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Therapeutic Itinerary Experienced By High Risk Pregnancy Preganant Women and Their Partners

Gisele Perin Guimarães[1]* and Jussara Gue Martini[2]

[1]Department of Obstetrical and Gynecological, Clinical nurse Neonatology Service of the Regional Hospital of St. Joseph and the Internment Facility Screening Obstetrical and Gynecological Hospital of the Federal University of Santa Catarina. Member of the Research Group on Health Education and Nursing. Brazil

[2]Lecturer and Researcher, Department of Nursing and the Graduate Program in Nursing at UFSC, Invited Professor at the Graduate Program in Respiratory Sciences, Federal University of Rio Grande do Sul Leader of the Center for Health Research; researcher group research in Nursing and Health Education and IEG. Brazil

***Corresponding Author:** Gisele Perin Guimarães, PhD in Nursing. Clinical nurse Neonatology Service of the Regional Hospital of St. Joseph and the Internment Facility Screening Obstetrical and Gynecological Hospital of the Federal University of Santa Catarina. Member of the Research Group on Health Education and Nursing. Brazil.

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Abstract

Background/purpose: The proportion of subjects with multiple medical conditions is increasing worldwide. Coexistence of tuberculosis (TB), human immunodeficiency virus (HIV) and diabetes mellitus (DM) in the same person was investigated.

This study was aimed at determining the therapeutic itinerary of high-risk pregnancies that underwent prenatal care in a hospital in southern Brazil. This is qualitative research, of the Convergent-Care type, with conducting factor based on the Libertarian pedagogy. Data collection was conducted from January to September 2012, with 12 high-risk pregnancies and 9 companions. The analysis was guided by the four generic processes of convergent analysis: gathering, synthesis, theory and transfer. The results indicate that the early prenatal care for 11 pregnant women took place at the Basic Health Units, namely in assisting low-risk pregnancies, only one pregnant woman began prenatal care directly at the tertiary health care. Most of the pregnant women studied was only referred to the high risk prenatal care in the second quarter, highlighting the delay in conducting complementing exams. It was observed that after being sent to the high-risk pregnancy services, these pregnant women felt more secure and with a sense that all their needs would be considered in this context. We conclude that the search for the Basic Health Units proved to be the first choice for these women, but that the primary health care services were still showing great difficulties meeting the needs of pregnant women who required imaging and laboratory tests that enable early detection of risky situations. When they were sent, along with their companions to the unit of reference, they signal that they were welcomed by the interdisciplinary team in a humane way and, consequently, feeling safer.

Keywords: *Pregnancy; Prenatal care; High risk; Health education; Nursing*

Abbreviations: MBasic Health Units: (HBS); Convergent-care type: (PCA); University Hospital, Federal University of Santa Catarina: HU/UFSC; Nursing consultation: (NC); Emergency room: (E.R.); Human papillomavirus: (HPV); Human hormone chorionic gonadotropin: (βHCG); National Program for the Humanization of the Prenatal and Birth: (PNHPN); Serology for syphilis: (VDRL); Human immunodeficiency virus: (HIV); Ministry of Health: (MS);

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Introduction

Gestation is considered a woman's natural and physiologic phenomenon and, supposedly, risk free, allowing for the monitoring through the pre-natal primary care services at the Basic Health Units (HBS). However, there is a group of pregnant women that due to specific characteristics or for some hardship, present increased chances of unfavorable development probabilities to either the mother, or, the baby, or even both. This segment constitutes a group denominated "High Risk Pregnant Women" [1].

Identification of high or low risk situations requires from the interdisciplinary team, a sensible and thorough analysis in order to realize the needs and to determine specific care actions. The needs of low risk pregnancies are addressed at the primary health services, whereas the high risk require specialized treatment from the services of reference at the hospital units. Early identification of high risk pregnancies as essential to promptly initiate proper treatment; increasing the probability of controlling and even modifying the development of an unfavorable pregnancy and, consequently, providing a positive outcome [2].

In order to provide a favorable outcome to the pregnant woman, the standards of assistance must allow for early and accurate identification of maternal and perinatal risk, as well as, required diagnostics, therapeutically procedures and what level of urgency those need to be done. Thus, "the pre-natal monitoring of pregnant women without issues shall be different from those presenting problems, be it in objectives, content, number of visits and type of assistance being provided." [1].

Thus, considering the different types of care for pregnant women, this study aims to understand the therapeutic itinerary/journey performed by pregnant women and their companions in the health care system; monitoring the high risk prenatal care of pregnant women who underwent this process in a hospital unit in southern Brazil

Materials and Methods

This is a qualitative research of the convergent-care type (PCA). This type of research is directed to the minimization or resolution of the problems of healthcare practice or educational practice in the context in which the researcher is performing his/hers professional duties. The driving engine to perform this study was the Liberating pedagogy of Paulo Freire; liberating education, which aims to stimulate the human capacity to be active in social changes and subject of his/hers own story.

This research was performed in the outpatient clinic "C" of the Polydoro Ernani de São Thiago University Hospital, Federal University of Santa Catarina-HU/UFSC.

The choice of subjects happened during an obstetric consultation, when the high-risk prenatal doctor identified the need for healthcare education. The referral to the researcher nurse was by appointment, or direct contact, when the situation called for a more immediate dialogic process.

The study subjects were 12 high risk pregnant women and 9 companions who were undergoing prenatal care at the instruction focus of this study, and who agreed to participate in the study, after understanding the goals, intentions and methods of participation.

It wasn't stipulated a minimum number of participants. It was only stipulated a six-month period -- from January to June 2012 -- to accept new pregnant women. At the end of these six months, prenatal care was continued with those who were already participating in the health education process, lasting until September; when all had finalized the reflexive and gestational processes.

The data collection took place during every contact between researcher and the subject, through individual nursing consultation (NC) with the high-risk pregnant women and their companions. That's when -- in these meetings -- a dialogue is established, pursuing the knowledge related to the therapeutic itinerary, from the moment the pregnancy was confirmed to the high risk determination. Data saturation occurred when all the needs in pregnant women health education and their companions were met.

The records of data collection was carried out through a field journal and digital recorder -- after signing the "Terms of Free & Knowledgeable Consent" by the subjects – at every contact with the participants. After a deeper theoretical understanding and involvement with the obtained data, the analysis thereof was guided by four generic processes of PCA: data entry, synthesis, theorizing and transfer, proposed by Morse and Field and followed by Trentini and Paim, which generated codes and categories [3].

This research was in compliance with the ethical principles established by resolution 196/96 from the National Health Council [4] and the principles of the code of professional ethics for standardizing investigative activities. The project was submitted for evaluation by the Committee of ethics in research with Human Beings, at UFSC, with a favorable opinion under n° 2257/11 and certificate of introduction to Ethics Assessment n° 448412.

Results and Discussion

As stated, when performing nursing consultations during prenatal care to pregnant women and their companions, we sought to understand the path taken by these subjects, from the time when the pregnancy was confirmed until the arrival to this hospital unit, considered reference in high risk prenatal care.

Of the pregnant women subject of this study, 11 of them began prenatal care in a HBS, in other words, in low risk prenatal care. Only one pregnant women began prenatal care straight at the tertiary health care. Access to the high risk services by this woman occurred because she sought help at the emergency room (E.R.) – context of this research – due to gastric discomfort. As reported: "I went to the emergency room because of pain in my belly. Then they asked for a pregnancy test to see if I were pregnant and it came back as I was. After that, they asked to do the prenatal care here "(Ruby). The reason for them to forward her directly to this unit is due to the fact that she was a teenager and carrying the Human papillomavirus (HPV) in an acute phase with extensive lesions.

We realize that, as Ruby, many pregnant teenagers went to health units because they started presenting some sort of discomfort or changes to their bodies, under the impression that it could be anything but being pregnant. This situation translates to the lack of knowledge about their own bodies, as well as, the non-use of contraception methods, combined with their immaturity, advent directly related to the period of adolescence -- denoting one more risk.

However, despite the hardships inherent to pregnancy in teenagers, it is believed that if the woman has social support, family support and guidance, these young ladies can develop resilience, starting to face this moment of their lives with a different perspective. They begin experiencing the gestation with future expectations [5].

It is necessary that the pregnant women accept the challenges of this new event in their lives, and that they get support in the family context and in the prenatal care. To Freire, the human being has full ability to modify its reality, or at least, improve it, and may be through curiosity; however, with responsibility [6].

Through another perspective, the 11 pregnant women who sought assistance at the HBS to start their prenatal care, already had an understanding of pregnancy, as they started noticing delays in their menstrual cycle and body changes; became suspicious of the possibility of a pregnancy. Upon noticing such changes, 8 pregnant women chose, as their first option, to perform an over the counter urine pregnancy test, which detects the amount of the human hormone chorionic gonadotropin (βHCG)-hormone found in pregnant women; however, short after receiving a "positive" result, they sought the Basic Health Unit.:

My period was pretty late, then I suspected that I was pregnant and I did the over the counter (Pharmacy) test (Pedra do Sol);

[...] When I felt my body was different, I did an exam and it came back as I was pregnant and I immediately scheduled my first prenatal consultation (Selenita);

[...] I started to get sick, then I was suspicious and I did the test that came back positive, I went to the health unit the following week. (Safira).

The perception of your body favors the early initiation of the prenatal care, considering the confirmed pregnancy -- through urine/blood tests showing the fecundity–promptly sought assistance, at the nearest location to their home, to carry out the monitoring of the pregnancy. However, it is notorious that there is still little awareness of the use of contraceptives methods, which could prevent an unwanted pregnancy. Another factor to be referenced, according to Alves, is persistent lack of sexual and reproductive health services, leaving unmet contraceptive needs [7].

A study with teenagers performed, shows that most teenagers are unaware of the existence of a fertile period in woman, as well as, the correct use of contraceptive methods available in the health network -- favoring an unwanted pregnancy. The authors highlight the importance of educational activities with the youth, taking into consideration that in today's world, everything happens quickly, from behavioral and existential transformations to body changes. The lack or little experience of adolescents regarding sexual life currently represents an international concern, not only related to an unwanted pregnancy, but also to sexually transmitted diseases [8].

In this study, one of the pregnant women, while having signs of pregnancy and perhaps for the fact that it was a planned pregnancy, immediately sought for prenatal care in a Basic Health Unit:

My pregnancy was very planned [...], so when I saw that my period didn't come, I promptly went to the clinic (Esmeralda).

Two other pregnant women stated to not have planned for the pregnancy, but as they had had sexual intercourse without a condom and as they did not use another contraceptive method, they soon suspected of pregnancy:

My pregnancy was not planned, but I did not prevent it and I knew I was pregnant, so I went to the nearest clinic by my house (Cristal);

As soon as I get pregnant, I know [...], as I had problems in my three pregnancies, I promptly went to the clinic to confirm (Ametista).

The search for the Basic Health Unit is the first choice of pregnant women, taking into consideration that the services that will be offered to the future mother consist of nursing care, doctor, scheduling exams, among other actions, enabling confirmation of pregnancy, as well as, the follow-up of each gestational period.

Access to the Basic Health Unit to receive prenatal care has a value and a very strong significance to the pregnant women, as it becomes a guarantee to obtain more information for their needs in regards to each moment of the pregnancy, bolstering even further their autonomy and empowerment in decision making.

Performing the prenatal assistance care is tied to the number of sessions held in this period, as recommended by the National Program for the Humanization of the Prenatal and Birth (PNHPN), it must be at least 7, but this reality is not for all women. As published by the Ministry of health is visible the deficit of adherence to prenatal care in some regions, being the northern region with lowest number of live births to mothers who held 7 or more appointments corresponding to 36.6%, and the region with the highest adherence to the program was the southern region with 75, 2% [9].

The possibility of pregnant women to have a space for the exchange of experiences, promotes a better understanding of the gestational process. This intercommunication between pregnant women and health care professionals should be prioritized on prenatal care, in order to provide transformation in the situations of changes, generated by the pregnancy itself [10].

The transition of prenatal care from low to high risk happened -- to pregnant women of this study -- in different situations. One of them, Ruby, was directed to the high-risk group shortly after diagnosis of pregnancy in the hospital itself, as she was a teenager and a carrier of HPV in acute phase; Crystal was walked to the tertiary health care for being a teenager and with emotional instability, and Ametista, for already having a previous obstetric history with adversity, despite of the advanced gestational time.

When I went to the clinic, the doctor said it would be best if I were monitored by the University Hospital staff; because I was a teenager and I was depressed, crying a lot and I didn't want to get out of bed [...] (Cristal);

During my first pregnancy I had leukemia, the second my children were born dead, they were twins, on the third I miscarried at 2 months, on the forth. I had severe anemia [...] with all that, the community clinic's doctor said she didn't think it was good idea to have the prenatal done at the clinic and she sent me here (Ametista).

These are examples of situations where the routing from the Basic Health Units to the tertiary care -- reference in the prenatal care -- was early; still in the first trimester of the pregnancy. One for being a teenager in a depressive state, and the other due to prior situation of risk in all previous pregnancies. However, other pregnant women as Safira, Diamante, Esmeralda and Olho de Gato were only directed to the high-risk clinic of the University Hospital - UFSC during their second or third trimester, after undergoing image examination that displayed some sort fetal alteration, evidencing fetal risk or even maternal-fetal risk, as per diagnosis.

The doctor ordered an ultrasound, but it took me a long to do it because there was no vacancy, when I had it done, it showed that my baby had crooked legs (Safira);

My blood work was done fast, but the one to see the baby took long [...] the doctor said that there was a little problem in the back of the head [...] (Diamante);

The examination at the clinic was going to take too long. I went ahead and paid for it by myself. That's when it showed that my son had some deformity. (Esmeralda);

They did an ultrasound because I had an accident and I told them I was pregnant. I had not been able to get it done at the clinic yet (Olho de Gato).

The slowness in getting additional exams for a proper clinical evaluation may compromise early obstetric interventions actions, as well as, the monitoring of the prenatal care and the direct relationship with health education which empowers these women to overcome fears and insecurities.

Authors reinforce that the lack or difficulty of pregnant women in getting prenatal consultations and exams directly compromises the care for the woman and the baby being developed. There is the need for the obstetric care services to have a humanized look, with a network of integrated care, providing a welcome and a stronger bond between pregnant women, their companions and the health system and the health education initiatives [11].

As recommended by the Ministry of health in protocols of attention to pregnant women's health, during the prenatal care there should be performed several exams amongst theses: blood group and Rh factor (when not done previously), serology for syphilis (VDRL), partial urine, hemoglobin and hematocrit, fasting glucose, human immunodeficiency virus (HIV) testing with counseling pretest and consent of the woman, serology for hepatitis B, serology for toxoplasmosis , oncotic colpocytology, when there is indication and

expansion of obstetric ultrasound to 100% of the pregnant women. When these women are classified as high-risk pregnant women it shall be added the following exams: platelet count, the dosage of proteins (24 hours urine), dosages of urea, creatinine and uric acid, electrocardiogram, obstetric ultrasound with Doppler and antepartum cardiotocography [9].

Notwithstanding, what is recommended by the Ministry of health - MS it's not always a reality experienced by all pregnant women. While carrying out studies on the implementation of minimum complementary laboratory exams during prenatal care it was found that less than half of the population has access to a complete and with quality prenatal care [12]. They also reinforce the concept that this reality will only change when health professionals, managers and community become aware of their rights and duties, in order to identify the pregnancy in an early stage and to demand the exams provided for by the Ministry of health during the prenatal care.

The relationship between users and health services becomes viable when various sectors of society walk in the same direction. For this reason, it is important that health services managers follow the recommendations set forth by Ministry of Health (MS) and that they give the minimum requirements to guarantee the pregnant woman and her fetus during prenatal care. This contribution of promoting health, is in the form of how health professionals involved in obstetric care lead the risk situations in the gestational period, whether individually or collectively, about the activities aimed at the behavioral transformation of individuals in this specific period of the couple's life [13].

The possibility for the pregnant women of having a broad range of actions that guide them to curative, palliative and preventive care, still within the first trimester of the pregnancy, enables unveiling some anomalies, malformations and diseases that affect pregnancy. In addition to the laboratory tests, the ultrasound is a practice that should be routinely used when determining the most accurate assessment of the gestational age, the detection of the number of fetuses and other risk situations [14].

So that the quality of services in the primary care network happens properly, it must be linked to several factors, among them, easier and guaranteed access to pregnant women of a prenatal care of quality, with qualified professionals that guide about the needs during gestation, assurance of follow up exams in each trimester of the pregnancy, as well as, a conducive dialogic process that encourages pregnant women to express their bio psychosocial needs.

It is perceived that the context in which these pregnant women began the prenatal care was not adequate in providing the required attention to the unique needs of each of these women classified as high-risk. This is due to the fact that those units are set up for low risk pregnancies. Health professionals involved in the Basic Health Units referred them to the University Hospital/UFSC for being a hospital of reference in the care of high-risk gestation, whether by maternal, fetal or both risks, and which has a multidisciplinary team that meets the needs as a whole, including the early diagnosis of diseases.

It is crucial that health care networks are connected to a common goal -- the citizen who uses the services -- seeking in this scenario a professional quality monitoring and risk-free [15].

We observed that pregnant women, after being walked to the service of reference in high-risk pregnancy, felt more secure and on condition that the assistance, and all their needs, would be considered in this context.

Since I came here, I was very well taken care of (Emeralda);

I was afraid it wasn't good, I didn't know anybody, but I was wrong, it was very good (Jade);

Here (referring to the University Hospital) I managed to do all my exams, the nurses, the doctors always asked me how I was doing [...] (Diamond).

These reports point out to the importance of acceptance/welcoming by the health team in the high risk unit of reference, for the continuity of the prenatal care. The possibility of relying on a specialized service, with qualified professionals has brought greater

assurance, not only on the obstetric portion, but especially on the rescued sense of affective security, through dialogue during the health education actions with the nurse.

Currently, pregnant women and their companions who go through a high-risk pregnancy seek prenatal care that go beyond the clinical aspects, the examination and medicate. But in fact, they want to be able to talk and be heard by the health care professionals, seeking to feel recognized and strengthened. This process of exchange of experiences, offers a more participative, reflective and educational build in the everyday health services between users and professionals, rescuing a more solidary society [16].

The importance of health education is a participatory perspective, where pregnant women and companions are not just receivers of information, but are also critical-beings in the dialogical relationship with the nurse, becoming aware of the situation being experienced [6].

To the pregnant women, it is during the prenatal care that everything transforms, and they start to realize the professionals involved as an opportunity to expand their knowledge and empowerment of the gestation. For this, Santos, Radovanovic and Marcon reinforce that we must encourage dialogue easing their doubts, fears and insecurities. The guidelines offered should be tailored to real needs and suitable for every situation, so as to enable the gestational process is experienced as tenuous and enjoyable as possible [17].

Conclusion

I was evidenced in this study that the search for basic health units-UBS turned out to be the first choice on the part of those women, not only for the confirmation of the pregnancy, as well as, for early prenatal care, denoting the responsibility on herself and for the baby being raised.

It was identified that the primary health care services still have great difficulties to meet the demand of pregnant women who need to carry out laboratory tests and imaging. Such additional tests allow for early diagnosis of fetal, maternal or maternal-fetal risks.

It is noticed that a qualified prenatal assistance should be directed to the maternal and fetal needs, to effectively promote the development of a more cozy and safe pregnancy, considerably reducing the conflict situations in the gestational period.

Results show that, after the risk assessment of pregnant women, the Basic Health Units managed to forward this clientele to the prenatal care of the high risk units of reference. That is, the services of reference and counter-reference in these situations are in tune, as provided for in the ministerial policy.

After being classified as high-risk pregnant women and directed with their companions to the unit of reference, they indicated being welcomed by the interdisciplinary team in a humane and individualized way, with easiness to carry out additional exams.

However, there still is the challenge of searching for quality improvements in the high risk prenatal care, based on health promotion, in the assurance of guided monitoring to the women's bio psychosocial needs, as well as health education with pregnant women, their companions and the involved professionals.

Conflict of interest

The authors would like to declare that there is no conflict of interest.

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