedical issues.^{2,4} This positioning contributes to care practices that are attentive only to signs and symptoms that translate the functioning of organic systems, neglecting subjectivity,¹² the historicity and life of the woman and her family.

The contribution of the use of Clinical Protocols and Therapeutic Guidelines (CPTG), supported by scientific evidence, in the development of diagnosis of health problems and treatment modes is discussed,¹³ however, assistance based exclusively on them may be insufficient in terms of aspects that encompass the uniqueness of each woman, family and life context, which integrate health needs. It is called, through advances in the quality of prenatal care, for the mobilization of CPTG in intersubjective relationships between professionals and the demands of their care. In advancing to more comprehensive and humane prenatal practices, meetings between professionals and pregnant women are required.¹²

It is questioned about the meeting between professionals and women, especially based on the complaints brought here: "What nature is he? What understanding does the professional have about his role in relation to commitments to health and to others? If there was an intention to meet, would women be denouncing 'short and quick' prenatal consultations as occurred in this study and in others?^{12,14} What to say when violent

attitudes are added, such as harshness or non-eye contact?”.

As a whole, it appears that the professional's interest in meeting women, their history and needs is scarce, including offering guidance, an action so common to health practices. Attitudes were felt by the participants while disinterest, producing passivity of the woman, who apparently fulfills the visit, but does not reveal herself in her. Expectations of being able to reveal needs, to reveal oneself with a view to pregnancy, childbirth and birth free, to the fullest of complications and suffering, brought up by the HV, which is in line with the intentions of prenatal care according to the documents guiding.^{1,5}

It is known that the correlation between the quality of prenatal care and the interaction between professional and care provider is a fact, with an urgency of investments for more effective communication, with chances of enhancing access and consideration to the context of each pregnant woman, her uniqueness and, consequently, result in greater adherence and satisfaction with the monitoring.¹⁵⁻⁶

It is considered that HV is one of the strategies for improving health care,¹⁷ mainly because it provides the professional with differentiated possibilities for insertion in the reality and life of the person demanding care, expanding its manifestation and speech.¹⁸ The home environment is reported to be conducive to health interventions, especially for the comfort it provides,¹⁸⁻⁹ aspect explained in this study. It becomes necessary, however, to ask if other assistance spaces do not have the potential to provide a similar context or if the discomfort felt in prenatal consultations should be taken while expected? Some participants gave way to the discomfort felt in the consultations and how much it inhibits the launching into the interactions, even wishing that the moment would end soon, as well as with the intention of being silent, keeping the annoyance of doubts and need for information that hover in internalized reflections.

It is noteworthy that women who experience high-risk pregnancies live with apprehension, feel fear, anxiety and uncertainty,²⁰ aspect that appears in the voice of the women in this study. It should be added that the indications for intervention are continuous, understandable and adequate information on the current diagnosis and condition.²⁰ It is noteworthy that it is in the realm of feeling that concerns, fears and desires are manifested and, when the professional makes investments in conversations, exploring them, it increases chances of meeting needs and welcoming them. It is believed that the way the professional conducts prenatal care is the differential,²¹ although the advantages of the home environment in the care and follow-up of

prenatal care are recognized. It is agreed that it is possible to promote care based on needs, perceptions and expectations in any space,²² to include those in which high-risk prenatal care is carried out, such as medical and nursing consultations.

It is emphasized that it is up to the nurse, and to all health professionals, the adoption of welcoming and listening as a horizon for care.²¹ Asking yourself about the feelings and expectations of the pregnant women in front of you can give access to women and trigger actions aligned with the doctrinal principles of UHS and prenatal care in Brazil. Humanized prenatal care is experienced when women experience interest and closeness in the relationship with the nurse, with bets on the bond, dialogical relationships and listening.¹⁴ Therefore, attention is needed in moving protocols and techniques in favor of the needs of each woman,⁴ aspect not revealed in the results of this study.

It is also noted the weakness in the continuity of care for high-risk pregnant women²³ and the HV was seen as a counterpoint resource. A reference professional is desired, when the nurse has the possibility to assume this place, especially due to the differentiated condition to promote bonding.²² It was demonstrated, in a study that discussed his work in high-risk prenatal care, his potential in approaching pregnant women and in the articulation of hard and light-hard technologies, a favorable aspect for a therapeutic and protective environment.²⁵

It should be noted that the results made it possible to affirm that high-risk pregnant women signify a worrying situation and cry out for specific attention when they seek to understand their condition, but do not reach understanding, with concerns, fears and anxieties arising. This experience is compounded with relationships with health professionals marked by lack of interest and focused on protocol and sometimes even violent aspects. These women withdraw, facing this scenario, in the interaction with the professional, experiencing dissatisfaction and, when they have the opportunity to receive HVs, the expectation of interaction with professionals receptive to their needs and willing to share knowledge that will compose their flourishes. Any chances between high-risk pregnant women and health professionals stop the chances of taking into account the singularities, an essential condition for care to emerge and be mutually woven.

CONCLUSION

In view of the proposed objective, the expectations of high-risk pregnant women about the possibility of receiving HV as part of prenatal

care were explored and, based on that, it was reflected on the qualification of this care.

It is concluded that, due to the concerns and uncertainties present in high-risk pregnancies, the women in this study deposited in the HV the supply of the insufficiencies felt in prenatal care, mainly regarding the informational and relational reception. It is believed that the attitude of the professional (s) who conducted prenatal care was lacking in listening, especially in relation to suffering, concerns and doubts.

The number of women participating is assumed as a limit, as well as the fact that it was developed in a single municipality, with the particularity of its health care. Despite this, refer to the literature, the revelations obtained from a qualitative approach, deriving notes and reflections that can be taken in the qualification of high-risk prenatal care in different contexts.

Therefore, future studies that explore the role of women in the course of high-risk prenatal care are suggested, as the data signaled the withdrawal of women in interactions with professionals, an aspect relevant to discussions of female empowerment in health care. It should also be noted that the issue of the reference professional, continued care and high-risk prenatal care are themes that have appeared and can obtain more specific exploration in new studies.

It was observed to be the professional nurse that makes up the high-risk prenatal team and the contributions of the study are to give visibility and make notes to the attitude of this professional in the meetings with women, especially regarding listening, information and valuing of feelings. It is constituted by the care philosophies that value the adoption of a reference professional, a possibility of qualifying prenatal care and Nursing.

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