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THE SEARCH FOR CARE BY HIGH RISK PREGNANT IN RELATION TO INTEGRALITY IN HEALTH

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ABSTRACT
The aim of this study was to understand the therapeutic itinerary of pregnant women at high risk in prenatal care from the perspective of Integrality in health care. A descriptive study, qualitative approach, which seeks to offer a reflective look for the search and production of care in condition of the high-risk pregnant women, attended at health unity due to hypertension in gestation. From the attentive reading and discussion of the data and, after the construction of therapeutic itinerary organized the analysis of data from two categories - Access to health care at the first sign or symptom and the impact of prenatal care; Comprehensive care in the walked way. The data analysis was based on the theoretical content analysis of Bardin. This research involved five high-risk pregnants attended at Women's Specialties Polyclinic Malu Sampaio. The access to the service proved, according to pregnant women, quickly; however, the continuity of care for the unity of origin still proved fragile before the integral and participatory approach in the lives of users.

Keywords: Pregnancy, High-Risk. Prenatal Care. Integrality in Health.

INTRODUCTION

Pregnancy is the physiological processing of the woman's body, which, through embryonic development, generates a baby. Due to the complexity of this phenomenon, great care is, and the mother needs to experience this phase with confidence and trust. Pregnancy, at first, is considered a low risk condition, the health team, if not carries embryonic risks or complications to the woman's body. On the other hand, it is considered high-risk pregnancy in that the expectant mother and her baby at risk of dying[1].

We observed numerous factors that increase the risk rating for each pregnant woman, however, there is to be discerning as to the identification of risk factors and the classification itself. This classification is verified and checked every prenatal visit until the time of parturition[2].

The approach of this issue is important, since pregnancy, considered physiological, in principle, can lead women to serious complications such as preeclampsia, eclampsia and gestational.

Hypertension, for example, complicates about 7 to 10% of all pregnancies. Eclampsia has an incidence of 1,3 per 1.000 births, ranging from 0,6 in developed countries, up to 4,5 in developing countries. The incidence of HELLP syndrome stands for the English term Hemolysis, Elevated Liver enzymes, Low Platelet count, the rarest between injuries varies between 2 and 12% of women diagnosed with preeclampsia[4].

Faced with the gravity of the current situation, the Ministry of Health (MOH) has been investing in the expansion and qualification of specialized services in compliance with high-risk pregnancies. According to MS, since May 2013, there are 196 reference hospitals in high-risk pregnancy accredited by the Government; however, the expectation for 2014 is that this number will reach 390, while the number of qualified beds reaches 2.885[5].

The focus of this research is the pre-natal

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considered transient risk. In this case, monitoring the pregnancy does not depend on admission, as a specialized team turns out to monitor and treat pregnant women in this situation. In this transient state, the woman continues traversing the primary care services in the reference and counter process.

Currently, there are few studies aimed at analyzing the integration of care networks in the country. Studies, mostly with regard to maternal and child care, are still based on a descriptive approach of services and health care characteristics, such as coverage, the number and adequacy of prenatal visits and type of parturition[6].

In this sense, we highlight the importance of comprehensive care as a guiding principle of the monitoring of high-risk pregnant women whose health needs often are not considered in prenatal care, since from now, the demands and health devices will be tight.

However, in order to better understand the dynamics of care production during the high risk and start applying for new health practices in the context of completeness, it is necessary to understand what a woman goes through paths in search of their care during pregnancy and how these practices are planned within the health system work[7].

The objective of this research was to understand the therapeutic itinerary of high-risk pregnant women in the city of Niteroi in prenatal care, from the perspective of integrality of health care.

METHODOLOGY

Descriptive study with a qualitative approach, which sought to provide a reflective look at the search and careful production under the conditions of pregnant women during the high-risk, attended the reference health facility in the city of Niteroi, in the state of Rio de Janeiro.

Defined the study based on the construction of the therapeutic itinerary, as it allows reflection on the full health in the care of high risk pregnancies, under the reference and counter-SUS, i.e., routing and monitoring unit of origin, early prenatal (PN), for the specialized unit at high risk; and when stabilized, his return to the source drive, the less complex, to continue the treatment.

Subjects were defined from the inclusion criteria: pregnant women older than 18, diagnosis of hypertension and who performed both treatments on the source drive as the specialist, and, as an exclusion criterion, the pregnant woman without the registration of SISPRENATAL.

The data was collected through semi-structured interviews, which established a more focused dialogue on the subject, however, flexible and quick adaptation. Although questions have been previously prepared according to the semi-structured interviews the interviewer held deepened, insofar as it enabled the interviewee. The questions were: How the team meets and welcomes you? What forms of care do you use? What are the places you have attended to get care?

This research involved the participation of 5 high-risk pregnant women in Polyclinic of Woman Specialties Malu Sampaio, in Niteroi, according to the inclusion and exclusion criteria. To provide confidentiality to respondents, we used identification codes: GA, GB, GC, GD, GE.

The meetings were held in the period from August to October 2013, and the narratives of the women provided the seizure of logic that directed the search of care, and also enabling the mapping of therapeutic itineraries.

This study centered on data obtained from accounts of high-risk pregnancies on the integral health, for the forwarding and returns the source drive to the specialized unit, featuring the reference and counter-SUS.

To enable this understanding, the various paths that trajectory have been mapped, thus composing the Therapeutic Itinerary (IT). The IT is based on the "journeys undertaken by the sick person and his family in the search for solving their health needs, as well as the logic that directs, woven in multiple formal and informal networks of support and belonging, among others, that can give them a certain sustainability in their illness experience[8:58)".

The interview data formed the corpus of analysis, which, subject to exhaustive reading, highlighted the IT pregnant women, behaving journeys undertaken by them and the meanings they attach to their experiences for the return of service to the source drive of the pre-natal. In the construction of IT, each route is shown by an arrow, whose direction specifies the direction of the movement undertaken by them between health services, their support network and, in some cases, the reference and counter-made.

Data analysis had as a theoretical content analysis in Bardin perspective[9]. A pre-analysis identified the main issue variables. Then the questions settled, so that then the most relevant information and created the specific categories defined above were identified.

This research follows the bioethical criteria of autonomy, non-maleficence, beneficence and justice, among others, to ensure the rights and duties with respect to the scientific community, established by Resolution 466/2012 of the National Health Council, for scientific research involving human beings, with the approval of the Research Ethics Committee of the University Hospital Antonio Pedro, through the protocol number: CAAE 11707413.0.0000.5243. All interviews were conducted after signing the consent form.

RESULTS AND DISCUSSION

This survey was conducted in one of the largest cities in the metropolitan region II of the state of Rio de Janeiro, where it is expected occurring through increased professional demand, access to clinical and other technologies and greater quantitative units, overcoming current conditions of access to health services as well as less painful therapeutic itineraries.

From the attentive reading and discussion of the data, there was organized the analysis of the sample with the construction of IT and two thematic categories. Namely: Access to health care at the first sign or symptom and the impact of prenatal care; and the comprehensive care in the road traveled.

The access to health before the first sign or symptom and the impact of maternity care

In this category, surprisingly, the description of tickets for various health services, featuring the pilgrimage on the network, has been described in only one interview, when, at the time of discovery of the pregnancy and the pursuit of prenatal initiation, the interviewee lived in São Gonçalo. In one of the excerpts from the interview, she tells how and when able to start the service:

> Care in São Gonçalo is horrible. I have no words to say what I went through at the beginning [of pregnancy]. Indeed, it was unattended [laughs], and I could not make this such card-SUS, then after months I could do the membership card, I moved in Barreto. There, I mean, I was already 4 months pregnant. (GC)

Registration with the SUS, represented above by 'card-carrying', it is necessary for the start of any activity within the public health services, so it is also required for prenatal care, recommended as soon as it is diagnosed pregnancy. In this case, the late onset of prenatal care can affect the quality of assistance provided, as the necessary vaccinations, laboratory tests and in health guidelines[10].

The experience of anxieties and possibilities built for this woman makes us direct a more careful look at the concept of pre-natal, as a follow-up action of women's health during intrauterine embryonic development, dependent on adherence to health services and an active participation in the process, issues related to universality and equity of SUS[11]. Thus, Figure 1 explains their therapeutic itinerary from the time of pregnancy until the beginning of the discovery and monitoring of prenatal care.

The GC pregnant woman who lives in Niteroi is newly, which ended up delaying the start of their business plan for the four months of pregnancy. Earlier in Sao Goncalo, she could not access to services by the lack of SUS card, condition for their entry into the system. It is considered high risk for being a woman of 42 years with hypertension and

diabetes mellitus. In the following steps, the trips to the hospital occur when there is some obstetric emergency, such as heavy bleeding, presence of hypertension or hyper / hypoglycemia. At the referral center for high-risk pregnancy, the service is monthly and specialized care. It is also advised to attend the source drive, which started the PN, however, reports that there is consultation, but the record, records, data related to blood pressure and blood glucose.

A characteristic found in the form of organization of network services for pregnant women in Niteroi is the difficulty of access to specialized care, because even when more stringent measures of reference are deployed, for example, assistance regulation through the first level units, access to specialized services remains cornered. This situation occurs due to the fact not follow the expansion of coverage, forming therefore true bottlenecks in the system, since the quantity and quality of consultations and examinations of the specialties are insufficient in view of the needs of the user population, resulting in an increased demand by pressure of this level of care[12-13].

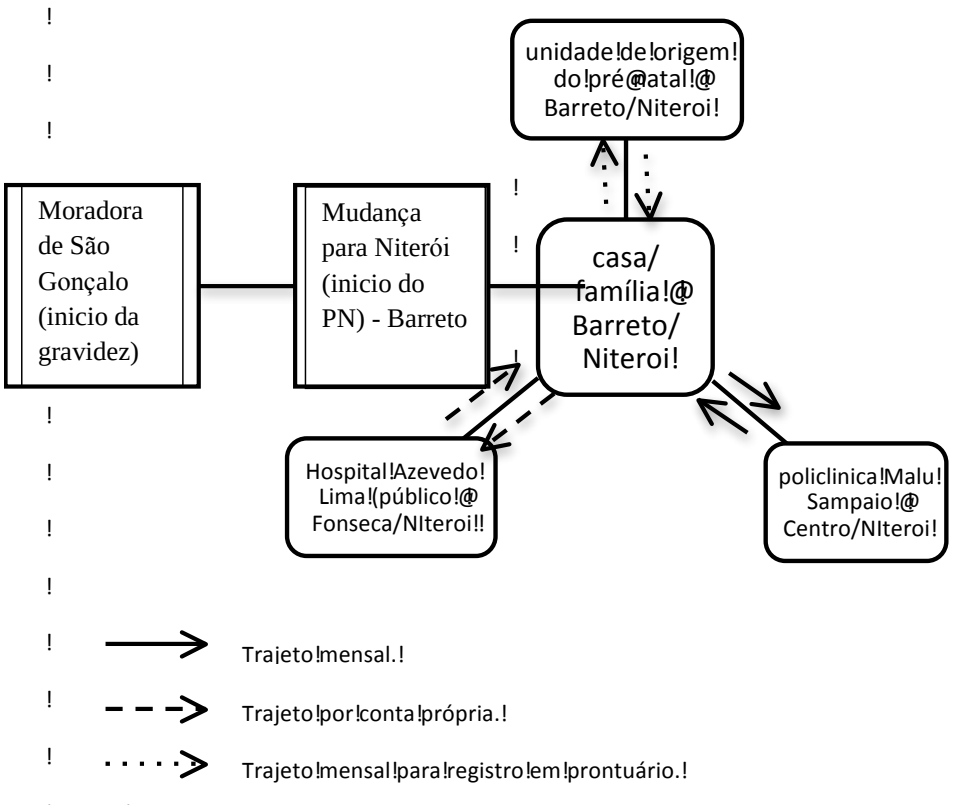

Figure 1. Therapeutic itinerary of pregnant woman GC.
Source: The author, 2013.

Women from the prenatal have lost the right to act on their own bodies, no longer protagonists of the act of giving birth, which can be observed by the GA:

> [...] she {the doctor} she said that when I get sick, or goes to the Azevedo [Hospital] or the Antonio Pedro [University Hospital] [...] now, in the second [son], I'm fear of not getting sick and being with dilation. My fear is of having no signal and not have medical to forward. (GA)

The situation of double bind, understood step in in health care, it is non-existent because the mother does not return the necessary care, since the PN source drive says not meet high-risk situations. In this narrative, fear and insecurity of not monitoring arises, reflecting the complete assistance of the gap.

Primary care must therefore be organized in order to meet the mother according to the attributes of the network services, such as the first contact, the longitudinally care, comprehensive care, coordination and orientation with a focus on family and community[7]. Regarding the professionals, the reference movement and counter, in the case of high risk pregnancies, is based on preconizations of the Ministry of Health[3].

Although some women have different ways of coping with the pregnancy, because I experienced this phase at some point in life, the guiding principle of our discussion moved to the aspect of subjectivity in the construction of its therapeutic pathways, focusing on possibilities of care for prenatal (like where to seek care and who), within the network of high-risk Niteroi services.

The monitoring of high-risk prenatal does not arise only as a dependent control of the pregnant woman, and yes, a totally dependent control of medical knowledge and health staff caring and therapeutic materials and resources involved. Start or continue prenatal without proper confidence in the health team presents itself as a relevant factor in the experience of the women interviewed:

> [...] I started treating me at the station near my house, there in the Basic Unit of Barreto, and 42, hypertensive. And I did a survey and found that I am also with sugar, high blood glucose, then what the unit transferred me here, because really my pregnancy is high risk, because these three little problems {laughs}. (GC)

> [...] Has a problem with the baby, was swollen right kidney and the doctor there sent me here, to the high risk. I do prenatal there in the station, close to home. There is good, there they [doctors] are well. If you get there feeling bad, they serves you right, you need not be a long time waiting for the query. They mark fast, you know? It's all fast, the medicine, only the ultras even if we paid to hit, but takes a long scoring at SUS [...] For me, it is good, help us come, faces no queue, number. (GD)

> I liked it because here Dr. X takes all doubts. In all antenatal I come, I'm not going to doubt home. And there [source drive], the medical station there, I do not speak ill of her, but she had thus an adequate response. (GE)

Referral to a specialist service, in other healthcare space, away from your house, and the comings and goings of women represent the degree of concern and attention to their health and/or the baby's health. In the above narrative, it is observed that the units correspond to the arrangement of the places for service, but do not highlight the work of a team in pregnant women's care, implementing disclosure of shares of antenatal high-risk programs, identifying priorities, seeking active pregnant women, and especially in the interaction of the multidisciplinary team and between health facilities. There is access, but with that quality?

Importantly, the concept of high risk is also subject discussed by other authors, since all pregnant women will experience a risk during pregnancy or for the mother or the baby, however, featuring a pregnancy as high will depend on the risk of changes in the metabolic processes during pregnancy.

Completeness of assistance on the road traveled

In Unit Malu Sampaio, most pregnant women had received some form of guidance group activity within the institution itself, and, as already indicated, they understand that prenatal care at high risk should be accompanied by the unit of origin; however, this double bind strategy ends up not being satisfactory when the service becomes just another logging activity. Next, the report and the therapeutic itinerary understood by GB:

> Have to do prenatal there [on the unit of origin] and here [in reference]. Do not have to go there for him [medical] write down my data, everything right, because it has to be there. After I stop here [to carry out the consultation], I keep there. He passed me here, but there came because this is high risk, pressure, whatever. So I came here. I think no need, I think one thing that does not need, because, for example, the other day was a day that my pregnancy, my blood pressure started to rise, then she [the doctor] is only here on Thursdays, and the doctor is every day. I went there and told him that my blood pressure was going up and asked if he could not increase the medication I was taking. He replied: No, your doctor is Dr. X, it only can change. So he did not serve me for nothing. I had to wait to see it. So what is the

need for you to have two doctors if you cannot do anything? I'm wrong? (GB)

The PN service on the source drive is through the record, medical record, the information already collected in Malu Sampaio unit, i.e., is identified by the pregnant woman herself, as a record of activity. In the narrative above, the logic of services, component of health care networks, is organized in a vertical structure not paid up, characterized by the lack of an alliance between the reference units and counter[7]. The double bind situation is not aggregated or valued by the source drive, and is not covered by the pregnant woman.

Significant references in the study reports that illustrate the current situation of health services for the treatment together with the referenced services, are the observations that pregnant women, in many cases, attend the source drive just for the record blood pressure and that do not perform prenatal consultation itself, considered as fundamental to create bonds and quality of care optimization in order to meet the expectations created[14].

I just step there [office of origin], I just take my prenatal card so they could fill my chart there, not to be vague, but I do not query there. There, I'll just check pressure, which is Monday, Wednesday and Friday, to bring X. If I get there and feel some pain, they talk like, 'Oh, look for the Lima Azevedo or Pedro Antonio'. But I do not query there. The emergence of these is Antonio Pedro Azevedo or Lima. I, when I feel something, I go immediately to the Antonio Pedro, in the emergency. (GE)

Therefore, Figure 2 explains the therapeutic itinerary of pregnant woman GE.

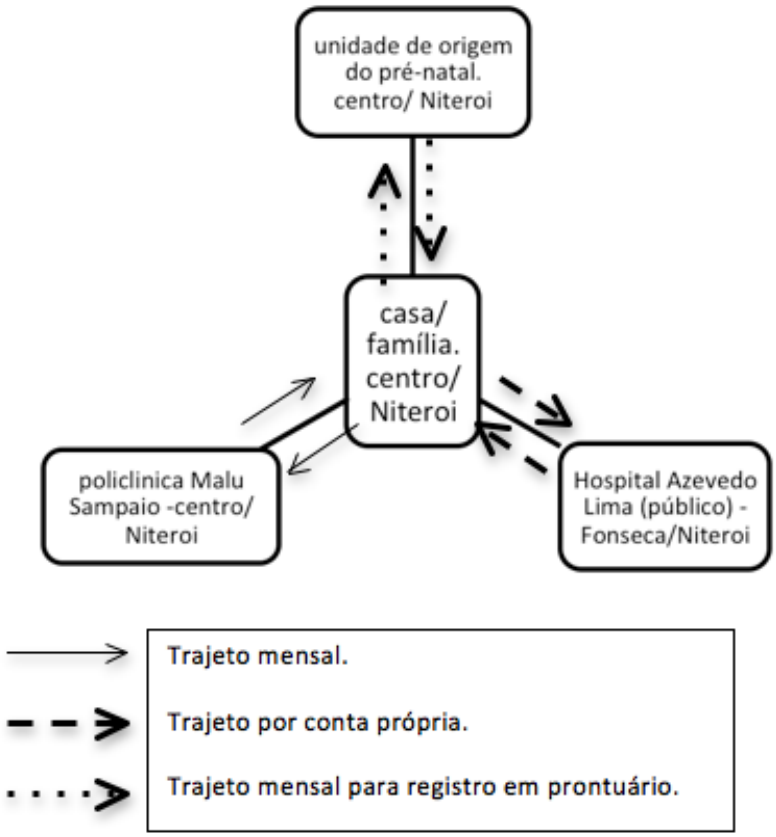

Figure 2. Therapeutic itinerary of pregnant woman GE. **Source:** The author, 2013.

Pregnant GE believes that pregnant women with the care offered by the reporting unit will not go home with any questions. It considers that the monthly trips to the source drive are a record of activity without consulting the PN value itself. In another report, by the pregnant woman GA, it is clear that the connection with the source drive takes place only after the baby is born, with the pediatrician's query:

> [...] From the prenatal, they sent me right here and were not given me over there {} on the source drive. Medical [the reference unit] told me to follow there, too, but they say they could not. It will only accompany the child in the case in childcare. (GA)

Thus, pregnant women do not attend other spaces beyond the public health network in order to seek other forms of care, such as educational groups, meetings with other high-risk pregnancies and physical exercise during pregnancy. However, it was found the support of other people considered as caregivers outside the health services. In this scenario, integrate family and friends, accompanying consultation with the mother and participate in this delicate health situation. In general, most of the women were surprised at diagnosis and at the same time, amazed at the risk pregnancy detection. Particularly in high-risk, how their social environment and sustains lives during treatment is extremely important for your recovery[15].

> Who takes care of me, so is my family, for my husband, my mother, which is all I care about, and she, medical, as well. Other people are also concerned, but not as much as her, because she is my doctor and my mother because a mother, you know. And my husband, as well. (GB)

> Who helps me are my mother and my mother in law. Both, actually, they help me much as they can, give all the support: no, this is so, hey, come on, go to the doctor. My mother and my mother are my caregivers. And inside the unit, and the medical people, right? (GC)

> [...] at home, everyone comes to me, my husband, my mother, the whole family. (GD)

The preservation of the role of women, mother, who works and takes care of the house, expresses a challenge in monitoring consultations, and the family must cooperate in the reconstruction of daily tasks and the new possibilities of structural changes in family environment. This emotional support, characterized by personal and family social network, should not be overlooked within the health care team, since in today's society; a large number of women play several social roles.

A stable social network, sensitive, active and reliable protects the person in everyday life, acts as help and forwarding agent, interferes with the construction and maintenance of self-esteem, accelerates the healing process and recovery, increases survival, health is generating both the physical aspects as the psychological and affective-emotional [16:185].

For pregnant women, the moment of parturition is not addressed during the prenatal, with regard to work in the health system, since they need to look for opportunities vacancies in Quaternary units in the city. In all accounts, they had no confirmation of place of birth, or even of the health team from the source drive or the referenced unit. The work in the health system, between the middle and the high complexity, is still a challenge for the care of high risk pregnancies[17].

> I got pain, and 'My God, where am I going?' I want the doctor to give me X, right? For I am now in the second cesarean section, so I'm more worried about it ... would get there, sick, do not know how the scheme. In twelve years, has changed a lot, and I wanted to talk to her about it even today, the concern. Now, eight months ... we are already getting tense, worried. We will see. (GE)

The narratives represent the gap in continuity of care for high risk pregnancies among primary care professionals and hospital regarding this institutional segmentation:

> The relationship between the activities of primary care and hospital should be continuity and complementarity. However, prenatal, which is the most appropriate time for preparation to birth and detection of possible changes of pregnancy, serious problems are found, such as the fact that the vast majority of women get "discharge" at its most critical moment around the eighth month - where worsen diseases such as hypertension and diabetes - without knowing which service resort facing a problem or at parturition[18:18].

Given this uncertainty, it is essential a reflection on the delicate health situation of high

risk pregnancies at the possibility of antepartum pilgrimage, which under these conditions can worsen the health of the woman and baby, causing inconvenience to both the Family and friends[19].

Thus, we emphasize different aspects that articulate with the reality of each woman and book this experience a particularity. Among the aspects related to it, include: the social and economic condition of the person; attitudes, values and shared beliefs in their social group; the specificity of the region in which it operates and the geographical area where moved throughout the gestational process; the limitations imposed by the signs and symptoms of pregnancy; social networks that are part of its context, as family, neighbors and other social groups; the provision of health services, as well as forms of received attention; the availability of services of professional care system; his biography and his life project, among others, which served as the basis for describing the therapeutic itinerary of high-risk pregnancies in Niteroi.

CONCLUSION

In this study, we sought to further understanding in the field of knowledge, prenatal high risk care and the demand for specialized health services for pregnant women with health complications before a flawed public system with few material resources and personal.

The therapeutic itinerary of the women studied for the treatment of complications of pregnancy, is crossed by tension, anxiety, adjustments to new habits, change in social roles and knowledge that are not described in any level of complexity of care, including major technological devices that will provide and satisfy your care.

We suggest, therefore, as an action strategy in the pursuit of comprehensive health care for pregnant women at high risk, the encouragement of inter-institutional integration programs and health education, aiming at the optimization of health professionals, both downtown as the medium complexity, and women's empowerment, public service users, to prevent avoidable health problems of pregnancy.

Thus, we conclude that they are gaps to be filled within the service to risk pregnant women: the fragility of the Health Network in providing services to pregnant women; the lack of health team action strategies; the need for more prenatal care, fully, between health units, from low to high complexity of care; and a more careful and committed approach. Access to the reference service proved, according to pregnant women, fast, however, the continuity of care for prenatal source drive still showed weak before the full and participatory approach in the lives of users.

You need to consider that women assisted in the unit have already broken the barriers of access to high-risk pregnant women even more precarious in public health services in neighboring municipalities. Thus, it is worth reiterating that the women interviewed have experienced a significant selection, which leads us to much more chaotic pictures on the reality of public health care in the country.

A BUSCA DO CUIDADO PELA GESTANTE DE ALTO RISCO E A RELAÇÃO INTEGRALIDADE EM SAÚDE

RESUMO

O objetivo deste estudo foi compreender o itinerário terapêutico da gestante de alto risco do município de Niterói no acompanhamento do seu pré-natal, sob a ótica da Integralidade da atenção à saúde. Trata-se de estudo descritivo, com abordagem qualitativa. Procura-se oferecer um olhar reflexivo para a busca e a produção de cuidado nas condições das gestantes durante o alto risco, atendidas na unidade de saúde de referência da cidade devido à hipertensão arterial na gestação. A partir de uma leitura atenciosa e da discussão dos dados obtidos, e após a construção do Itinerário Terapêutico, organizou-se a análise dos dados em função de duas categorias: o acesso à saúde diante do primeiro sinal ou sintoma e a repercussão da assistência à gestante; e a integralidade da assistência no caminho percorrido. A avaliação dos dados teve como referencial teórico a análise de conteúdo de Bardin. Esta pesquisa envolveu 5 gestantes de alto risco, atendidas na Policlínica de Especialidades da Mulher Malu Sampaio. O acesso ao serviço de referência revelou-se, de acordo com as gestantes, rápido, porém, a continuidade da atenção pela unidade de origem do pré-natal ainda se mostrou frágil perante a abordagem integral e participativa na vida das usuárias.

Palavras-chave: Gravidez de Alto Risco. Cuidado Pré-Natal. Integralidade em Saúde.

LA BÚSQUEDA DE LA ATENCIÓN POR LA EMBARAZADA DE ALTO RIESGO Y LA RELACIÓN INTEGRALIDAD EN SALUD

RESUMEN

El objetivo de este estudio fue comprender el itinerario terapéutico de las embarazadas de alto riesgo de la ciudad de Niterói en el acompañamiento de su prenatal, bajo la perspectiva de la Integralidad de la atención a la salud. Se trata de un estudio descriptivo, con enfoque cualitativo, que busca ofrecer una mirada reflexiva para la búsqueda y producción de cuidado en las condiciones de las embarazadas durante el alto riesgo, atendidas en la unidad de salud de referencia de la cuidad debido a la hipertensión arterial en el embarazo. A partir de una lectura atenta y de la discusión de los datos obtenidos y, después de la construcción del Itinerario Terapéutico, se organizó el análisis de los datos en función de dos categorías: el acceso a la salud delante del primer indicio o síntoma y el impacto de la atención a la embarazada; y la integralidad de la atención en el camino recorrido. La evaluación de los datos tuvo como referencial teórico el análisis de contenido de Bardin. Esta investigación involucró a cinco embarazadas de alto riesgo, tratadas en la Policlínica de Especialidades de la Mujer Malu Sampaio. El acceso al servicio de referencia se reveló, de acuerdo con las embarazadas, rápido, aunque la continuidad de la atención por la unidad de origen de prenatal se presentó frágil delante del enfoque integral y participativo en la vida de las usuarias.

Palabras clave: Embarazo de Alto Riesgo. Atención Prenatal. Integralidad en Salud.

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