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Original article

Expectations and satisfaction of pregnant women: unveiling prenatal care in primary care

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Expectations and satisfaction of pregnant women: revealing prenatal care in primary care

Objective. To analyze the perception of primiparous women about prenatal care in Basic Health Units in a municipality in southern Brazil. **Methods**. This is a qualitative research from the perspective of Social Representation Theory, from the following question: How has been the pre-natal care for you? Eighteen pregnant women were interviewed. **Results**. The analysis resulted in three categories: Expectation representation about prenatal care; Rescuing the care offered in prenatal consultation; Unveiling the (dis) satisfaction with prenatal consultation. The prenatal care was apprehended as an essential moment for safe pregnancy, although centered on the doctor's figure and guarantee access to early laboratory and imaging tests. On the other hand, dissatisfaction was revealed from the reception at the entrance to the health unit to the consultations access, although some statements suggest timely satisfaction. **Conclusion**. Prenatal care did not meet the specific expectations of the study group and unveiled that the nurse did not supply it, as a member of the multidisciplinary team. The organization of the nursing work process in primary care, related to prenatal care, needs to be revisited to promote the effectiveness of its actions.

Key words: prenatal care; primary health care; quality of health care; nursing.

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Expectativas y satisfacción de gestantes: revelando el cuidado prenatal en la atención primaria

Objetivo. Analizar la percepción de las mujeres primíparas sobre el cuidado prenatal en las Unidades Básicas de Salud en una ciudad del sur de Brasil. **Métodos.** Investigación cualitativa de la perspectiva de la Teoría de las Representaciones Sociales, de la pregunta norteadora: ¿Cómo ha sido el cuidado prenatal para usted? Para el presente estudio, se entrevistaron 18 mujeres embarazadas. **Resultados**. Del análisis emergieron tres categorías: Representación de la expectativa del cuidado prenatal; Rescatando el cuidado ofrecido en la consulta prenatal; y Revelando la (in)satisfacción con la consulta prenatal. Se comprendió que el cuidado prenatal es un momento esencial para un embarazo seguro (aunque es enfocado en el médico) y garantiza el acceso a los exámenes de laboratorio e imagen temprana. Por otro lado, se reveló insatisfacción de la recepción en la entrada de la unidad de salud hasta el acceso a las consultas, aunque algunos discursos apuntaron satisfacción puntual. **Conclusión**. El cuidado prenatal, no cumplió con las expectativas específicas del grupo en estudio y se desveló que el enfermero, como miembro del equipo multidisciplinario, no se dio cuenta. La organización del proceso de trabajo del enfermero en atención primaria en relación con la asistencia prenatal tiene que ser redirigido a favorecer la efectividad de sus acciones.

Palabras clave: cuidado prenatal; atención primaria de salud; calidad de la atención de salud; enfermería.

Expectativas e satisfação de gestantes: desvelando o cuidado pré-natal na atenção primária

Objetivo. Analisar a percepção de mulheres primíparas sobre o cuidado pré-natal em Unidades Básicas de Saúde, Londrina-PR, Brasil. **Métodos.** Pesquisa qualitativa sob o olhar da Teoria das Representações Sociais, a partir da seguinte questão norteadora: Como tem sido o cuidado pré-natal para você? Foram entrevistadas dezoito gestantes. **Resultados.** A análise resultou em três categorias: Representação da expectativa quanto ao cuidado pré-natal; Resgatando o cuidado ofertado na consulta de pré-natal; Desvelando a (in)satisfação em relação à consulta de pré-natal. Apreendeu-se o cuidado pré-natal como momento essencial para gravidez segura, embora centrado na figura do médico e; garantia de acesso a exames laboratoriais e de imagem precocemente. Por outro lado, revelou-se insatisfação a partir do acolhimento na entrada à unidade de saúde até o acesso às consultas e; orientações insuficientes, apesar de alguns discursos apontar necessidades e satisfação pontual. **Conclusão.** O cuidado pré-natal, não atendeu às expectativas específicas do grupo em estudo e desvelou que o enfermeiro não às supriu, enquanto membro da equipe multiprofissional. A organização do processo de trabalho do enfermeiro na atenção primária em relação à assistência pré-natal precisa ser revisitada para favorecer a efetividade de suas ações.

Palavras chave: cuidado pré-natal; atenção primária à saúde; qualidade da assistência à saúde; enfermagem.

Introduction

The attention to pregnant women is one of the priorities of public health policies in Brazil, and its monitoring is configured as one of the main indicators of the effectiveness of primary care because their procedures follow the same logic to other actions in health and can be used to assess the quality of care.[1] Similarly, the user's satisfaction is a fundamental tool through which it is possible to rescue its opinion about the received care.[2] Currently, Brazil, together with more than 190 countries, must meet the Objectives for the Millennium Development with reduction of maternal mortality as one of the priorities, which is high. In 2010, the rate was 60.1/100 000 living births, well below the rate recommended by the World Health Organization of 20/100 000. It is observed that the deaths occur mostly from preventable and detectable causes during prenatal, reflecting the technological conditions resulting from interventions, omissions, incorrect treatment; economic and cultural precarious.[1-3]

The main causes of maternal deaths in Brazil are due to hypertensive disease (23%), sepsis (10%) and bleeding (8%), all preventable causes through appropriate care assistance in prenatal, delivery and postpartum.[1] Concerning perinatal morbidities, special attention should be given to the total gain weight of pregnant women that is associated with the child's weight at birth and,

if excessive, can determine future childhood obesity.[4] In this context, access to maternal health services and the quality of these services, considered guiding principles in the analysis of determining health problems,[5] places prenatal consultation in a prominent place in the logic of comprehensive care to women's health in the experience of pregnancy and childbirth cycle. In this sense, in 2010, the new model was implemented in networks in the country by the Ministry of Health which aims to promote the availability of a continuous and comprehensive care through unique mission, common objectives and joint planning and therefore, spurred the creation of the Stork Network in 2011, to ensure this assistance to women.[1,5,6]

The advance of prenatal consultation quality is evidenced in the scientific literature.[6,7] However, the diagnosis of work organization process in primary care makes it clear that the infrastructure, especially of human resources, is not enough even to meet the real demand. Added to this fact, the insufficient number of doctors and nurses, qualified and available to operate at this level of care.[8] The implementation of prenatal consultation in this context turns out to deviate from its reception and humanization features, being centralized in the biological/clinical care, disadvantaging the use of this moment as active listening space to meet the individual needs of women inherent to pregnancy.[9,10]

This study aimed to analyze the perception of primiparous women about prenatal care in Basic Health Units in a municipality of Southern Brazil, with the assumption of Social Representations Theory that enables the analysis of cognitive interaction, reality interpretation and the orientation of conduct and social relations related to the study object. The importance of this study lies in the fact to unveil that prenatal care, especially when performed by nurses, in addition to meet the prerequisites proposed by the Ministry of Health (minimum number of queries equal to six, prenatal beginning on the 1st quarter, immunization update, laboratory and imaging examinations every quarter, etc.) must also meet the expectations and desires of pregnant women. In this context, the nurse's action is a big differential to the goals achieve of prenatal coverage and the effectiveness of the quality of care in primary health care.

Methods

This is a qualitative research, with the methodological, theoretical reference the Social Representations Theory and Content Analysis.[11,12] This theory aims to integrate an unfamiliar social phenomenon that can cause fear and anxiety in the daily life of individuals or groups. Therefore, it is feasible to assimilate the conceptual framework to become familiar as it is re-elaborated, becoming a new way of knowledge called consensus, arising from discussions and consensus among members.[12] The social representations are socially organized and shared form of knowledge, which has practical purpose and contributes to the creation of a reality common to a social group, which can be denominated as knowledge of common sense or natural knowledge.[11,12] They are recognized as interpretation systems that drive our relationship with the world and with others. They guide and establish the behavior and social communications. Similarly, they are involved in various processes such as diffusion and assimilation of knowledge, individual and collective development, the definition of personal and social identities, the expression of groups and social transformation.[11]

The study population consisted of primiparous women of normal risk, with over 18 years old, who had attended at least six prenatal consultations in Basic Health Units (BHU) in the city under study, between April and June 2012. The primary care health system consists of 53 BHU, distributed in six regions (north, south, east, west, central and rural), which provide the monitoring program in prenatal care for low-risk pregnancy. For the composition of the study subjects, the following steps were followed: random selection of a pregnant woman by region, in the SISPRENATAL register, telephone contact to verify their interest

in participating in the study and schedule the date and interview time at home.

Data collection was carried out after signing the informed consent form, through instrument with semi-structured questions. Initially, the socio-demographic conditions were identified as: marital status, education, age and family income. After, there was the interview recorded from the following guiding question to elucidate the research objective: *How has been the prenatal care for you?* The study subjects totaled 18 pregnant women; many participants considered sufficient from the moment that statements did not bring new information, featuring the theoretical saturation of data. For the data analysis, the following steps were followed: pre-analysis of the material (organization); material exploration and; results processing (interpretation and inference). The statements of the pregnant women were identified with the initial P of pregnant, followed by Arabic number according to the order of the interviews and thus, remained the confidentiality of the subject. After transcription, all interviews were discarded. The research was approved by the Municipal Department of Health and approved by the Research Ethics Committee of the State University of Londrina, opinion number. 240/2011, CAAE: 0222.0.268.000-11.

Results

Taking the Social Representations Theory as a presupposition, analyzing the expectations and satisfaction of these women, it is observed that they organize their stories and common sense knowledge in a situational context that is common to them, but also consists of their individual characteristics. In this case, the experience of prenatal care, which is characterized as group identification moment and personal history, limit the cognitive explanations of each subject. The average age of survey participant pregnant women was 21 years old, the minimum age of 19 and maximum of 33 years old. Regarding education, three had complete elementary school, and three had higher education and another high school. Family income ranged from one to three minimum wages, considering the salary in force in the state in 2011, which was R$ 783.20 (Brazilian currency). Only one of the study participants was separated from the child's father while the other lived with a partner. Through observation, first training process of social representation in which it seeks the objectification of something abstract giving it a meaning, as the anchor, second training process, where there is the construction of the network of meanings for understanding and description of a new knowledge[12], a framework of analysis was structured that resulted in three categories that made up the central core[13] originated from the content analysis of the statements of the pregnant women, described as follows:

Category I: Medical follow-up; Access to tests; Early beginning; Group activity; Guidelines about pregnancy and childcare; and aggravations identification.

Category II: Delay and lack of priority attention; Lack of obstetricians; Pilgrimage to conduct examinations; Pilgrimage to outsourced consultations; Interpersonal relationships as a barrier; and Insufficient specific guidelines.

Category III: Presence of qualified professionals; Active listening; Access to guidelines related to pregnancy; and Clarification of personal questions.

Central Core: Safety during pregnancy, delivery, and childbirth; Maintaining a healthy balanced state; Work process and care organization; Professional qualification.

From the guiding research question, it was possible to reveal the central core of the representations in question, structured from the following categories: Expectation representation about prenatal care; Rescuing the care offered in prenatal consultation; Unveiling the (dis) satisfaction with prenatal consultation. Each category has its respective peripheral elements, which are nothing more than the representation characteristics object.[12]

Expectation representation about prenatal care

This category shows that women consider prenatal care as an essential moment in the experience of pregnancy. They are expected to medical follow-up in the health service, with guaranteed access to laboratory and image tests with an early beginning. This follow-up is represented by prenatal consultation and activity moments of the group, which should be provided guidance about pregnancy and caring for their child as well as the identification of maternal-fetal diseases. This idealization materializes to these women safe in pregnancy, delivery, and the childbirth and maintaining a balanced health state at this time of life: *I decided to make the prenatal to be better informed, to know what will happen in my pregnancy, risks, or which care I must have not to harm the child in the future, however I would not have any risk, but I need to know that I was not at any risk* (G5)*; To have consultations with the doctor, take the doubts and make the exams* (G7)*; Since I found out I was pregnant I went to the health unit, I think it is important to do, to have a follow-up because of the baby health, the treatment, as it is my first child...I have had an abortion and oh! This child is well expected* (G11)*;...I think more support and more encouragement, even breastfeeding, groups, especially for first-time mothers like me, groups that I could speak more about pregnancy, explain how it is a delivery, we have no support for this... it is only prenatal with the doctor, and that's all, I had no lecture, had nothing* (G17).

Rescuing the care offered in prenatal consultation

This category highlights a diagnosis about the organization of the work process, the pregnant-professional interpersonal relationships, and practice of health education in the basic units where these women are followed. The delay and lack of priority in the care of pregnant women, the lack of obstetricians and pilgrimage for exams, and outsourced queries appear as complicating factors of work organization process and, consequently, the care process. In the specific context of prenatal consultation, an interpersonal relationship is characterized as a barrier to the resolution of doubts that these women consider significant. Similarly, access to specific guidance about the pregnancy changes, delivery, postpartum and childcare, were reported as insufficient. On the other hand, some statements extol care about nutrition during pregnancy: *There is a lot of people that is in the queue waiting outside, to be attended by nurse, even those who are not pregnant, there is no doctor, and the queue remains big and there is no place to sit...there is water and bathroom* (G1)*; She did not speak anything to me about delivery yet, I do not know where I'm going to have...how progress is...where I must go if I feel something during the weekend or night...I do not know if she will say something on the next consultation...I know that if I have pain, the bag burst...I have to go to Maternity, but I know because of my aunts...*(G4)*;....Mostly things we change on feeding...reduce the salt of the food, I put a lot of salt. I started to eat more fruit, less bread; walking...*(G7)*; It has been much to be desired. He (doctor) could give more attention, explain more, give more space, especially when is the first child, we have many doubts* (G8)*; The waiting time to enter the consultation sometimes takes a little bit...the clinic where I'm doing ultrasound also...I think it is very bad because I get there, and he (doctor) puts the machine... ah everything it's okay, bye – like he does not see anything, you know? Neither see the baby nor show me anything, just listen to the heart and ok...could...more showing the baby to us, it would be only two minutes. He attends in the morning...sometimes I arrive at 6:30 am to be attended at 8 am...*(G9)*; First it had to improve accommodation in the post and after the delay... because I am pregnant, and my appointment is scheduled at ten o'clock...it would be at the scheduled time because it is uncomfortable to wait there for hours...poorly accommodated, waiting...the mother has priority, but is not like this in many places...*(G13)*...The exams are horrible because are to the public, but does not have much time to attend...sometimes mark 7 am and will attend at 9:30 am, 10 am in the*

morning and for those who work is complicated... loses all morning (G16).

Unveiling the (dis) satisfaction with prenatal visit

This category shows that the presence of qualified professionals who can do active listening, access to inherent guidelines at this moment to clarify the doubts of common sense of women and to care technologies, are representations of satisfaction of half the subjects. However, the absence or inadequacy of the same factors are reported as triggering dissatisfaction: *...at first; it was difficult because the doctor of the unit is always away...I was being attended more by nursing, as it is my first baby I was kind scared, I was scared because I had no medical care... we go without an appointment, you have to wait for everybody to see if the doctor can fit us. I had to wait also with the doctor, it was at the beginning, I did the first urine tests and gave infection...But then the nurse (nursing assistant) said to me, you come back in a month...I went back because there was no doctor, nobody gave me medicine...I went back to ask and make an appointment, the nurse was rude to me... just missed told me I was irresponsible...she send me to the emergency...I got there and the doctor ordered another examination, and I did not have anything this time, I made 4 urinalyses, one has infection, the other did not, the doctor told me to make a particular, I had to pay to have a guaranteed result that I did not have infection* (G2)*; ...I had one day I get sick and seek the unit and the head nurse attended me, and she made the same medical procedures, it was very good, it could have more consultation with them, they also understand a lot, she asked exams, everything ok* (G4)*; It could have more consultations and more tests, they ask for exams at the very beginning of pregnancy and then just ask again at the end, if something happens in that period we need to know, especially when it is the first child, take more doubts, as I am alone here, I have to be wondering, guessing things* (G7)*; ...It should have a little more attention, I told him about discharge, he could have picked, looked...as my exams have anything he says that is by nervousness...but do not ask if has smell, what color is...I do not understand anything, I was ever pregnant, sometimes can be something serious, I end up losing a child and I do not know it was because of that discharge that was from the beginning of pregnancy* (G9)*; ... It was more than I expected...the doctor is good, the nurses who attend me are good, the staff of the unit are good...I thought it would be bad because is public...but there I found all that I have doubts, if they do not know they find out, especially the nurses, they find out and are always treat us well* (G16) *...More guidance, lectures, more dynamism between doctor and patient, both first-time pregnant as they say, he should have the notion to say what will happen from today. Because the mother...to have more than one child already knows, the mother who is pregnant for the first time she does not know what will happen...it should have more guidance, medical fellowship, more talk. It is only lack of goodwill ...* (G17).

Discussion

The expectations and consequent user's satisfaction can translate into powerful information for the analysis of effectiveness and solvability of the shares offered actions by the health service.[14] In Brazil, the first movement in this direction took place through national satisfaction survey, which involved education services, social security and health in a sample of 8 000 households and its greatest achievement, to the detriment of specific results in terms of user satisfaction, was to officialize the evaluation of the user's perception of the quality of received service.[15] Thus, the apprehension and understanding of the relationship between user's needs with professionals and health services for the search for answers are critical.[16] Therefore, unveiling the subjective dimension, using the Social Representation Theory, allows to recognize and value the cognitive aspect of the individual, according to this perspective interferes in social practices, attitudes, and behaviors related to the representation object. It also focuses its

attention on the knowledge of the participants to understand their daily lives, as well as clarify how is the facts assimilation process and how they are constructed and expressed through communication and behavior.[12] This disclosure allows the nurse who usually coordinated health-care programs in primary care seek shared strategies for the establishment of a common reality to a social group (natural knowledge) and intervene to reorganize the work process to adapt and qualify the assistance to women during pregnancy period.

The adequacy of prenatal care is seen as a challenge to be overcome in Brazil. Despite being an action inherent to the nurse activity that works in partnership with medical interspersing consultations in low-risk cases, there are still minimum ineffectiveness and fulfillment of the basic components recommended by the Stork Network, with numerous failures, such as limitation of laboratory and imaging examinations, guidance (particularly primiparae or term), persisting adverse perinatal results, despite the increase in prenatal coverage.[17]

A research that aimed to analyze the prenatal care in public and private health services, through audit of 500 books of pregnant women, identified that the frequency of six or more prenatal consultations was significant and predominantly in private service (91.9 %), there were differences of assistance according to the care local, showing excellent and good quality in the private and regular in the public for ultrasound and blood type/Rh factor; regular quality in the private and bad in public for urine tests and weight and other laboratory tests, obstetrical and vaccination regimens, poor or very bad quality in the two systems, requiring improved prenatal care provided mainly by the public service.[18] Such flaws were evident in the statements of the subjects of this study, and, in another research conducted in São Paulo, with 169 mothers attended at a teaching hospital, to identify care for pregnant women in prenatal care and their opinions about this service, showing that although all have received prenatal care, 78.0% did not participate in a group of pregnant women and could not answer certain questions, recommending that the health team provide better service. This same study found that pregnant women who had access to a service with professionals, in particular nurses, who performed active listening and clarified their doubts, and the tests, reported satisfaction with the received prenatal care.[19]

In another qualitative research to understand the social representations of puerperal women about prenatal care in primary health care, developed in nine Family Health Centers, Fortaleza, Ceará, Brazil, revealed that social representations of users about the prenatal are anchored in the protocol dimension and socio-educational dimension, highlighting gaps in care, as dissatisfaction with the received care because sharing of knowledge and interaction between users and health team is almost non-existent.[20] Similar results were also observed in a descriptive qualitative research with eleven women attended in a large public hospital in the city of Porto Alegre, which sought to identify how the users mothers perceived the care provided by the health team in the prenatal and what they think about access, the reception, and the service received during this period.[21]

Thus, the formation of specific groups developed by nurses for pregnant women has been cited as an effective tool, which when associated with consultations is an appropriate strategy for prenatal care quality.[17,20,22,23] Furthermore, research conducted in the city of Cajazeiras-PB, observed that the perception and knowledge of pregnant women about changes of pregnancy were related only to weight, breast, and abdomen gain, but these changes were not highlighted by every woman according to pregnancy.[24]

The central core of representations built by women, study subjects, is not different from the findings of other studies, regardless of the methodological approach, a fact that becomes very significant about the object under study. This consideration is possible since done through analysis with a quantitative approach, in which vulnerabilities can be evidenced, or qualitative, which the subject is

studied in their personal identity and as part of a group, the evidence are similar. It can be said that 'Safety in pregnancy, delivery and the childbirth', 'Maintenance of a balanced health state', 'Work process organization and care' and 'Professional qualification', were developed and sustained images by these women from their social relations, with and in the public space. Thus, although a long time, in the health area, satisfaction reported by the user to be considered with indifference and even distrust,[17,20] it is believed that this new knowledge must be assumed to understand this particular reality.

It is highlighted that the quality of care depends on the developed activities among health professionals and pregnant women, considering the needs and individual and group expectations on an active listening space, clarifying their doubts, providing information and guidance relevant to pregnancy and childbirth, as the new model in the network. This is a space that should be occupied by the nurse since they have the following characteristics: the constant permanence in the service, bonds creation with the user, the practice of reception, the absence of gender conflict and training grounded in the promotion and preventive health. These features add to the strengthening of knowledge and autonomy of nursing as a discipline that results in essential responsibilities necessary for care management.[25] Cohesion between professional-pregnant woman has been identified as beneficial for the development of pregnancy, delivery, postpartum and care for their safe and quiet child, reducing feelings of fear, tension and anxiety.[2,6,7,19,21]

The conclusion of this study is that, analyzing the perception of primiparous women about care in prenatal consultation in the Social Representations Theory, it was possible to understand that the experience of pregnancy brought elements of the social environment that were reproduced, elaborated and rebuilt in the prenatal care routine and revealed the unique needs that in part, were not met by nurses, although recommended in the protocols. This may be the result of possible nursing work gap, despite the implementation of new care models in primary health care. Therefore, the restructuring of the work process in the units is necessary. It is essential to consider user satisfaction to subsidize health care policies, providing infrastructure and qualified human resources, since in these primary inputs are low cost when compared to levels of greater complexity. Effective nursing work can change this context, revisiting the organization of their practice through the prioritization of health care at the expense of management actions involved in their work process.

As study limitation is pointed out that the analysis was directed to a group of pregnant women, and cannot be generalized to other groups or populations though its importance is unquestionable for the particular diagnosis, which will support the review of programmatic actions in the city.

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