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PERCEPTION OF PREGNANT WOMEN REGARDING THE PERFORMANCE OF NURSES IN PRENATAL CARE

*Percepção de gestantes quanto à atuação do enfermeiro no pré-natal**Percepción de las gestantes sobre la actuación del enfermero en el prenatal*Laíssa Araújo Severino¹ Renata Evangelista Tavares Machado² Thalyta Cássia de Freitas Martins³ France Araújo Coelho⁴ Daniel Rodrigues Machado⁵ 

ABSTRACT

Objective: to identify the perception of pregnant women regarding the role of nurses in prenatal care. **Method:** phenomenological research that interviewed 10 pregnant women in a city in Minas Gerais, Brazil. The statements were organized into categories and analyzed according to Alfred Schütz's social phenomenology and thematic literature. **Results:** the categories "Care centered on technical actions", "Fragility in communication between nurse and pregnant woman" and the expectation of "qualified guidelines developed through collective activities" emerged. **Final considerations:** the results raise the need to value subjective and communicational aspects in prenatal care, in addition to technical actions, with a view to establishing the bond between actors, expanding adherence and quality of prenatal care. To this end, continuing education activities are recommended.

DESCRIPTORS: Perception; Pregnant women; Prenatal care; Nursing; Primary health care;

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RESUMO

Objetivo: identificar a percepção de gestantes quanto à atuação do enfermeiro no pré-natal. **Método:** pesquisa fenomenológica que entrevistou 10 gestantes de um município de Minas Gerais, Brasil. Os depoimentos foram organizados em categorias e analisados segundo a fenomenologia social de Alfred Schütz e literatura temática. **Resultados:** emergiram as categorias “Assistência centrada em ações técnicas”, “Fragilidade na comunicação entre enfermeiro e gestante” e a expectativa de “orientações qualificadas desenvolvidas mediante atividades coletivas”. **Considerações finais:** os resultados suscitam a necessidade de valorizar os aspectos subjetivos e comunicacionais no pré-natal, para além das ações técnicas, com vistas a efetivação do vínculo entre os atores, ampliação da adesão e da qualidade do pré-natal. Para tal, recomenda-se atividades de educação permanente.

DESCRITORES: Percepção; Gestantes; Cuidado pré-natal; Enfermagem; Atenção primária à saúde;

RESUMEN

Objetivos: identificar la percepción de las gestantes sobre el papel del enfermero en el prenatal. **Método:** investigación fenomenológica que entrevistó a 10 mujeres embarazadas en una ciudad de Minas Gerais, Brasil. Los enunciados fueron organizados en categorías y analizados según la fenomenología social y la literatura temática de Alfred Schütz. **Resultados:** surgieron las categorías “Cuidado centrado en acciones técnicas”, “Fragilidad en la comunicación entre enfermero y gestante” y la expectativa de “orientaciones calificadas desarrolladas a través de actividades colectivas”. **Consideraciones finales:** los resultados plantean la necesidad de valorar los aspectos subjetivos y comunicacionales en el prenatal, además de las acciones técnicas, con miras a establecer el vínculo entre los actores, ampliando la adherencia y la calidad del prenatal. Para ello, se recomiendan actividades de educación continua.

DESCRIPTORES: Percepción; Mujeres embarazadas; Atención Prenatal; Enfermería; primeros auxilios.

INTRODUCTION

Maternal death rates from preventable causes are still high, especially in developing countries such as Brazil, and the World Health Organization constantly sets new targets with signatory countries to reduce these rates. With this in mind, one of the Sustainable Development Goals is to reduce the maternal mortality rate to less than 70 cases per 100,000 live births by 2030.¹

In order to promote quality prenatal care, with a consequent reduction in maternal mortality, it is of the utmost importance that the Health Care Network is aligned with the social and health needs of pregnant women, reducing the risk of iatrogenies resulting from fragmented care.² In addition, it is necessary to strengthen the care provided by the multi-professional team in order to increase reception, adherence to prenatal care and comprehensiveness.²

Within the scope of Primary Health Care (PHC), nurses can monitor low-risk prenatal care.³ In this context, they are expected to advise pregnant women on the importance of prenatal care, monitor the frequency of their appointments, carry out rapid tests, provide guidance on vaccinations and breastfeeding, among other duties.³

Prenatal consultations carried out by nurses have the potential to maximize satisfaction and feelings of safety, and when carried out interspersed with medical consultations, they increase the chances of more comprehensive guidance compared to those conducted by just one professional.⁴⁻⁶

In PHC, person-centered care should also be considered as a means of fostering co-responsibility and valuing the perspective of the health service user, in order to encourage greater responsiveness to health care by professionals and management.⁷ This study therefore aimed to identify the perception of pregnant

women regarding the role of nurses in prenatal care. The guiding questions were: how do pregnant women perceive the role of prenatal care nurses? What do they expect from it?

METHOD

Qualitative research, based on the theoretical-methodological framework of Alfred Schütz's sociological phenomenology.⁸ This considers the meaning of individuals' actions in the social world. Action is understood as conscious conduct, endowed with intentionality and based on intersubjective relationships. In order to understand actions stemming from past and present experiences, "motives-why" are sought and, in order to know expectations, motives in view of which one wants to act, "motives-for" are sought.⁸ In this study, the set of "motives-why" and "motives-for" of pregnant women's perception of the nurse's role in prenatal care is presented.

The research was carried out in Basic Health Units (BHUs) located in a small municipality in the Zona da Mata, Minas Gerais, with an estimated population of 11,090 inhabitants. The city's PHC service network is made up of four BHUs, 100% of which are covered by the Family Health Strategy.

The study included pregnant women who met the inclusion criteria: being in the second or third trimester of pregnancy; having low-risk prenatal care at the BHU; having at least three prenatal consultations with the nurse. Excluded were pregnant women who were unable to communicate verbally, under 18 years of age; who had prenatal care in the private network or in the public network outside the municipality.

Authorization was requested from the Municipal Health Department to begin the study in all the BHUs in the area. With

this authorization, the nurse in charge of each unit was contacted to request a list of the pregnant women who met the inclusion criteria. The list included: name, telephone number, address and the date of the last menstrual period in order to calculate gestational age. The pregnant women were then contacted by telephone to explain the aim of the research, invite them to take part in the study and arrange a date, place and time for the interview.

The statements were collected between March and July 2022 by the researcher. The instrument used was the phenomenological interview, in which face-to-face contact between the researcher and the interviewee allows the data to emerge and the phenomenon to be apprehended from the interaction, dialog and exchange between them.⁸ A semi-structured script with the following questions was used to guide the interview: How do you perceive the prenatal care provided by the nurse? What do you expect from their prenatal care? In addition, personal and socio-economic data was added to the script.

Before starting the interview, the researcher explained to the pregnant women the objectives of the research, the ethical aspects involved and the need to sign the Informed Consent Form. The interviewees were asked for their permission to use an audio recorder so that their statements could be recorded in full and analyzed later. The interview took approximately 20 minutes. There were no refusals or withdrawals. The number of participants was not established a priori. There were 10 interviews and all the testimonies obtained were included in the study. Data collection ended when the significant content of the data had been reached and no new themes emerged, showing that the objective of the study had been achieved and the questions that guided the research had been answered.⁹

The interviews took place at the participants' homes or on the premises of the BHU, according to the interviewee's decision. A private space restricted to the researcher and the participant was used in order to provide privacy and security for the verbalization of their experiences. The audio recordings were stored in a place accessible only to the researcher. To guarantee anonymity, the statements were identified by the letter "E" (interview), followed by Arabic numerals corresponding to the order of the interviews.

The organization and analysis of the results were based on assumptions described in a theoretical study based on Alfred Schütz's social phenomenology.⁸ First, each transcribed statement was read and re-read in detail. Afterwards, a comprehensive analysis and organization of the statements was carried out, the content of which was grouped by similarity of meaning, enabling the construction of thematic categories. The past and present experiences of pregnant women during prenatal care carried out by nurses resulted in the construction of categories referring to the "reasons why", while the tangible expectations of this care led to the formation of a category expressing the "reasons for". Finally, the results were interpreted using social phenomenology and the theoretical framework related to the topic studied.

The research complied with the steps recommended by the Consolidated Criteria for Reporting Qualitative Studies (Coreq)

protocol. It complied with the recommendations of Resolution 466/12 of the National Health Council. Approved by the Research Ethics Committee of the Centro Universitário Governador Ozanam Coelho under Opinion No. 5.233.323, CAAE: 55036722.6.0000.8108.

RESULTS

The sample consisted of women who were in their second trimester of pregnancy, aged between 21 and 41, married, with an income of approximately one minimum wage, and with completed secondary education.

Assistance centered on technical actions (reasons why)

Pregnant women reported that nurses assess weight, check vaccination status, carry out rapid tests, provide guidance on exams and are not very good at providing guidance on breastfeeding:

The nurse checks the blood pressure, the weight [...], if the vaccination card is up to date. [...] gave me advice when I came for my exams, the HIV and syphilis tests [...] gives a lot of guidance [...] for half an hour or so, on the importance of breastfeeding, what pregnancy would be like, what discomforts there are. (E1)

She administered vaccines, the Covid vaccine and one that every pregnant woman has to have, the dTpa vaccine, she did the rapid tests when I found out I was pregnant. [...] I didn't have any guidance on breastfeeding or anything, I learned at home with my mother. (E2)

The nurse did the rapid test, said it was important to do it to find out if you have any diseases [...] I had the dTpa vaccine [...] the nurse looked at my vaccination card, said it was very important to have it up to date and scheduled another vaccine that I'm going to have later. (E5)

The nurse gave me the vaccine, checked my blood pressure and weight [...] did some tests, three or four rapid tests. She made the first appointment with the doctor, explained to me exactly why I needed to have the tests [...] checked my vaccination card. (E7)

The pregnant women reported that communication with the nurse was fragile and superficial:

For me, who has no experience whatsoever with pregnancy, I feel the need for more guidance [...] I look at things on YouTube to clear up any doubts. (E3)

I found out I was pregnant very quickly, and I was also disoriented, not knowing who to look for [...] The nurse lacks better guidance on the subjects [...] She doesn't go into much detail. (E5)

There's a lack of better communication between us and the nurse. It's all very automatic, there's no communication. (E6)

As it's my first child, I have no experience of anything, I don't know. I think I could have received more guidance, because it's my first child, we want to know more about things [...] Communication isn't very good with the nurse, I would have liked to have received more guidance from her and talked more to clear up my doubts. (E8)

Qualified guidance developed through collective activities (reasons for)

Pregnant women expect the nurse to expand guidance by giving talks in the waiting room and in operational groups:

[...] I hope the nurses train the pregnant women [...] to have this, this preparation. So I think there could be more information, a lecture to explain, to help [...] be done with all pregnant women who are expecting at once. (E4)

[...] I hope there will be a mothers' group [...] I would have expected more information from the nurse, even asking if we have any doubts [...]. (E5)

I hope there are talks for pregnant women, because we spend a lot of time waiting to be seen, so it would be more useful, it would be really nice. I hope to receive more guidance. [...] that the nurse explains first aid as well. (E9)

I hope the nurse holds meetings with pregnant women. When you have an orientation, you already know how it's going to go [...], because the doctor gives guidance, but a nurse would be better [...], communication is everything. (E10)

DISCUSSION

Pregnant women's perception of the role of nurses in low-risk prenatal care is based on an emphasis on technical actions, such as weight assessment, checking vaccination status, rapid tests, guidance on exams and little guidance on breastfeeding.

A study carried out in Pará, Brazil, found that pregnant women assisted by prenatal care nurses perceived an emphasis on technical procedures, as pointed out by the participants in this investigation, and additionally cited gestational age calculation, physical examination with auscultation of fetal heartbeats and obstetric palpation.¹⁰

The technical procedures are set out in protocol determinations, such as the Basic Care Handbook for low-risk prenatal care.³ These documents guide health professionals, including nurses, to carry them out, including the constant assessment of gestational risk. It should be emphasized that assessing gestational risk allows Primary Health Care to become a coordinator of care and an organizer of care flows, enabling safe, timely and comprehensive access for pregnant women to the Health Care Network.

Among the technical procedures mentioned by the participants were rapid tests, mainly for HIV and syphilis. Both are scheduled to be carried out at the first prenatal appointment, in the third trimester and at the time of delivery or in the event of miscarriage, regardless of previous tests.¹¹

A study carried out in Ceará, Brazil, showed that despite the widespread availability of rapid tests for syphilis diagnosis, nurses perceived difficulties in preventing this disease, especially social factors, late start of prenatal care, lack of sexual partner adherence to treatment and lack of knowledge of the seriousness of congenital syphilis on the part of pregnant women.¹² It is therefore appropriate that, in addition to rapid tests, strategies are put in place for early screening of pregnant women, prenatal care for partners, and the use of clear and accessible language during guidance.

According to the Birth in Brazil Survey, prenatal care in Brazil tends to focus on the professional and the health service, to the detriment of the centrality of the woman and her subjective aspects.¹³ Corroborating this result, the interviewees in this investigation realized that in the prenatal care provided by nurses there is a weakness in communication, which is considered superficial.

The perception of superficiality in the guidance provided by nurses during prenatal consultations may be linked to the fact that they do not question pregnant women's possible doubts, their emotional state or worry about the support they receive in their family relationships.¹⁴ It may also be related to the fact that they do not address the type of delivery,¹⁵ weight gain during pregnancy, self-care, puerperium, return to sexual life and care for the newborn.¹⁶

A systematic review study, based on research carried out with pregnant women who had prenatal consultations with nurses in the United States, Canada, Brazil, Ghana and South Africa, showed that quality communication, in their perception, was when the professional respected them, accepted them, listened to them, treated them with dignity and without judgment.¹⁴

Communication aspects deserve to be valued in prenatal consultations, as it is considered an opportune space for building intersubjective relationships. In intersubjective relationships, the social actors, nurse and pregnant woman, are aware of each other and are mutually focused, sharing the same time and space.⁸ This requires active and qualified listening that will culminate in the establishment of a bond, which is a pillar for building co-responsibility in care, to reduce negative outcomes and evasion in prenatal care.¹⁰

A study carried out with nurses in Paraná, Brazil, pointed out that there are factors that contribute to undermining effective communication, such as the high turnover of nursing professionals, making it difficult to establish a bond with users and the PHC team, production evaluation based on quantitative targets, excessive bureaucratic work, among others.¹⁷

It can be seen that the factors that hinder communication aspects may stem from weaknesses in PHC management. In this context, investment should be made in longer forms of contracting: complete Family Health Strategy (FHS) teams, minimizing the chances of overloading nurses, who tend to carry out activities inherent to other professionals when there are absences in the teams and constantly re-evaluating territorialization so that the number of people enrolled is in line with what is recommended in the National Primary Care Policy.¹⁹

The pregnant women taking part in the study expect to receive qualified guidance developed through collective activities such as lectures/meetings and educational groups. A study that assessed the quality of prenatal care in PHC revealed that only 60% of pregnant women received all the recommended prenatal care guidance.²⁰ Health professionals should therefore use a variety of strategies to provide qualified guidance to pregnant women, and as indicated, collective activities are one of these strategies.

Collective activities can have different meanings and purposes. Lectures generally centralize knowledge in the health professional, ignoring the particularities of each pregnant woman. This practice can contribute to the adoption of a passive stance, where it is up to them to accept what has been imposed. On the other hand, educational groups allow for dialog, meetings, sharing of knowledge, demystification of practices and taboos. They can also help to promote personalized, comprehensive care for pregnant women and the people involved in this process.¹²

The lack of educational groups, despite the fact that they are part of the scope of recommendations for prenatal care,³ together with the identification of care weaknesses perceived by the interviewees, point to the need for actions aimed at continuing education. This, in turn, encourages learning based on situations experienced in the day-to-day running of the health service, leading to reflection and changes in paradigms and care practices. For this to happen, it is important to have a triad of factors as a backdrop: the professional's interest in taking part in learning activities; a working environment that encourages learning; and available technical support.¹⁷

This study has limitations related to the qualitative method, as the results presented are specific evidence of the group studied, which belongs to a reality that may differ from another, which prevents the results from being generalized. Therefore, other investigative possibilities need to be considered and implemented.

FINAL CONSIDERATIONS

Alfred Schütz's social phenomenology revealed that pregnant women perceive that nurses provide care centered on technical actions and that their communication is weak and superficial. These perceptions contributed to the desire for qualified guidance developed through collective activities, such as lectures/meetings and educational groups.

The results raise the need to value the subjective and communicational aspects of prenatal care, in addition to technical actions. To this end, permanent health education activities are recommended to overcome the perceived weaknesses. These aspects contribute to the creation and consolidation of the bond between the nurse and the pregnant woman, and can result in increased adherence to and quality of prenatal care.

It is hoped that this study will arouse interest in future studies that seek to unveil the nuances understood in the nurse-pregnant woman relationship, especially during the prenatal consultation, with a view to enabling it to take place in such a way as to meet the wishes of both players.

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