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Puerperal women's perceptions of prenatal care in primary health care

Percepções de puérperas sobre o cuidado pré-natal na atenção primária à saúde

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ABSTRACT
Prenatal care is essential due to the significant physiological and socio-emotional changes experienced during this period. Aim: To understand how women perceive health care during prenatal care. Method: qualitative study with data collection carried out between October 2021 and May 2022. 24 semi-structured interviews were conducted in four units of Regional Health IV, in Fortaleza, Ceará. Thematic analysis was carried out. The data were analyzed based on Ricardo Ayres' theoretical framework, focusing on the theme "health care" and within this theme, two analytical categories were worked on: "technical care", "care as a bond". Results: the provision of care focused on technical procedures was valued by women. A significant aspect that did not receive attention was the construction of strong bonds focused on social and emotional aspects. Conclusion: fragility in the dialogical relationship between health providers and women, indicating that health services still prioritize the biomedical model.

Keywords: Primary Healthcare. Prenatal Care. Qualitative Research.

RESUMO
O cuidado pré-natal é essencial devido as significativas alterações fisiológicas e socioemocionais vivenciadas nesse período. Objetivo: Compreender como as mulheres percebem o acompanhamento em saúde durante o pré-natal. Método: estudo qualitativo com coleta de dados realizada entre outubro de 2021 e maio de 2022. Foram conduzidas 24 entrevistas semiestruturadas em quatro unidades da Regional de Saúde IV, em Fortaleza, Ceará. Realizou-se análise temática. Os dados foram analisados a partir do referencial teórico de Ricardo Ayres, focou-se no tema "cuidado em saúde" e nesse tema, trabalhou-se duas categorias analíticas: "cuidado técnico", "cuidado como vínculo". Resultados: a prestação do cuidado focada em procedimentos técnicos foi valorizada pelas mulheres. Um aspecto significativo que não recebeu atenção foi a construção de vínculos fortes e focados em aspectos sociais e emocionais. Conclusão: fragilidade na relação dialógica entre os prestadores de saúde e as mulheres, indicando que os serviços de saúde ainda priorizam o modelo biomédico.

Palavras-chave: Atenção Primária à Saúde. Cuidado Pré-Natal. Pesquisa Qualitativa.

INTRODUCTION

Healthcare is about providing people with the tools and resources they need to meet their specific needs throughout their lives. The aim of care is to help individuals to be happy, healthy, safe and independent so that they can live a fulfilling life. Care is important because it helps people pursue their goals and maintain the lifestyle they choose[1,2]

This care does not exclude the importance of clinical or scientific experience, but emphasizes the importance of incorporating individuals' stories, experiences and autonomy. From this perspective, patients are not passive recipients of healthcare, but active participants with the responsibility to contribute to their own health, including matters relevant to their specific health needs and aspirations. This inclusive and empowering approach is essential for achieving the best health outcomes[3,4].

In the context of prenatal care, monitoring the health of pregnant and postpartum women is crucial due to the unique physical and emotional changes of this phase, including anxiety, sleep problems, mood fluctuations and hormonal changes. These changes have a significant impact on their self-esteem, mainly due to the substantial weight gain during pregnancy and the subsequent difficulty in losing weight after giving birth. Proper monitoring can ensure the health and well-being of mother and baby. Fear of childbirth is also a common concern and deserves greater attention, as it can have a profound effect on a woman's overall well-being[5,6,7].

As such, care can bring together care practices and everyday life, by combining both technical skills and people's individual and social aspects. This results in a holistic approach to care that achieves both technical success - such as consultations that improve quality of life - and practical success, in which care guidelines are adapted to people's lives, allowing them to experience fulfillment, joy and happiness[1].

Likewise, health care is established through actions that prioritize the care of individuals as the guiding principle of its practices. This comes as a result of interactions between individuals, and has positive effects and consequences for users, professionals and institutions. Valuing patient dignity and respect leads to better healthcare, as it shifts the focus from the patient to the individual with their own experiences of health and illness, promoting their autonomy in the care process[8,9].

Studies carried out in other countries, as well as in Brazil, on women's perceptions of prenatal care show that there is a significant emphasis on investigating aspects related to the quality of care and the satisfaction of pregnant women. In addition, these studies also delve into the dynamics of the doctor-patient relationship, with the aim of understanding the intricacies of this relationship and potential areas for improvement. However, it is worth noting that there is a substantial gap in the literature when it comes to exploring the emotional well-being and subjective experiences of women during this crucial phase of their lives[10,11,12].

The ethical issue arises when personal interactions and dialogue are no longer prioritized over technical aspects, ultimately compromising the effectiveness of these interactions. This dilemma revolves around the need to find a balance between advances in technology and the fundamental role of human connection in ensuring successful interactions. It emphasizes the importance of valuing and nurturing interpersonal relationships, as they play a key role in promoting effective communication and understanding. In this context, it becomes crucial not to allow the allure of technological advances to overshadow the essence of genuine human interactions, since these interactions are the basis on which fruitful dialogue can flourish[13].

Little has been discussed in the literature about care that incorporates technical and relational dimensions during prenatal care, which could contribute to improving quality of life and well-being during this period. The aim of this study is therefore to understand the perceptions and experiences of postpartum women about health care during prenatal care.

METHODOLOGY

This study adopts the epistemological perspective of the qualitative approach to health research. Qualitative research is based on the idea that knowledge is subjective and is formed

through interaction between the researcher and the participant. Some theories suggest that it is developed by the individuals as they engage with their social environment[14].

The study presented here is an excerpt from the intervention research entitled: "Strategy for the management of excess weight in Primary Health Care" (Call No. 02/2020/FUNCAP), carried out with overweight or obese postpartum women to evaluate the effect of motivational interviewing for adherence to the Food Guide on body weight change. Due to the multifactorial nature of obesity, before the intervention stage, the participants were interviewed about their perceptions of prenatal health care. This approach provided the basis for this study.

The study was carried out in four Basic Health Units (UBS) in Fortaleza - Ceará (Health Region IV), linked to the territory agreed with the State University of Ceará. These units were easily accessible and offered the usual services, such as the HIPERDIA program (hypertension and diabetes), prenatal care, childcare and spontaneous demand.

The present study included 24 women in the postpartum period who did not have pre-existing health conditions such as cancer, hypertension or diabetes. The closing of the sample was based on the criterion of information power; which takes into account the necessary density (or subjective accumulation) to answer the research question. This is because qualitative research focuses on gaining a greater understanding rather than collecting a large amount of data[15].

After recruiting the participants for the larger study, a single interview was held with each of them before the intervention phase of the larger study began. The appointment was made according to availability and interest in taking part. In some cases, the participants were contacted via the WhatsApp application to facilitate communication.

The interviews were carried out from October 2021 to May 2022 at the health units or at the participants' homes, taking into account their preferences, convenience, comfort, challenges and limitations of the postpartum period. In addition, the COVID-19 pandemic restricted visits to health units. When these interviews took place at the UBS, they took place in offices and unused rooms made available by the health units.

The interviews were recorded and transcribed in full, based on the following trigger question: "Today we're going to talk a bit about how your prenatal care went. What can you tell me about that period?" As the conversation went on, other questions were asked in case the the participant didn't speak spontaneously, such as whether she had received any guidance during her appointments, what this guidance was and how she felt during her prenatal appointments.

The individuals were identified by the initial letter M (which stands for 'mulher' – woman in Portuguese), followed by increasing Arabic numerals, as in the following examples: (M1, M2, ...) to preserve the individual identification of the respondents in the presentation of the results.

The researchers themselves transcribed the audio-recorded discursive material. The categorization process followed Braun and Clarke's[16] thematic analysis, involving six stages. Initially, all the material was transcribed, read and reviewed to familiarize the author with the statements generated in the interviews (stage 1.Familiarization with the data). The process continues with the generation of initial codes, followed by the systematic organization and coding of relevant aspects in the database to gather important excerpts for each code (step 2. Generating initial codes). Next, the codes are gathered into potential themes and the information is combined to flesh out these themes (step 3. Searching for themes). The themes are then revised by checking excerpts of speech against the themes created (step 4. Revising themes). Subsequently, the themes are refined and checked thoroughly to confirm and name them (step 5. Defining and naming themes). Finally, the report, with an analysis of all the material, is produced through a final review of the selected extracts from the speeches, the initial research question and the support of the literature (stage 6. Producing the report).

Interpretation was based on cross-sectional and vertical readings of the material, providing a better understanding of the meaning of the "whole" of each statement, as well as identifying the central themes that aggregated the various dimensions present in the narratives and

which constituted the axes of the network of meanings, a construct developed by the researchers, based on the themes and dimensions emerging in the empirical material and their interlocution with the theoretical framework on Health Care according to the author José Ricardo de Carvalho Mesquita Ayres. The present studied worked with two analytical categories: "technical care" and "care as a bond".

The research followed the ethical principles set out in Resolution 466/12 of the National Health Council[17] which is in line with international guidelines for research involving human beings. It was approved by the Research Ethics Committee of the State University of Ceará under CAAE: 38311920.6.0000.5534, Consolidated Opinion No. 4.442.057.

RESULTS

Of the 24 participants in the study, 11 were primiparous mothers, 9 had given birth vaginally and 19 were in a stable union. Most had completed high school and earned between 1 and 2 minimum wages. The participants' perspectives on prenatal care emerged from their own experiences, including comparing the care they received during previous pregnancies or with the care received by others.

In terms of health care, the focus of wellness should not only be on healing or promoting health, but on preparing a supportive environment that promotes behaviors and actions that lead to healing[18].

This approach to healthcare values both clinical expertise and personal experiences, emphasizing the importance of individuals playing an active role in their own healthcare and exploring new methods to improve their well-being[3,4].

The empirical material on health care, which enabled the analysis of the two analytical categories already described: technical care and care as a bond, will now be discussed.

TECHNICAL CARE

The women in this study believed that receiving predominantly technical care during prenatal care was sufficient. In their reports, we observed that the focus was on the technical aspect of care, a priority also reflected in official Ministry of Health documents[5].

This aspect was characterized by the regularity of tasks such as checking blood pressure, measuring fundal height, listening to the baby's heartbeat, as well as the number of appointments and test requests. This suggests that the importance of technical skills in providing a service was recognized by those involved, and for them it was important for professionals to have specialized knowledge in order to conduct prenatal care.

In addition, the valuing of technical attributes during care, the ability to have technical and instrumental competence over what should be prescribed was legitimized by the participants.

> Here at the clinic, it was a normal, routine follow-up, right? the measurement of blood pressure, the question of blood glucose, which I had...yeah...a problem with blood pressure and diabetes during my pregnancy [...] the doctor looked at my tests, right?... as everything was fine he just said everything was fine, when there wasn't anything to add we did other tests, that sort of thing, and took my belly measurements, and everything, just that sort of thing. [M2]

> Activities were getting the card, checking the baby's weight on the card, how many weeks of pregnancy it was and the heartbeat. That was it. It was monthly, I went every month. Then towards the end, near the birth, it was every 15 days. [M7]

> And I think there's a lack of a specialist, as I said, an obstetrician, which there isn't, I think there should be an obstetrician to monitor breastfeeding women... pregnant women. The obstetrician is very important, because he

> understands more, he's the professional in the area. [M7]

Technical care is a fundamental aspect of health, but professionals need to recognize the importance of integrating care practices with the personal and social aspects of individuals. This holistic approach not only improves technical outcomes, but also improves individuals' overall quality of life, considering their happiness and various dimensions of well-being.

This notion of care challenges the traditional understanding of health, which is predominantly focused on the physical well-being of individuals. Adopting a broader perspective that considers various dimensions of well-being, including happiness and other social factors, is advocated by Ayres[13]. This shift in perspective recognizes that health is not only determined by physical illness, but also influenced by psychological, emotional and social factors.

Ayres[1] highlights the importance of technical care in healthcare, emphasizing that professionals are responsible for providing it effectively. However, care goes beyond mere technical expertise and encompasses the integration of care practices with the personal and social aspects of individuals. This holistic approach to care not only improves technical outcomes, but also improves individuals' overall quality of life. By adopting this comprehensive approach to care, professionals can effectively address the diverse needs of individuals and promote their overall well-being. It recognizes that a person's quality of life depends not only on the absence of illness or disease, but also on their ability to experience happiness, fulfillment and social connection.

In a similar study, Livramento[19] revealed that for the women interviewed, the quality of prenatal care goes beyond merely carrying out planned procedures and providing information. They identified that attention, a humanized welcome, listening, consideration of subjectivity and support for pregnant women play a crucial role in determining the quality of prenatal care. Even so, there is a lack of similar studies, revealing a gap in the literature about how women feel during their prenatal care.

Prenatal programs and government initiatives for women's health care often fail to respond appropriately to the specific needs of pregnant women in terms of their emotional well-being and support. Consequently, this aspect of care is often neglected[20,21].

Considering the issue of care from the point of view of health promotion, specialists and managers participating in a study on health promotion in primary care say that it is necessary to broaden the view restricted to illness, taking into account the knowledge of the people being cared for, without imposition and decontextualized prescriptions. However, the participants also understood that the biological aspects of the disease should not be ignored. They also emphasized the inseparable nature of health promotion and care[22].

Another issue observed in the participants' speeches referred to their lack of understanding of the activities and duties of basic health units within the SUS system (Brazil's National Health System):

> So, yeah, we get apprehensive, because we depend on the SUS and often the SUS system doesn't... doesn't deliver, so I wanted this follow-up [*at the high-risk prenatal clinic*] because maybe she [*the doctor*] could tell me something I didn't know, like whether I was producing too much fluid or not, things that the doctor here wouldn't be able to tell me [...] but thank God my daughter was born well, she didn't have any problems, thank God, she was only born prematurely. (M4)

They believed that the UBS was inadequate and failed in some activities because it lacked certain complex procedures and medical specialties, ignoring the fact that PHC (Primary Health Care) is defined as the gateway for users to access the SUS system[5]. Thus, it was clear that there was no understanding of the SUS system and the levels of health care.

The women were unaware of the true nature of PHC responsibilities, and consequently considered their activities to be lacking in complexity and technological capacity:

> Well, as far as possible, he [*the health professional*] did what he could for me, right? Some things couldn't be done in terms of exams, procedures, because [*the basic health unit*] didn't have the structure for it. [M6]

For Maximino[23], basic care is often seen as simple and less complex, which results in it being undervalued. It is worth questioning whether the women's limited understanding was linked to the lack of information they received when they sought the service and started prenatal care. Their focus on the technological aspects of their care reinforces their desire and search for technically competent care.

Some of the participants felt that prenatal care in hospitals was more effective than in a UBS. For them, hospitals had better resources and equipment for more complex tests, which made them feel more confident and secure in their prenatal care.

Of course, medium and high-complexity hospitals have the equipment, laboratories and multi-professional teams to deal with more complex illnesses that require hospitalization, which is not the case with a low-risk pregnancy. So, this perception in the speeches shows, once again, a lack of understanding of how prenatal care services work in the health system, since low-risk prenatal care doesn't require specialized procedures or high-complexity hospitals.

The following speech explains this issue well and shows how one participant felt well looked after, mainly because several tests were carried out. It should be noted that this only happened because it was a high-risk pregnancy, which required hospitalization and greater monitoring:

> I was admitted with 36 weeks of pregnancy, and I had him with 37. The hospital itself was great, everyone was very attentive, always asking questions, doing tests and I had tests in the morning and afternoon. They gave me medication in the early hours of the morning. The nurses always came to check on me, measure my blood pressure, and all. I have nothing to complain about the hospital. [M22]

The lack of knowledge about prenatal care procedures, in terms of referral and counter-referral, emerges from the speech of a participant who had recurrent episodes of urinary infection during pregnancy:

> My prenatal care was very complicated, because I didn't have any medical follow-up, the follow-up was with the nurse. I had three complications of urinary infection, I had a urinary infection, and the treatment didn't go well, and I was even hospitalized. So, in my seventh month of pregnancy I was admitted to the HGF Hospital, I had pyelonephritis. I spent a week in treatment there. After that third urinary infection, I did my prenatal care there, with the doctors there. [M8]

In her speech, it was clear that she attributed the ability to solve her problem to one professional category or attributed the lack of a certain professional to the presence of complications during prenatal care that required hospitalization.

And in this scenario of lack of knowledge about how the health system works, in terms of levels of care, the search for information in the digital world was an alternative found by women to clarify doubts:

> Then I'd look online and see doctors talking on Instagram, doctors' pages. I'd have doubts and I'd take them to my doctor and nurse to see whether they were really valid, the

> doubts, whether I needed them or not. [M17]

The reality of our modern world is that social media has become an integral part of the way people communicate and seek information about their health. With platforms such as Facebook, YouTube and Instagram, individuals have the ability to share their own personal health experiences and reach out to others, including health professionals, for advice and support[20,21]. This use of social media represents an opportunity to improve the link between healthcare providers and pregnant women, placing greater emphasis on open and continuous dialogue.

In order to transform our approach to healthcare, it is imperative to adopt a broader understanding of well-being and happiness, rather than remaining solely within the current biomedical perspective. This shift is crucial because it is firmly believed that in order to truly revolutionize healthcare practices, we must question the rigid biomedical norms that currently dictate how health-related actions are assessed and supported[13].

CARE AS A BOND

The relationship between user and health professional is characterized by the creation of affection and trust, forming a strong bond. This bond not only promotes a greater sense of shared responsibility for health, but also evolves and strengthens over time. Furthermore, this relationship has therapeutic value[5].

During prenatal care, the participants did not report this strong bond, in which affection and concern with social and emotional issues were observed, but a bond strictly focused on the provision of technical services and instrumental interventions. Responsibility was not shared but focused on the health professionals who prescribed health procedures and tests.

In their speeches, it was possible to notice that they believed it was crucial to have an attentive listener who knew the procedures that had to be carried out. However, there was a divergence in their understanding of what this entailed. For some, the warmth of the service and the resolution of any technical concerns during prenatal consultations was enough:

> The service, that's it, the service with the doctor was also very good. He gave me the tests, all that care and... I didn't have any problems, I didn't have any problems during the pregnancy, so my only problem was my TSH, my thyroid hormone, which changed, it got high, so it was detected both here and in the healthcare plan, (*the participant also used the healthcare plan*) and they had the right conduction for this treatment, right? [M3]

Some of the women believed that it was crucial to go beyond the technical aspects and give importance to an approach that is more attentive to their subjectivities. They valued health professionals who were interested in their general well-being and not just focused on the pregnancy and the baby's growth. This perception of the professionals' behavior during prenatal care was intertwined with the expectations they had of the services and support that would be provided:

> They ask a lot of questions, don't they? They take... at least for me, and I think that people talk badly about the SUS system, but they take good care of us, they pay attention, in my case, they checked... they checked the baby's heartbeat, it was a very long, very detailed consultation and they are very attentive. [M7]

In the context of care relationships and interactions between health professionals and users, welcoming plays a crucial role. It encompasses the act of being open and receptive to individuals, recognizing their unique needs and understanding their susceptibility and possible dangers[9]. This aspect of care involves actively listening and empathizing with people, ensuring that their concerns are heard and that their well-being is prioritized. By being receptive

and attentive, healthcare professionals can establish a foundation of trust and understanding, fostering a positive and supportive environment for individuals seeking care.

Promoting health based on dialogic and liberating practices that respect different types of knowledge is not yet a consolidated practice in primary care, but it is necessary and possible[22].

In addition, welcoming also involves recognizing people's diverse needs and circumstances, adapting care plans and interventions. Through this conscious approach, health professionals can effectively address the specific challenges and risks faced by individuals, ultimately promoting their overall health and well-being.

Based on the analysis of the participants' statements, it is possible to observe that the level of care provided did not prioritize women's active involvement and leadership throughout their pregnancy journey:

> The nurse gave me some guidance on what could and couldn't be done during pregnancy, but the doctor... he didn't give me any guidance, and I didn't ask too many questions either, because he just took a piece of paper, wrote something down, marked it and didn't talk much either, he didn't ask many questions, so I didn't have much to talk about either. [M11]

> It was a fight every time I went there; the little scoldings I got, but I spoke up. I'd say that I hadn't been able to avoid it and they'd scold me, because I had to remember that I had a child, so my blood pressure couldn't go up, so that I wouldn't have any problems in the future with my pregnancy. [M20]

Instead, it showed that the participants were constantly in a state of anticipation, waiting for the professionals to dictate the course of their pregnancy without promoting the essential and necessary dialogue to establish a meaningful relationship.

In a study carried out by Kawatsu[24] on the prenatal care of postpartum women, the authors also found satisfaction regarding the support and assistance provided by health professionals during prenatal care, childbirth and the postpartum period. However, unlike what was found in the present study, the satisfaction they showed was related to care as a bond between professionals and pregnant women, with attentive listening, an empathetic approach and the creation of a warm and welcoming environment.

There are cases where establishing a connection between pregnant women and healthcare providers can be a challenge, often due to the frequent turnover of professionals in the healthcare system. This lack of continuity in care can make it difficult to provide consistent support and guidance to women during their pregnancy journey.

> The only thing that's left to be desired is that the red team just keeps changing doctors. For example: I make an appointment, sometimes even a month from now. Then, when you come for the appointment, the doctor has already left. Now you must reschedule, so you reschedule the appointment and, when you come back, the doctor has already left again. [M22]

> But they asked everything, everything from the beginning, because it was usually a different professional who would see me every month, so I had to start from scratch. They would ask everything so that I could get to where I was on the day I was there for him to finally make the report. So, he had to start from scratch again, ask the same questions all over again because it was someone else; I would never see the same person again. [M24]

It's important to note that pregnancy is a period of significant emotional and psychological changes, which require support at every meeting. By having a dedicated health professional who remains involved throughout the gestational period, pregnant women are more likely to attend appointments and feel more confident. This connection can improve the quality of care and also promote a strong bond between the caregiver and the mother-to-be, leading to a better understanding of their unique needs and enabling them to satisfy their cravings.

In this study, the women did not perceive the need to form a bond with their caregiver. Their main concern was receiving effective care and having a positive outcome to their pregnancy, specifically achieving a successful delivery:

> [...] Everything was normal according to the ultrasounds I had, the obstetrician at the maternity hospital told me that you can't see whether there's too much fluid or not, and that having too much fluid is an indication of premature birth, it can be born earlier and so on, so I didn't question it, because... I didn't have any problems. If I had, maybe I could have asked it, but I didn't, right? Not regarding labor, not at all, and the baby was born with no problems at all. [M4]

This focus on practical aspects is completely understandable and crucial during this significant period in a woman's life. Just because they didn't express a strong interest in subjective and emotional issues, it doesn't mean that these aspects weren't important to them. It's possible that these concerns arose during the follow-up process but were put aside after the pregnancy had successfully ended. Or they might not even have been noticed, due to the strong presence of the biomedical model in the care.

When it comes to caring for people, it is crucial to take the time to truly understand their perspectives. This can be achieved by asking questions that show genuine interest in their thoughts and feelings, and by actively listening to them, without any preconceived ideas or prejudices. Unfortunately, this approach is often underestimated and doesn't receive the attention it deserves. However, it is actually a highly effective way of establishing a deep bond with individuals[1].

The findings of this study offer valuable information on the experience of pregnant women during prenatal care, with contributions and practical implications for professionals and health services in prenatal care. These contributions point to a broader view of the pregnancy process, with the creation of a welcoming environment that favors dialogue and puts women at the forefront of their gestational process.

CONCLUSION

The provision of care focused on performing technical procedures was valued by the women in the present study and was shown to be the most important issue to be considered in health monitoring during this period. The emphasis on the biomedical model creates challenges in establishing deep and meaningful connections with healthcare providers and compromises the quality of prenatal care.

The participants also lacked knowledge of the responsibilities of the different health services, leading to misunderstandings about the quality of care provided at the various levels of care.

An important aspect that did not receive enough attention and importance among the women was the process of building strong bonds focused on social and emotional aspects.

The results of this study highlighted a significant absence of a dialogical relationship between healthcare providers and women, indicating that health services continue to prioritize the biomedical model. The study showed that women's emotions and needs were not taken into account during prenatal care, and that the participants did not perceive this gap, as if emotional and social issues did not need to be addressed during prenatal care. This shows that the biomedical model is also valued, albeit unconsciously, by the participants.

Satisfaction or dissatisfaction with the service is not the only thing that matters, but also the potential for critical thinking about the objectives and structure of the service. It is not just something to act on, but something that can actively act on the factors that influence health and illness.

A possible limitation of the study would be the fact that participants are postpartum women, and this could have influenced their memory of prenatal care, due to the time elapsed between pregnancy and the moment of the interview. However, it is important to note that none of the participants showed any signs of difficulty in remembering the appointments they had received.

Nevertheless, the present study stresses the need for more qualitative studies on healthcare provision, especially during pregnancy.

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