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ORIGINAL ARTICLE

PRENATAL CARE IN THE PERCEPTION OF MOTHERS OF PREMATURE HOSPITALIZED IN NEONATAL UNIT

ASSISTÊNCIA PRÉ-NATAL NA PERCEPÇÃO DE MÃES DE PREMATUROS INTERNADOS EM UNIDADE NEONATAL

ASISTENCIA PRENATAL EN LA PERCEPCIÓN DE MADRES DE PREMATUROS INTERNADOS EN UNIDAD NEONATAL

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ABSTRACT

Objective: to know the perception of mothers of hospitalized premature in the neonatal unit of a public hospital in the prenatal care received. **Method:** a qualitative study of 21 mothers of premature children. Data were generated through semi-structured interviews and subjected to content analysis technique. The research project was approved by the Research Ethics, CAAE: 07451812.9.0000.5129. **Results:** the results showed as prenatal difficulties: late monitoring, lack of examinations access and long interval between consultations. The disease diagnosis and referral for motherhood were related to the importance of prenatal care. **Conclusion:** mothers recognize the prenatal as an important strategy for maternal and neonatal health, but they do not link the role in pregnancy, childbirth and the process. **Descriptors:** Prenatal Care; premature; Policies on Health

RESUMO

Objetivo: conhecer a percepção de mães de prematuros internados na Unidade Neonatal de um hospital público quanto à assistência pré-natal recebida. **Método:** estudo qualitativo com 21 mães de prematuros. Os dados foram produzidos por meio de entrevistas semiestruturadas e submetidos à Técnica de Análise de Conteúdo. O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa, CAAE: 07451812.9.0000.5129. **Resultados:** evidenciaram-se como dificuldades do pré-natal: início tardio do acompanhamento, dificuldade de acesso a exames e intervalo longo entre consultas. O diagnóstico de doenças e o reconhecimento para a maternidade foram relacionados à importância do pré-natal. **Conclusão:** as mães reconhecem o pré-natal como estratégia importante para a saúde materna e neonatal, porém não o correlacionam com seu papel de protagonista no processo de gestação, parto e puerpério. **Descritores:** Cuidado Pré-Natal; Prematuro; Políticas Públicas de Saúde.

RESUMEN

Objetivo: conocer la percepción de madres de prematuros internados en la Unidad Neonatal de un hospital público en la asistencia pre-natal recibida. **Método:** estudio cualitativo con 21 madres de prematuros. Los datos fueron producidos por medio de entrevistas semi-estructuradas y sometidos a Técnica de Análisis de contenido. El proyecto de investigación fue aprobado por el Comité de Ética en Investigación, CAAE: 07451812.9.0000.5129. **Resultados:** las dificultades del pre-natal fueron: inicio tardío del acompañamiento, dificultad de acceso a exámenes y largo intervalo entre consultas. El diagnóstico de enfermedades y el referencial para la maternidad fueron relacionados a la importancia del pre-natal. **Conclusión:** las madres reconocen el pre-natal como estrategia importante para la salud materna y neonatal, sin embargo no lo relacionan con su papel de protagonista en el proceso de gestación, parto y puerperio. **Descriptor:** Cuidado Pre-Natal; Prematuro; Políticas Públicas de Salud.

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INTRODUCTION

Infant mortality is an indicator of the population condition of life and health. In Brazil, this indicator is falling progressively, but less than expected.¹ According to the report "World's Children Situation 2013," published in late May 2013 by the United Nations Children's Fund (UNICEF), Brazil decreased from 19 to 16 on infant mortality rate. In 2012 edition, Brazil was 103 in the ranking where the first position is with the worst mortality rate. Currently, the country is in 107² and neonatal mortality is approximately 70% responsible of deaths in the first year of life and proper care to the newborn has been one of the challenges to reduce mortality rates in country.¹

The birth weight and prematurity are considered the main causes of neonatal mortality and they are associated with lack of basic procedures in the care of pregnant women, childbirth and newborn.³⁻⁴ In this context, prenatal care helps in the diagnosis and treatment of numerous complications during pregnancy and the reduction or elimination of factors and risk behaviors.⁵

Although data from the Ministry of Health (MH) indicating increased coverage of prenatal care and the number of consultations for pregnant women in the last 15 years, a study investigating the deaths of children under one year old in Brazil in the period 1997-2006 using the list of preventable deaths interventions of the Unified Health System (SUS), showed reduction of all preventable deaths, except those related to adequate prenatal care, suggesting poor quality of this type of care.⁶

Given the above, the need to broaden the understanding of the factors influencing the quality of prenatal care is necessary, especially on the point of view of the women's users.

The objective of this study was to know the perceptions of mothers of premature children hospitalized to the neonatal unit of a public hospital in the prenatal care received.

METHOD

Article elaborated from the dissertation <<Prenatal care of mothers of premature children at a public hospital in Belo Horizonte >> presented to the Multidisciplinary Residency Program at Children's Health of the Municipal Hospital Odilon Behrens. Belo Horizonte-MG, Brazil, 2013.

This is a descriptive study, exploratory type and qualitative approach. The research was conducted in a municipal public hospital in

Belo Horizonte, where teaching, research and service activities are carried out, with reference to high-risk pregnancies in the municipal and state health care system.

The subjects were mothers of premature newborns (NBs) (gestational age <37 weeks), born in the institution and forwarded to the Neonatal Unit between first of October to 30 of November 2012. In Neonatal Unit 31 RNs were hospitalized, having three twins. Of the 28 mothers, 21 agreed to participate and were included in the sample.

Data were collected through individual semi-structured interviews, with specific script, containing questions about planning for pregnancy, prenatal care received and the outcome of pregnancy. They were recorded with the permission of the participants and transcribed. These data were then subjected to content analysis, following the guidelines of Bardin, allowing to define and explore themes categories.⁷

The analysis was organized into three chronological periods: pre-analysis, analytical description and referential interpretation.⁷

The pre-analysis was to organize the material. This step occurred simultaneously with data collection, because, as the interviews were conducted, they were transcribed and stored. During transcription of the interviews, there was the codification of the participants, to avoid identifying individual subjects.

In the second step analytical description was performed. The empirical material was subjected to a careful reading, always returning to the research objective. During this step, the procedures clipping of statements were carried out, followed by the classification and categorization of them. Each clipping of the statements was rated according to their unit, which allowed the recognition of three themes: "pregnancy planning", "The importance of prenatal care" and "Difficulties found in performing the prenatal".

To finish the step of analytical description, the narrative of each category was organized, allowing to approximate meanings present in selected passages, making relationship of them.

The third step of data analysis occurred through referential interpretation. At this step the relationship between the empirical and the theoretical. For this reason, reflecting based on empirical data, allowed the establishment of relations and deepening of ideas.

To complete the data obtained through interviews and to provide a better

understanding of the context of prenatal care received by these women, prenatal cards and newborn medical records were used as sources of auxiliary data. These data were analyzed using descriptive statistical technique, generating averages and percentages, providing a brief description of the profile of the interviewees.

Before starting data collection, each participant was invited and informed about the research objectives; protection and custody of the collected material, and their use by the researchers; the voluntary nature of participation and freedom to quit from the study when they want; and to guarantee the anonymity of the subjects. For the anonymity, women were identified with the letter "W" followed by the numbers 1-21. Interviews were conducted only after signing the consent form for each participant, and authorization to use the recorder was also requested.

This study followed the standards established by Resolution 196/1996⁸ which regulates research involving human subjects and it was approved by the Ethics Committee in Research of the Municipal Hospital Odilon Behrens (CAAE: 07451812.9.0000.5129).

RESULTS AND DISCUSSION

• The profile of the interviewees

From 21 respondents, 15 (71.43%) were married or had stable marriage and six (28.57%) were single. The age of respondents ranged from 14 to 41 years old, emphasizing that a third of mothers were less than 19 or more than 35 years old, considered a risk factor for preterm birth. About the educational, six (28.57%) had incomplete elementary school, six (28.57%) had completed elementary school, seven (33.33%) had completed high school and two had (9.53%) higher education. About their occupation, nine (42.85%) had paid job, one (4.76%) had not job, one (4.76%) was a student and 10 (47.61%) were housewives. Most mothers resided in Belo Horizonte, corresponding to 76.19% (16 mothers) of the sample; four (19.04%) were residing in the Metropolitan Region (Vespasian, Ibirité and Ribeirão das Neves) and one (4.76%) in the state countryside.

The average of the Gestational Age (GA) at birth was 31 weeks, ranging between 27 weeks and 36 weeks and four days. From the respondents, 10 (47.61%) had Prenatal High Risk (PNAR), with indications: sickle cell anemia (20%), chronic hypertension (30%), multiple births (30%), asthma (10%) and obesity (10%). The main indication for the cesarean delivery was severe preeclampsia

associated with fetal complications, corresponding to 64.70% of the indications for cesarean section.

The average number of prenatal consultations was 5.2 per woman, ranging from 1 to 15 consultations. From these mothers, 16 (76.19%) had the least number of consultations according to gestational age, 20 (95.23%) began prenatal care at least 120 days of gestation; 20 (95.23%) had complete tetanus vaccination schedule; 11 (52.38%) had performed the basic tests, including obstetrical ultrasound and only three (14.28%) participated in educational activities. From the 21 mothers interviewed, 13 (61.90%) had the prenatal card for evaluation, identifying that as maternity reference, only three cards (23.07%) were completed with that information. In addition, three of the mothers (23.07%) did not present information on the card and did not even know what was the maternity reference and six (28.57%) did not have the baby in a referral hospital.

Despite this is a qualitative approach study, it was important to analyze information on the socioeconomic profile and the prenatal care to understand the context in which the participants are entered, to understand the information obtained through the interviews. This analysis identified that, although most of the interviewees have the number of consultations recommended by national guidelines on prenatal care and initiated prenatal care in the first trimester, most of them had not received or participated in all of the recommended minimum actions program for the Humanization of Childbirth (PHPN), and the greatest weaknesses were on participation in educational activities and referrals to maternity. Not having the minimum criteria established by PHPN makes the findings of other studies that show low participation in educational activities,⁹ and not achieving the recommended examinations and the inadequacy of the minimum number of recommended consultations and puerperal consultation.⁹⁻¹⁰

It is recognized that this study does not present sampling with statistical power that enables any generalization of the results, but, despite being a small sample, the results show important aspects of prenatal care, in a unique context, which deserve to be investigated, especially in studies with larger samples.

• The speech of the interviewees

The interview analysis allowed to identify three themes discussed below:

• Category 1 - Planning Pregnancy

This category was from the question asked to the mothers about pregnancy planning and how they felt when they find out they were pregnant. From the 21 mothers interviewed, only three had planned the pregnancy, the others had not planned, but well accepted pregnancy, as evidenced below:

Oh, it was a mix of feelings, right [...] despair with happiness. Despair because I was not expecting it, it was not planned, and happiness, because, you know, right [...] a baby [...] (W8).

It was noted in the speech of mothers, ambivalent feelings such as fear, despair and happiness. These feelings reflect an experience of an unplanned pregnancy, culminating with the birth of a premature baby and the various problems such as: long periods of hospitalization of the infant, the separation of mother/son, and fear for the fragile condition of the neonate and many others. It remains even like this, the feeling of happiness for their son who arrived or will arrive.

Data from the Ministry of Health indicate that, in Brazil, at least half of pregnancies are not planned initially, but may be desired,¹¹ have problems for the care of pregnant women and the fetus. There is evidence that the occurrence of an unplanned pregnancy has a negative impact on the of prenatal care, the guidance on breastfeeding, infant nutritional status and rates of maternal and infant morbidity and mortality. Unplanned pregnancy increases risk of anxiety and depression, especially in the postpartum period.¹²

It was seen in the reporting of some mothers that despite not planning the pregnancy and being aware of the need to use contraception, they did not perform interventions to prevent pregnancy or performed improperly, the fact that in some cases, provided an unfavorable outcome of pregnancy.

It was not a surprise, I already knew I could not get pregnant anymore, I was on risk [...] (W20).

Other testimony indicated the occurrence of pregnancies at short intervals and without planning, a fact that suggests a weak health services, such as the effectiveness of the puerperal consultation, one of the actions recommended by the PHPN, which has as one of its objectives main guidelines on family planning and activation of contraception chosen by women.

I found out and I almost died. I never imagined that I would get pregnant so fast. I have a three year old son and one year old, and I get pregnant as well, in less than a year (W18).

Unwanted pregnancy is not restricted to the conscious factors, there is an association between conscious and unconscious motives in its occurrence¹³ and, even those reasons are valued, access to information and contraceptive methods should be valued because they allow women have some control over their fertility and can make choices according to their wishes.¹⁴

The occurrence of unwanted pregnancy is related to the fundamental right of women about their fertility, a fact associated with a complex combination of factors ranging from access to information or contraception, also passing by female autonomy regarding decisions that take issue about their sexuality and reproduction as a characteristic of individual freedom directly influenced by socioeconomic and cultural factors, and especially influenced by the position of women in society and the relationships built with their partners.¹⁵

In this sense, some interviews show the influence that the desire of the partner plays in making women's decision in opting for pregnancy:

It was not planned. My boyfriend liked it more than me, right [...]? Because I did not want to and he wanted to have [...] (W11).

According to a study conducted in northeastern Brazil, men have great influence on the choice of contraceptive method used by the couple, while recognizing that the responsibility for contraception is from both of them. This fact has not been explored enough, so the true influence of the father in the phenomenon of unplanned pregnancy is not known.¹⁶

Concerning the planning of pregnancy, it is noted that most respondents who planned their pregnancy, prenatal care began early, held the largest number of consultations and had all the recommended tests. They were forwarded to the Prenatal High Risk (PNAR) due to the presence of risk factors such as twinning and hemoglobinopathies.

It is known that the planned and pre-contraceptive reduces pregnancy rates of maternal and perinatal morbidity and mortality. Therefore, there is a need to reorganize primary care, investing in public policies for family planning and health education, defining the points of attention and corresponding responsibilities, minimizing bottlenecks and shortcomings of the current regulatory programs, the referral and counter-referral and follow-up of women, pregnant women and newborns in the network of health services.

● Category 2 - The importance of prenatal

This category has been built from the perception of mothers about the importance of prenatal care. It was found that the respondents attributed the following aspects of the importance of prenatal care: possible diagnosis and treatment of diseases; access to examinations; monitoring of fetal growth and development; referencing to maternity and childbirth which will reduce risks and diseases, improving the outcome of pregnancy.

The importance given to the prenatal detection of problems in pregnancy and prevention of harm to maternal and newborn health can be illustrated from the statements below:

[...] in the prenatal they find out if we have a problem, they will avoid it, they give the medicine. So what prenatal care is important, really (W1).

Oh, because if we do not do prenatal we may not know how that is our child inside of us, what is happening to him, if he will be born with something or not (W11).

Pregnancy is a physiological phenomenon, so its evolution takes place, mostly uneventfully. Nevertheless, there is a small percentage of women who, because they had some disease, some suffer injury or develop problems, have a higher probability of unfavorable outcome for both the fetus and the mother. Thus, the guidelines of prenatal care should enable the early and timely identification of problems that the mother has, in addition to diagnostic and therapeutic procedures necessary determining what level of care they should be performed.¹⁷

It is known that prenatal care contributes to more favorable outcomes because it allows early detection and timely treatment of diseases, and controlling risk factors that bring complications for women's health and the baby.¹⁸

Prenatal care requires a dynamic assessment of risk situations to identify problems to be able to intervene, to prevent an unfavorable outcome. The absence of prenatal control, may increase the risk for the mother or neonate. It is noteworthy that a pregnancy that takes place may well become risk at any time during the course of pregnancy or during labor. The timely intervention prevents delays in the assistance that can generate severe morbidity, maternal or perinatal death.¹⁷

One mother stressed the importance of prenatal care by ensuring referrals to maternity where delivery will be:

You have the place where you go, right? It is very important because you're not going to Maternity 'A' or to maternity 'B', you know where you have to go [...] (W4).

The lack of relationship between prenatal care and delivery assistance leads women into labor on a pilgrimage in search of vacancies in hospitals, injuring a fundamental aspect of citizenship rights. It is known that a large percentage of maternal deaths occur in the peripartum hours, so interventions to ensure adequate care at this point are necessary.¹⁹ Thus, one of the principles of PHPN is precisely to guarantee that all pregnant women know that maternity where they will be at birth and have their access.¹¹

In Primary Care, the team responsible for monitoring the pregnant woman should inform what will be the reference for their maternity childbirth, including a guided visit to the maternity, offering educational activities and dental evaluation. Educational activities, and disseminate information about pregnancy, the possibility of types of delivery, positions and methods of pain relief and information about breastfeeding, also enable the construction of a space of coexistence among pregnant women who share their experiences during the meetings.¹¹ In this study, we observed that only three mothers participated in educational activities and 28.57% (6 mothers) did not have the baby in the maternity reference, which deserves to be considered in order to seek improvements in the quality of care which is currently offered to pregnant women.

• Category 3 - Difficulties found in performing the prenatal

This category was formed from the reports of mothers on prenatal care and the difficulties found during this journey. The following problems were reported by interviewees: late prenatal care; need for hospitalization during pregnancy, lack of access to specific exams PNAR, long interval between consultations and difficulty in performing obstetric ultrasound.

In the early prenatal difficulties to make the diagnosis and initiate prenatal care in health centers were reported:

They take too long, I have had two weeks that I was going there and they took too long to schedule my prenatal care and in the hospital, then on the next day they schedule (W9).

This reality is because mothers should be of concern to professionals and health administrators directly impacting the success of the monitoring of pregnant women. It is known that early initiation of prenatal care aims to strengthen the accession of women to systematically monitor and track possible risk factors. Moreover, the success of prenatal depends, in large part, from the moment it starts and the number of consultations, which

may vary according to the pregnancy month and the events during gestation.²⁰

Once the mothers reported difficulty as the need to present a certificate attesting pregnancy test to start prenatal care and the lack of information on which the Basic Health Unit should seek to:

I had to have the blood test to schedule prenatal. Then I went in the office with the exam, then they were just playing forward [...] It's because I do not know the neighborhood where I lived, was not sure which center it was to go. So it took a little bit too because of it (W21).

This report shows the distance between the recommendations of PHPN establishing prioritization of care for women with suspected pregnancy and early initiation of prenatal care and the reality of care in primary care services. It discusses also the capacity of the health care network in early capture this pregnant woman and guide her appropriately regarding prenatal care. In this case, the late prenatal caused inadequacy in relation to the number of consultations and prenatal tests, as seen in their prenatal card.

As for the range and number of consultations, one mother expressed the need to provide closer monitoring in situations of risk, for example, in multiple pregnancy. According to the Ministry of Health protocol, schedule of prenatal care should be programmed according to the gestational periods of increased maternal and perinatal risk. Thus, it must be started early (first trimester) and should be regular and complete, guaranteeing that all required reviews are conducted. The largest number of consultations in late pregnancy aims to evaluate the perinatal risk and the most common clinical and obstetric complications in this period, such as preterm labor, preeclampsia and eclampsia, premature rupture of membranes and fetal death.¹¹

Some evidence shows that reducing the number of prenatal consultations is not associated with worse maternal and perinatal outcomes, although women, especially in developed countries, referring less satisfaction with care model with few consultations.²¹ On the other hand, a national study on the adequacy of prenatal care, women with fewer visits had lower fitness exams, vaccinations and guidance on delivery and breastfeeding.¹⁸ This direct association between number of consultations and exams and procedures was also pointed out by other researchers.²²⁻²³

In theory, a larger number of consultations can give more opportunities for preventive care and health promotion, especially in high-

risk pregnancies, most likely to affect the perinatal outcomes.²⁴ However, the most important discussion is about the quality of these consultations and the use these contacts with other services for conducting effective helath care.¹⁸

Some reports showed difficulties in relation to the achievement of pre-natal examinations, especially the specific prenatal high risk:

Exams [...] was very difficult. I paid several of them ([...]) because I was worried because the doctor spoke I have to do it, and I could not do it by SUS (W5).

The conduct of examinations during pregnancy helps to prevent, identify and correct the changes that may affect the mother and the fetus, and institute treatment of existing diseases or that may occur during gestation.²⁵

Regarding routine laboratory examinations of prenatal mothers reported no difficulties. These basic laboratory tests are considered fundamental in prenatal care, as they complement the analysis of clinical and obstetric data, favoring the adoption of appropriate diagnostics and conducts regarding mesmos.²⁶

One of the difficulties reported more often by mothers refers to conducting ultrasonography, as the following statement:

Except ultrasound, other tests [...] of blood, urine, and stool [...] I did all at SUS. Ultrasound does not. Morphological ultrasound, nuchal translucency not. I paid all. Ultrasound, which were the most expensive, wait long [...] it was going to spend the day to do it, then I prefer, I chose to do it, right (W15).

Obstetric ultrasound besides to determine general characteristics of the fetus and identify multiple pregnancies, is also able to answer questions about the health and fetus welfare.²⁷ Furthermore, ultrasound constitutes a moment of very intense emotions and important for the pregnant woman and the relationship with the baby, a fact that makes mothers value the performance of this test during prenatal care.

The routine of ultrasonography during pregnancy, despite being commonplace procedure remains controversial. There is no scientific proof that routinely performed, has any benefit on the reduction of maternal or perinatal morbidity and mortality.¹¹

It is stressed out that the rational use of ultrasonography in pregnancy is important for the sustainability of health systems. A low risk of pregnancy should be offered at least one ultrasound, which should be done preferably in the second quarter. According to the Brazilian Medical Association (AMA), the best scientific evidence indicates the completion

of obstetric ultrasound during the second trimester to determine gestational age and congenital anomalies search, since this strategy has a significant impact on maternal and fetal outcomes.²⁸

Given the testimonies of the mothers interviewed, there is a need to better accommodate these women, prioritizing early initiation of prenatal care, providing accurate information about how will be the follow-up, which the particulars of the examinations, besides ensuring a multidisciplinary care to soften the emotional and social conflicts experienced by pregnant women. Therefore, it is necessary to invest in the training of professionals involved in prenatal care and provide subsidies so that it becomes possible to offer a qualified and effective assistance through a network of assistance and articulated integral care.

Some statements emphasize the importance of prenatal care to guarantee a favorable outcome of pregnancy, such as the following:

If we look for a bad mode, you'd say: ah, you had a premature birth and her baby is in the ICU, but my baby is in the ICU, in quotes, good for her gestational age and, precisely because of prenatal, who was caring ([...]). It resulted in premature birth, but it could have been worse, could have culminated in my death or even my baby, if I was not careful (W4).

Despite the premature birth, it was found that this mother recognized the importance of prenatal care in reducing diseases, since both the mother and the baby received care and assistance in a timely manner, favoring the survival of the mother and the baby.

According to the guidelines PHPN a prenatal and postpartum qualified and humanized is through the incorporation of conduct cozy and without unnecessary interventions, easy access to quality health services, which integrates all levels of care: promotion, prevention and health care of pregnant women and newborns, from primary care outpatient hospital care for high risk.¹¹

Thus, prenatal care is considered the first goal to be achieved to reduce the high rates of maternal and perinatal morbidity and mortality and therefore, the viability of the programs requires, among other actions, the competent professional practice.²⁶

Therefore, we note that the respondents are aware of the importance of completing the prenatal care for reducing maternal and neonatal morbidity and mortality, enhancing consultations, exams, ease of access to health services, which are essential aspects for quality of prenatal care. However, none of

the mothers cited the importance of their starring role during pregnancy, which can be associated, among many reasons, the absence or inadequacy of educational activities as a tool for empowerment of these women.

CONCLUSION

Prenatal care is a key strategy for reducing maternal and perinatal mortality rates registered in the country. In this context, the PHPN was established by MH to determine the minimum care practices that should be implemented to impact of these indicators is considered a milestone in the politics of prenatal care.

The statements of the interviewees were elucidated difficulties that must be valued, especially with regard to access to prenatal care, referral to hospitals and educational activities. Nevertheless, women recognize the prenatal care as an important strategy for maternal and neonatal health, but most of the interviewees did not realize their starring role in this whole process.

Beyond this reality presented here, we still have to consider the multitude of factors that make up this complex web surrounding the reality of the care of pregnant women in our society and the socioeconomic context in which they operate.

The results of this study demonstrate the need for investments in family planning strategies and prenatal care, especially in light technologies, enhancing the role of protagonist of women in pregnancy, childbirth and the process, but gaps remain that need to be investigated to facilitate the timely interventions.

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