ABSTRACT

Objective: to discuss the woman's reception directed from birth center to the unit of reference and the impact on woman's perspective. Method: qualitative field research done in 2007 and 2008 in a birth center in Rio de Janeiro. Two focus groups, with six women each one, were used after signed the informed consent form. It was submitted to the Research Ethics Committee of the Municipal Health Office of Rio de Janeiro, obtaining authorization number 199/07. The content analysis proposed by Bardin was used. Results: the referral to the unit of reference is generating source of feelings as fear, apprehension, sadness and deception. The childbirths happened in a context that distanced the woman from her relatives, companions and baby. Conclusion: the reception was based on an medicalized attendance, based in the practices of the model technocratic, active routine of the unit of reference. Descriptors: reception; obstetrical nursing; humanization of assistance; health services; Sistema Único de Saúde (SUS).

RESUMO


The study was produced from the dissertation "Experience from reception of the woman sent from the Childbirth House David Capistrano Filho to the reference unit >> State University of Rio de Janeiro - UERJ, 2008."
INTRODUCTION

The hegemonic and technocratic model of health care currently experienced by most of the population is not satisfying the needs and demands of users' health. In practice, the experience of women who used health services and are still based on the technocratic model of care, reveals the rejection as a basic premise; Their emotions are suppressed, doubts and fears about their condition are evident, lack of dialogue, to provide information and clarification are also present.

The mismatch between the woman and health professional is evident, because we found hierarchical postures, and ritualistic routine care focused on compliance with technical protocol, fragmented communication which reflects the devaluation of attention to women's demands.

In this sense, the reception has brought a possible, desirable and necessary proposal for building a model of health care consistent with the principles of the SUS. These principles have central focus in the attention and in the user's viewpoint, in their care needs, health, access, and citizenship. The reception then means the care humanization and sensitive listening and solidarity with the suffering of others. It goes further than just a service in the strict sense of the word, it is to solve, answer or resolve in a qualified and humanized way the medical condition of the user. The professional needs to take on the responsibility of the resolution creating a link between service and user.

To begin the contextualization about reception, we won't fail to mention the proposal for health care recommended by the National Health System (SUS), since this brings the reception as a basic operating guideline and as a strategy of quality health care. As a primary source, the guideline of reception to the operating practices of health production defines the reception as an action of approach, that is, a being with and a being close to the user, as an attitude of inclusion of this subject. The manual reiterates the reception as a guideline of great relevance ethics, aesthetics and politics of the National Policy of Humanization of SUS.

Attending to the guideline of reception with the evaluation and risk classification, an ethical paradigm, aesthetic, into healthcare, means that the reception is a technical assistance action that reveals the need to change the relationship among the professional, user and family, change which is guided by technical, ethical, humanitarian and solidarity parameters, which sees the user as social actor and participant in the primary production of health.

Four dimensions of reception are identified: access - geographical and organizational: it is reflected in the mode of transportation, displacement time and distance between the user's home and the health service; posture - listening, professional attitude and multi professional relation: this dimension assumes an appropriate posture of the health team that enables to welcome and in a humane way the user, including commiserating with the suffering; technique - teamwork, professional training and acquisition of technology, knowledge and practice: it involves the provision of tools that comply with the demands of the user, and the incorporation of new agents in the work process, but it also expands and enhances the access to the user; reorientation of services - institutional design, supervision and work process: the reception assumes the condition of reorganizing the work process, identifying the customer's demands and reorganizing the service.

As one dimension of the reception, the work process has been redesigned the health care model, since it opens up spaces for projects of non-medical professionals, with emphasis on the nurse's work, revealing the construction of spaces in the public micro policy among other possible spaces.

By bringing the reception to women's health, it is understood as a determining factor for quality monitoring of pregnant women, the reception, being the responsibility of the health care team to understand the various meanings of pregnancy and birth process for women and their families.

In this sense the creation of the Maternity Hospital of Rio de Janeiro as a municipal politics strategy to put into practice a project according to the principles of care, nurture unmedicalized spaces where women will prioritize the humanized model of care. Thus, the nursing gives a qualitative leap in its strategy to work, as it receives heteronomy of superior political bodies, since its autonomy was accredited and reaffirmed as a proposal for positive assistance to the demands of users of SUS. The potential of the nurse formerly underused has acquired a potential and now it has been more appreciated and used in the health service.
The question of our study is related to the fact of knowing that motherhood of reference, to where the user is transferred, reveals in its staff of professionals with different conceptions of health care over the humanized model practiced in the maternity hospital. The hospital area where the woman is sent is composed of health professionals who make up a hybrid set of knowledge, each one operates according to their theoretical practice conceptions and according to the hospital where they belong to. The hybridity of health practices aimed at the conception of each group of professionals has been acting significantly on women’s health.  

Despite the efforts of various groups of health professionals in order to humanize care, the reference unit of the maternity still has difficulty to put into practice the National Policy of Humanization. The medical group, who are involved and imbued with the old technocratic model, resist the new conceptions of care aimed at the humanization of delivery and birth. The woman goes through a break in her care, so, she has to adapt to the new perspectives and dimensions of the humanized care diluted in the medicalized hospital care. The National Policy of Humanization brings the guideline of reception that in practice, in essence, it is able to contribute to change the reality of health services, with respect to the host offered to women. 

Thus, it is identified as a research subject: the host offered to women, moved from childbirth home, at the unit of reference. To realize the object of study, it was created to describe the reception offered to the user in the unit of reference, of the birth house, after their transfer and the impact on the woman’s perspective. This study will provide subsidy to the discussions about the reception of the woman who is referred by nurses in a hybrid model of care and contribute to the advancement of the discussions about models of care to the delivery.

**METHOD**

Field research of qualitative approach that took place at a birth center, located in the city of Rio de Janeiro, in the planning area (PA) 5.1. It is characterized as an independent health establishment or community, it is also known as single unit, i.e. it is not attached to a hospital, but with a reference unit in the rear and it is the only project already inaugurated in the city of Rio de Janeiro.

The reference unit is located in the city of Rio de Janeiro, the planning area (AP) 3.3, receives and takes care of the woman who develops the medium and high risk, and it is removed from Childbirth House David Capistrano Filho - Casa de Parto David Capistrano Filho (CPDCF) within a distance of seven kilometers of CPDCF.

The relation of communication between the two health units to start the process of transferring the woman to the unit of reference is given as follows: the obstetric nurse - after the decision of the need for referral of the pregnant woman, childbirth, postpartum or newborn -, contacts the obstetric nurse on duty or chief of duty in the unit of reference to communicate the need for referral of women who developed obstetric risk. The nurse follows the woman in an ambulance for this purpose, to the reference unit, with an initial diagnosis and detailed report of all assistance provided to women at CPDCF.

The subjects of this study were women who had prenatal care in the home birth in the first four years of its existence, they attended the collective steering groups (prenatal), had at least six prenatal visits, were sent to maternity reference in the third trimester of pregnancy because they have developed medium or high risk pregnancy, and they participated on the research with the signing of consent duly read and understood after explanation of the research objectives.

In the process of data collection as part of the a methodological resource we used the focus group interview, recorded in MP3 player, which happened in the collective consultation room at CPDCF. The focus group is a meeting between people, a dynamic, that happens to the discussion of the research object, and it is not restricted in questions created by the researcher and objective answers provided by the individuals. 

The groups were composed of six women and the sessions had an average duration of four hours, four meetings were held, one per week, because the object of study was thoroughly discussed so that the experiences, living, related facts and phenomena had been repeated by the women. After the non-appearance of new facts, the discussions were ended.

For the treatment and data analysis used the method of thematic content analysis. To improve this work and deepening of discussions, we substantiate data collected from the host guideline of the Ministry of Health.
The Ethics Committee in Research of the Municipal Health Department - CEP / SMS - RJ, established under the Resolution CNS n° 196/9612 and duly registered with the National Research Ethics Committee, received, examined and given a favorable opinion on the documentation received for the research, the research protocol approval No. 199/07, and the authorization of CPDCF and the use of their name.

RESULTS AND DISCUSSION

The reception that i’d like to have received: cautions that could have been used to relieve the repercussions

The discussions starts focused on the host that the woman would have received after her referral to the reference unit. It is necessary to expose and analyze the clarifications cited by women because it is understood that they are the subject of the action received and no one better to describe what kind of host is more favorable than the woman herself.

The first few lines remind us the typical woman’s satisfaction, as she thought she was actually received during childbirth.

[…] The treatment, the way I was received is not how I expected to be right here. I was sure it would be here […], but the service does not have that thing, a word of comfort, an affection that we need at this time […], so I really wanted it was everything different, everything new, a most remarkable experience, but there I think there isn’t how […] more attention, more caring. (E1)

The testimony reveals that the expectations presented by the woman in connection with the reception received was not permeated by the treatment and care that both expected. She reports that she hoped to have received a word of comfort and care as a necessary care for her at that moment, defining the treatment offered as “just the service itself.” She concludes her thoughts reporting that she would like to have been welcomed in a different way from that experienced by her, I would like to have had a truly remarkable experience, with attention and maybe even with fondling.

It should be noted at this point that a word of affection, comfort and attention to the woman’s demands was expressed as more care, extra care, as the care was not permeated by these elements, routinely, and being offered only when a professional has kindness enough to provide a care with comfort, warmth and attention.

In a study about the host of women in a health unit, it was evident that many women are not treated as they wish, getting from professional health a quick care, endowed with impatience that depersonalize and disqualifies the assistance, so the woman describes the service as being of poor quality. Good care for women is seen as one endowed with affection and attention from the health professional.13

The sensitivity and the ability of perception of the health professional in identifying the demands of attention, care and comfort of women during the birthing process are basic conditions for the health knowledge to be available, this woman and her entire family.13

To respect and value the women’s needs, which in this case resulted in the need for attention, affection and comfort is above all respect their family background, their uniqueness and culture of this population in particular. The woman is more sensitive and vulnerable during pregnancy, because she is experiencing a period considered critical and transitional part of the specific development of women. 14

It is understood that the experience of the pregnancy to her required more care, attention and comfort through a friendly word of health professionals, but the reality of this woman’s daily life was not expected by her, making the experience something new, that is, a natural childbirth.

It is understood after the analysis of speech that the suffered repercussions are exactly because of the health institution has not provided the woman a remarkable experience for her. She kept expecting the childbirth as something that was truly remarkable in her life, i.e., an experience she could remember as a positive and transformative moment in her entire life, but it was not possible.

I wanted her father had watched my delivery, we planned that he would watch the birth, but he didn’t, everything was totally different than I had imagined, the nurses, I thought I was well assisted, but I was not well served […]. (E7)

This report brings us a new element such the presence of her partner during labor and delivery. She also reports that her expectations did not happen according to what she imagined for herself. She also relates the nurses’ assistance, who also did not meet her expectations.

Two ways of understanding the host are
identified in the woman’s speech, which are: one as a posture toward the user and her needs, ie the intermittent investigation of the demands of the user’s health and how to satisfy her during all the birthing process. And as another strategy to reorganize the service in order to meet the woman’s demand, thus valuing the humanization in the service.

In a study about the host in the municipal health system indicates that the host assumes the execution in an appropriate and humane way the user’s health demands, so the professionals need to be receptive and attentive to these needs.1,15

The chances of the appropriate host dictated in the woman’s speech are no longer understood as a need for a possible contribution in her health, beyond that her partner can not watch the birth, since the reorganization of the service to meet this need did not happen and the assistance was assessed as inefficient, understood through the speech, “I thought I was well assisted, but I was not well assisted.”

The fragment of speech “everything was totally different than I had imagined,” reminds us of the disappointment faced by her, understood here as a backlash experienced in this process, since her unique demands of a woman who lives pregnancy were not assisted.

New data keep appearing as the following speech:

I wanted to have Mariana in the water, taking pictures, shoot, and all I could do, listen to music, I could not do it, but I could [...]. (E10)

In the speech fragment we identified another type of need felt by the woman. She describes what kind of delivery she would liked to have, how she would like to have recorded this moment so important, that is, taking pictures, filming, listening to music, and concludes by saying that somehow, there was no possibility of being assisted in her own demands.

The professional practice in study shows that the quality of care provided by professionals from public and private network reflects the lack of preparation of these to waive compliance with predetermined and rigid protocols that prevent them from realizing the real health needs of the user.13

Faced with these roles the professional is tempted to accomplish them, failing to grasp the existence of other possibilities good and effective care to the women’s health. We are relating about the demands described by the interviewee in the analyzed speech, such as a water birth, or even the simplest strategies, which requires little or no change in the physical environment or service organization, such as registering the birth through photography and film or music to make the birthing process more enjoyable.

By inserting the host guideline, studies about the thematic reveals us that while the technique, the host implies in the implementation of actions that may be suitable to the demands made by the user. This implies the reorganization of the work process, or give another direction to the service so that the health needs presented by women are properly met, or even rearrange the service based on the identified demand.1,15

In this specific case the service is not organized and the professional is not mobilized to comply with the health needs raised by the interviewee, even the simplest and easiest demands to be implemented. Thus, the host offered was fragmented, since the real health needs of the user were not met the way she wanted.

In the statements below it is found another aspect to consider. Some suggestions are identified to qualify more the service received and a long rant about this same service:

To improve the assistance and nurses are better polite, you know, they are there, they studied for that, so if they are in a bad mood, if the night was not good for them, last night, it is not our fault, the same way we do they also do, so I think they should be more aware of what they say and how they act with people, I think there is no dog, no animal to they treat us how they do, the same way I need you need, they need, and everyone needs. Do you understand? If we have conditions to have the child in a private hospital, a good plan, I think everyone here would want to have them. Do you agree? Right. If we had a good plan, conditions if we had, you would want to have it [...]. (E8)

In this speech, considered by us as an outburst, several elements were identified as important in a service of quality. She cited to be treated with education, humor and conscience. The inability of health professionals in dealing and communicating with the users was also part of speech.

As we saw in the user’s outburst, putting into practice the policy of the host requires the health professional an attitude of change.
in relation to the user, requires a change into healthcare and implies the encounter between professional and user.3

The dimension posture presupposes an ethical and humane attitude of the professional in relation to the user, it requires the recognition of each other with an attitude that allows to receive it well with education, valuing their complaints and pains.3,16

To the assistance of their health needs during the birthing process, everything that the woman wanted was to be treated with education, humor, respect, more aware when the professionals speaks certain words, deeds and actions, understanding that the health professional, through reckless acts, can be a great creator of conflicting demands during the birthing process.

At the end of the statement we identified that the economic factor17 has been influencing the experience of the mother directly: “[…] if we have conditions to have the child in a private hospital, a good plan, I think everyone here would want to have them. […]” In this case the user said that only had the delivery in a public maternity hospital because of financial deficiency. She reports emphasizing that if she had a good health plan, she would have had her baby in private hospital. So the economic factor was crucial and decisive for the choice of network service, public or private, that the user wished assistance in her birthing process.

In a study about teenage mothers it was perceived how the economic factor is present and directly influence the family environment and directs the health / disease for the whole family18. In another speech:

I wish people were more human, we know that the public hospital is getting worse, so it is very difficult, isn’t it? […] (E12)

Differently from other testimonies, this user was concerned with the humanization of care, noting that health professionals should be more human, ie they should make their practice a more humane practice.

The health demands of this interviewee were not linked to environmental factors, comfort, technology and others, everything she wanted was to be treated as a human being she is. In the phrase “I wish people were more human […]” assumes that being more human, they would treat the users with more humanization.

While aesthetic guideline the host brings for human relationships the implementation of actions that contribute to the dignity of user's life and the development of humanity in the health professional's life.3,15

Important items are still considered in the host: to be treated well by the team, to be known for her, punctuality in attendance, cleanliness and organization of the area, attention and interest provided to the customer, to receive positive answers or explanations to her questions, to receive guidance of professionals health spontaneously.3,5,7,16

To the host for the woman can be part of the practice of health professionals is necessary that assistance occurs through humanized actions and attitudes, such as: to respect the context of each woman and her family; to stimulate a partner in consultations of prenatal and hosting during the process of childbirth and postpartum period, to host the story that every pregnant woman carries upon her entry into the health service; to put the professional expertise available to the woman and her family; to keep an open and attentive listening, without prejudice about revealed facts, assuring them privacy and confidentiality; call the woman by the name, informing them about the conduct and procedures to be performed.3,5,7,16

To assist the user's healthcare demands of SUS is more than eliminating disease, it is more than the remission of symptoms, it is more than answering their complaints, assist with quality, it is to host with dignity, to translate the real needs of women, according to their way of life and their culture, in order to improve the quality of life for this user.

CONCLUSION

When discussing the admission of women sent from the maternity hospital for the unit of reference based on the theory of diversity and universality of cultural care, the referral to the unit of reference is evidenced as a generator of impact in the women's health, involving mainly feelings of fear, sadness and the disappointment. We also identifies that the host was based on a medicalized attendance, agreeing with the attendance based on the practices of the technocratic model still in practice and active in the care routine of the unit of reference and, thus, not reaching the essence of the guideline host of the Ministry of Health.

It is observed that the host offered to women was based on institutional coldness; at structural inadequacy to host and assist; in the use of practices often used improperly: fluid restriction, food and repeated and frequent vaginal examinations for more than
one health professional.

In the reception offered by the health professional at the referral center is evidenced how unprepared the professional are in dealing with the uniqueness of the woman; the trivialization of pain during labor and delivery; the provision of general care provided with impatience in which the users were treated the same way; the disharmony in the relation professional and user; and the disengagement of the professional to be involved with the health problems of women.

There is the weakening of collective bonds of which are essential for the professional to affect positively the user with their care. The anesthesia of the professional attitude makes impossible the relations of trust, harmony and support among health professionals and users. Thus, preventing a daily relationship of joy, peace and value to the human dignity.

It is evident that the experience of the process and delivery of women at the referral center brought repercussions in the process of delivery, because it was not experienced with pleasure. She was deprived of experiencing this unique moment in her life, because she was in a state of permanent tension, always concerned about the progress of delivery.

There are also envisions in the relationship between the woman, her partner and baby. It is observed that the births took place in a favorable context to the woman's physiology, away from her family and her partner; what affected the establishment of a healthy relationship and hindered the formation of bonds of attachment with the baby and family ties which are important in healthy development of the human being.

For having lived a birthing process that led to the dissatisfaction of the user, so she doesn't want to get involved again in another pregnancy process, affecting not only the woman's psychological as well as affecting marriage and family life of the couple, because the partner did not share the same desire.

It is understood that to mitigate the impact of host on women's health is necessary that the reference unit hosts and assists in the philosophical and humanistic manners, according to the guideline host. Thus, the adaptation of women to the new environment will be facilitated since the health unit will provide quality care involving the cultural context of the user.

Finally, we observed that the tendency of the assistance goes to a practice according to the National Humanization Policy of the Ministry of Health, with the host guideline as an ethical, aesthetic and political device in implementing a truly and effective care; and, in the hard, the difficult task of building professionals with service profile facing the commitment and accountability to solve the user's health problems. It is necessary to plan strategies for training of professionals in the construction of ability and individual and collective cultural competence sufficient to assist the users within their cultural context, highlighting the way of life, popular knowledge and care of specific cultural groups of women.

REFERENCES


Reception in women health: a respect...