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Women with high-risk pregnancy: experiences and perceptions of needs and care

Mulheres com gravidez de maior risco: vivências e percepções de necessidades e cuidado

Mujeres con embarazo de alto riesgo: experiencias y percepciones de necesidades y cuidados

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Abstract

Objective: To understand experiences and perceptions of women with higher risk pregnancy relating to problems/needs of health and care practices. **Methods:** The study was descriptive and qualitative, held in Cuiaba, Mato Grosso, with 12 women in prenatal care in a specialized public service, through semi-structured interviews and thematic content analysis. **Results:** The participants express the experience of important non-medical events that affect their health, such as disinformation, fears and concerns, the disorganization of daily and family life, financial needs, and others. However, for prenatal, care guided by the perspective of risk, of control of medical problems are analyzed. There was the need for extensive care, but to do so, seek support within the family and community social support network. **Conclusion:** Understanding the experiences and views of pregnant women is essential to the construction of prenatal actions that can respond to the needs of extensive care.

Keywords: Pregnant women; Pregnancy, High-Risk; Prenatal Care; Family Health Strategy.

Resumo

Objetivo: Compreender vivências e percepções de mulheres com gestação de maior risco, relativas aos problemas/necessidades de saúde e práticas de cuidado. **Métodos:** Estudo descritivo-qualitativo, realizado em Cuiabá, Mato Grosso, com 12 mulheres em acompanhamento pré-natal em um serviço público especializado, por meio de entrevista semiestruturada e análise de conteúdo temática. **Resultados:** As participantes expressam a vivência de importantes eventos não médicos, que influem em sua saúde, como desinformação, medos, preocupações, desorganização da vida cotidiana e familiar, carências financeiras, e outras. Contudo, para o pré-natal, avalizam cuidados orientados pela perspectiva de risco, de controle dos problemas médicos. Reportam-se à necessidade de cuidados amplos, mas, para isso, buscam suporte na família e rede social comunitária de apoio. **Conclusão:** A compreensão das vivências e dos pontos de vista das mulheres grávidas é imprescindível à construção de ações pré-natais que respondam a necessidades de cuidados abrangentes.

Palavras-chave: Gestantes; Gravidez de Alto Risco; Cuidado Pré-Natal; Estratégia Saúde da Família.

Resumen

Objetivo: Comprender las experiencias y percepciones de las mujeres con mayor riesgo gestacional acerca de los problemas/necesidades y prácticas de cuidado en salud. **Métodos:** Estudio descriptivo, cualitativo, realizado con 12 mujeres en atención prenatal en un servicio público especializado en Cuiabá (MT), por medio de entrevistas semiestructuradas y análisis de contenido temático. **Resultados:** Las participantes relataron eventos no médicos importantes que afectan su salud, como la desinformación, los miedos y temores, desordenes de la vida cotidiana y familiar, las necesidades financieras, y otros. Sin embargo, para el cuidado prenatal, refrendan cuidados guiados por la perspectiva de riesgos, de control de los problemas médicos. Hace falta una amplia atención, pero, para ello, buscan apoyo en la familia y en la red comunitaria de apoyo social. **Conclusión:** Comprender las experiencias y opiniones de las gestantes es indispensable para la construcción de acciones prenatales que puedan responder a las necesidades de atención integral.

Palabras-clave: Embarazadas; Embarazo de alto riesgo; Atención Prenatal; Estrategia de Salud Familiar.

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INTRODUCTION

A research[1] in FHS was held in this municipality, showing that, although women have several health needs - physical, social, emotional, educational, among others -, professionals usually prioritize the physical aspects and obstetric control of pregnancy preventive-curative actions.

However, if the pregnancy produces health needs of prime order, women face exhibitions and susceptibilities that provide, in addition to the emergence and aggravation of medical problems, the commitment of all of their lives and health.

The practice of prenatal care in the country is effective within a model of health care and social history, in permanent opening and requalification[2]. This model, although expressing the influences of different discourses about possible ways to operate and manage the technologies, is guided by the biomedical perspective, who exerts strong influence thus in prenatal care. In this, the approach of the susceptibilities and the problems/health needs arising of the pregnant woman, is set mainly in the optics of the risks.

This perspective is based on the intersection of the fields of biomedicine and classical epidemiology. Under their guidance, the identification and control of the presence of risk factors that make pregnant women more susceptible to diseases are prioritized, as well as the control of diseases manifests.

Risk refers to the probability of an unfavorable result for health - a biological damage or unwanted phenomenon - evidenced through scientific studies of cause-effect relationship, statistical base. This concept and its application in health practices have contributed significantly to the prevention and control of diseases[3]. In reproductive health, it has resulted in reduction of fetal, neonatal and maternal morbidity and mortality, a priority objective of care to the woman and childcare in the country. In prenatal care, the pregnancies are routinely classified as a usual or higher risk. In this last situation, the woman usually is forwarded to a referral service to specialized monitoring.

The perspective of vulnerabilities can redeem and better light these aspects. It anchored in social epidemiology and constructions of integrality of healthcare. Vulnerability guides the resumption of the relationship between health and the interweaving of environmental, social, political, cultural, institutional, community, family and individual aspects[2,4]. In this perspective, prenatal search consider, in addition to the risks, interlacing effects between individual and contextual conditions in pregnant exposure not only to diseases, but also to the suffering and the limitation of potential unfavorable situations of confrontation.

Women experience pregnancy assigning meanings to the reproductive process, the needs and problems faced, their causes, the actions and resources of health and other services. The meanings constructed influence in their health and in their participation in the care of themselves, and may be also in event generator of vulnerabilities. Thus, it is important that prenatal care is challenged to learn, understand and consider the experiences and the women's point of view about the pregnancy and that affects, and what they deem relevant to their health and their son.

Generally, the experiences around a phenomenon are meant so singular for people, depending on the personality, biography, the participation of each one in the history. But this meaning is not the individual. It is configured in social relations and interactions between people, and therefore social nature. The meanings are established in collective social spaces that people share somehow and they are constituting[5,6].

Thus, in this study, it is assumed that the experiences meant by women diagnosed with higher-risk pregnancy reveal peculiar and social characteristics being reference to the construction of more comprehensive social assistance practices, incorporating also the perspective of the vulnerabilities.

Several published studies discuss experiences and perceptions of pregnant women in a situation of a higher risk. However, they also most related to specific risks and problems[7]. There are few current studies (the last five years) on the subject hereof. They are about how women diagnosed at greatest risk feel during pregnancy[8-11], on higher risk pregnancy conditions, conditions that women bear in front of the problem, more frequent risk[8], consequences[8,9] and care[9,10]. In them, the susceptibilities of the pregnant women are not covered from the perspective of the vulnerabilities, although some consider it to the biological factors.

Considering this, the objective of the research is to understand the experiences and perceptions of women with pregnancy diagnosed at higher risk, relating to their problems/needs and health care practices adopted/required. With this work, it is sought to contribute to the improvement of prenatal care from the perspective of integrality.

METHOD

Descriptive, qualitative study, with 12 women in prenatal follow up in a public hospital of reference for the high-risk gestation, Cuiabá, MT. This was selected for assisting only patients from SUS and be a training field in healthcare.

In the choice of the participants, it was considered that in qualitative research, it is essential to establish the attributes that are of interest to the research objectives and subject better representing it[12]. Thereby, it was defined that women should have the pregnancy classified as higher risk, have been referenced by an urban unit of the FHS in the municipality; and be in specialized monitoring for at least two consultations, in order to obtain an account of their experiences of pregnancy and also with the care referral service. The exclusion criteria was of those with diseases that would impede all their participation in the study (which did not occur).

In the initial period of data collection 205 pregnant women in 15 non-sequential days were addressed, for identification of possible participants. Of these, 163 were specialized monitoring and 12 had all attributes of interest and agreed to participate in the study.

Despite this initial number, in the process of data collection and analysis it was regarded as sufficient, based on the completeness of the information, as proposed by the sample closing by saturation. This qualitative research methodological feature sets that the interruption of data collection should be with the empirical confidence that they no longer provide new elements to the categorization and theorizing, empirical limits relief, the integration of data with the theory and theoretical sensitivity of the researcher[12].

Firstly, it was examined the material obtained with six women coming up the general axes of meaning units selected. For each axis, the experiences and the views of women were detailed. A framework was elaborated with the identification of each woman and the findings obtained. Thus, it was made a new collection and analysis of data from three more women. This process did not provide new elements to the study. To check and ensure the saturation[12] this phase of field with three more interviews were concluded. With this strategy, it was sought to respect the criteria "objective validity" of the set of information interpreted, that is, the use of legitimate assumptions for inferences and the possibility of "transfer" of knowledge produced to other groups/individuals with similarities[5,6].

The empirical research of construction occurred in March and April 2013, in the hospital. The interview was held with semi-structured instrument[6], by face-to-face contact of 45 minutes. The issues addressed: demographic and social conditions of women's work; experiences with pregnancy and services; and views on pregnancy, health care situation and relations with the services involved. The data record occurred in a field journal and through recording in audio, after permission of the participants.

An interaction of trust and respect to women was established, through informal conversations, listening intently, individualization of the interviews, answers to inquiries and requests, and explanation of the research, academic interest, of the ethical aspects involved.

The data were subjected to content analysis of thematic type[5,6], guided by the goal of the research. The material was organized, reading/rereading it and in addition to all of the material seized senses, the subjects or units of meaning of interest were highlighted. It was considered in the analysis, the explicit and implicit messages. As a result, the themes were aggregated for similarities, classified and reclassified, and served as a basis for the inference supported also in theory. This process resulted in two broad categories: experiences of medical and non-medical events; relief of medical events like prenatal care services object.

The study was approved by the Ethics Committee in Research of the University Hospital Júlio Müller, in 2/27/2013, Opinion 206,916. The rules of Resolution 196 from the National Health Council in force at the time were respected. The participants signed an informed consent term (TFCC), after the explanations of their contents and on research. The participants were identified by a code name (flowers), to preserve their identities.

RESULTS AND DISCUSSIONS

Contextualization of the study

The women in the study were forwarded by units of the FHS in the referral service. In those, the prenatal period mainly consists of systematic offer of pre-consultation, medical and nursing consultation, and home visits by community agents. The first appointment is made by the nurse and the subsequent interspersed with the doctor. The referral of women to specialized prenatal is made by both, acting in complementarity

In Cuiaba, there are five three hospitals and polyclinics gestational references to the greatest risk, one public and two convened. The referral service included in the study offer screening, hospitalization, outpatient diagnostic and follow-up support for high-risk pregnancy. In prenatal women it assists usual and high-risk gestation for free demand and routing made by the health services of the State/municipality, central line of regulation, according to availability of vacancies. The consultations are made by doctors and medical students.

Experiences of medical and non-medical events

To evaluate pregnant women on their health needs, the professionals of specialized service and prenatal FHS prioritize the risk perspective. Thus, the diagnosis of the participants in the study was done based on medical events faced by them, associated with, or not, the individual factors and/or obstetric history and adverse health. They are: twin gestation; hypertension and previous neonatal death; pre-existing and current diabetes and hypertension; gestational diabetes; gestational diabetes and age greater than 35 years old; hyperthyroidism; IgG and IgM positive serology for Cytomegalovirus; vaginal bleeding and age less than 20 years old; varicose veins in lower limbs; prior and current epileptic picture; nephrolithiasis; congenital microcephaly of woman.

However, these women experience and express several biological, behavioral, affective events, linked to social, institutional and family situations, to extrapolate those problems diagnosed, with adverse health with possible consequences to their son. That it, they face occurrences and situations that affect or may affect their health as a whole, including their reproductive process and their ability to care for themselves.

Unpreparedness to act with autonomy in the care of themselves

The factors and problems that give rise to the diagnosis of higher risk are presented by gestational women professionals. They know how to mentioned them. However, they have little information about their causes/possible causes, consequences/possible consequences and care and their possible effects.

Thus, the women reveal some difficulty in translating, their own problem, its implications and alternatives for their resolution, which is associated with the doubts, worries and fears:

Orquídea - They said it was the virus of Citalomegalovirus, I have the risk of getting it. I was supposed to eat meat enough fries, wash the food thoroughly and not to mess with no land and cats. I was going to have to take a pill to help don't get it.

Interviewer - why do you have the risk of getting the virus?

I don't know [...] In my family, no one knew what it was. When I came here (specialized services), they said there was a risk, if I get the virus, when the child is born, he is born deaf. Then we got really scared [...]. (Orquídea, 22 years old, primiparous, IgG and IgM positive serology for Cytomegalovirus).

[...] because we know that when a normal gestation, quiet, we do a perfect follow up by the clinic. When it comes to monitoring more closely, it's not normal, have a certain risk, I don't know what level, if it's to much, if is little, but it has. If I didn't have it I wouldn't have been forwarded here (reference). So, it's only concern [...] (Rosa, 33 years old, G2, P1, hyperthyroidism).

With little information, women are exposed to new physical, emotional care problems and the possibilities to protect them and their son. Not understanding the intimacy of their own body, the dangers to which they are subject, what their need to do to better take care of themselves and of the son, and unaware of resources and care, make them susceptible to new occurrences. Unwanted pregnancies and adverse physical conditions is an example of this:

[...] I got pregnant on any medications to avoid it. It was during exchange of medicine. The doctor didn't tell me that I had to use a condom during those 30 days. That's where I got pregnant [...]. When you're taking the injection and return to the pill, you have to use a condom, and she (medical) did not warn me. Hence, I was ingesting the contraceptive pill already being pregnant, without knowing (Jasmim, 23 years old, G3, P2, varicose veins in the lower limbs).

Among the women, the need expressed to have health information at the moment of pregnancy and beyond the understanding of the problems in courses. It also covers childbirth and childcare.

For now, I think the biggest need is to know how is my baby, and find a doctor to solve it; tell me what's going on because, so far, no one has told me what's going on [...] If you're in a high-risk pregnancy, I think they have to pay more attention, because I do not know, the doctor told me that the child may have malformation [...] (Orquídea, 22 years old, primiparous, IgG and IgM positive serology for Cytomegalovirus).

Study on the satisfaction and expectations of women with prenatal care, in Cajazeiras, Paraíba, highlights the experience of this need. The information demanded include organic and behavioral aspects of pregnancy (nutrition, water intake, exercise, breast preparation), physical and emotional aspects of childbirth, childcare and the practice of breastfeeding[13].

Pregnant women access to detailed information about their own health and of their child is a very important component of prenatal care. In many contexts, by lack of information, the woman lives a condition of dependence, lack of autonomy and of mistreatment[8].

Sharing information among health professionals and women, at the right time and in a personalized manner, not only direct communication between both, but also providing the satisfaction of need for knowledge that express and furthermore be able to them. That is, it strengthens the ability of pregnant women to decide about their body and care of themselves with autonomy.

This does not mean that there is a relationship of linearity between information/knowledge and autonomy. The autonomy is in the relationships, in shared culture[14] and contextual conditions. In addition to access to information, the development of levels of autonomy possible requires ability to handle dependencies and to intensify participation in the therapeutic process[14] and in decision-making.

Thus, in addition to sharing information about the medical problems that women have, prenatal care must direct all customer service and relations established for the development of levels of autonomy among them. To this end, workers must get to know them better in their potential, weaknesses and needs, and understand their actions, their feelings and the meanings they attach to life, to the reproductive process, the problems, the care.

In addition, it is important to undertake systematic and group actions of health education with the active participation of them, in which to adopt strategies based on their health needs, determined by their social conditions, education, the environment in which they develop and perceptions that have about their reproductive and sexual health[8].

Affective-cultural suffering

Before the pregnancy, the women reveal feelings of satisfaction and happiness, by achieving the desire to have a son, from a social ideal of motherhood that they have. But, in addition, they also reveal insecurities, fears and anxiety before the imponderable.

I'm happy, because a son is always welcome, is always good, but also somewhat worried, afraid of what might happen by the end of the pregnancy, but I am happy, I'm happy, I'm waiting excited, but scared, psychologically well scared (Rosa, 33 years old, G2, P1, bearer of hyperthyroidism).

The diagnosis of greatest risk, when informed to the woman, produces suffering, for their possible impact especially on child health.

> *[...] By the time the doctor said that my pregnancy was at risk for the baby I was desperate, I cried a lot because, until then, I didn't understand what it was. Then, after I came here (specialized services), they explained to me what was the risk. Then, I was more quiet (Nigella, 34 years old, G3, P2, gestational diabetes).*

The suffering of women is higher when she has no space in the service to talk, express themselves and better understand what the diagnosis means. The trivialization, by professionals, the need for knowledge of the pregnant women strengthens their insecurity.

The pregnancy is accompanied by several changes - social, family, physical, intersubjective. Usual activities of the woman are magazines; often projects are stopped; new family demands appearing. Such changes often come accompanied by worries, fears, tensions, conflicts, guilt, among other feelings.

With the diagnosis of higher risk pregnancy, these feelings tend to intensify, because, besides the medical problem often unexpected, new demands and difficulties appear, related to the problems, their consequences and the care required.

> *I'm worried by the pregnancy being of risk. I stay alone most of the time, at home, and have some crisis (epileptic). This all raises concerns [...] So, it is worrying that I could fall, hurting, or so, start having it (epileptic crisis) and have no one around, happen a bleeding, something like this (Margarida, 19 years old, Primiparous, picture an epileptic prior to pregnancy and current).*
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> *[...] I walked a little bit, but I get tired, a lot of back pain, and I am very lazy, I sleep too much. We also eat more and you have to control it, and you can't... I'm eating very salty [...] (Flor-de-lis, 29 years old, G2, P1, visually impaired, neonatal death previous history and current hypertension).*

Study with the objective of obtaining criteria to build nursing interventions with pregnant women at greatest risk, made with 10 Colombian women, points to the presence of stress and feelings of ambivalence among them. On one hand, the enthusiasm for pregnancy and, on the other hand, imbalances with changes affecting their quality of life[8].

When addressing high-risk pregnancy experiences, a research done in Divinópolis, Minas Gerais, points out that the woman feels broken to learn that is generating a child in situations of higher risk. The impact that the news promotes, the need to (re) organization of life and deprivation of certain features associated with insecurity and fear. Women feel vulnerable, afraid of dying, fear of her son's death, premature birth and deformities, although they have some confidence in the success of experience[10,11].

This same study, showing the relationship between these women and a team of health, found that the care of professionals, to clarify doubts and give detailed guidance, eases those feelings. With the dialogue surrounding the diagnosis and assistance actions to women, commonly, feel more secure[10,11].

Systematic educational actions also can minimize the fears, concerns, blaming, conflicts, and the difficulties of managing the changes. They can provide, for women, the opportunity to speak about themselves, to express needs, feelings and concerns. Professionals should treat them with understanding, in the context of tensions that arise among the personal, interpersonal and social areas. For that, they need to know and consider the psychosocial and cultural conditions that influence the way they experience and deal with pregnancy and problems[8].

Difficulties of personal and family life: sociocultural and economic aspects

In some situations, women do not perceive themselves with personal conditions for having a baby or to give an account of the new tasks that another child will "require", in a context of division of labor in private between men and women:

> *I don't feel prepared, because I think I'm still young to have a son, 22-year-old is not good (Orquídea, 22 years old, primiparous, IgG and IgM positive serology for Cytomegalovirus).*
>
> *When it was just one, it was a lot easier. Now these two (twin gestation). I don't know how I'm going to do, to create two at once, the same size. The others are three, only, so each one is of a different age. So, it's different. These two I don't know how I'm going to do [...] (Girassol, 27 years, G4, P3, twin pregnancy).*

They are faced with difficulties to work around problems that arise due to personal and family conditions they have, in a less social protection. To move to the specialized service, they require making alternatives to the care of their children, during their absence from home.

> *A lot of things I had to stop doing. Leave my children at home to be able to come (to the specialized service) and many things also which is the diabetes, like: I cannot lift weight, have difficulties in home services. But then I have to fulfill what they (medical professionals) are asking, why can't they talk and I don't make (Dália, 31 years old, G6, P4, A1, diabetes and pre-existing hypertension and current).*

Some women need to broaden the number of contacts with health services (FHS and hospital) and, for this, they have to rearrange the house activities for which they are responsible. With this requirement, they feel tired and tension.

> *I changed (routine), because I have to come here every week (specialized services), and every week on the health center. So, it is tiring, very heavy, keep coming every week here. So, it changed enough [...] In addition, you have to go on a diet, cut sugar, soda, bread, taking insulin. I have done this, the diet and take insulin (Nigella, 34 years old, G3, P2, bearer of gestational diabetes).*

The situation requires further change everyday habits of rest, activity and food with personal implications, for the whole family and finances. New demands of care expand the expenses, and they do not always have the financial resources to supply them.

> *[...] I don't really eat. I ate once in a while, at lunch, but a lot of vegetables. I'm not much for eating rice. Now, in pregnancy, I haven't been able to eat rice, beans, meat and vegetables. [...] There are days that you don't want to eat this and eat that, but will weighing, because, nowadays, fruit and vegetables are the most expensive. So your pocket weighs (Orquídea, 22 years old, primiparous, IgG and IgM positive serology for cytomegalovirus).*

Women in the study live with adverse social conditions. All them reside in poor areas with little service structure. Ten live with their partners, but one still resides with her parents and brothers and another with one only with one daughter. Only five of them have their own home, the other live in a rented house or borrowed. Four have paid employment; the two interrupted with pregnancy and school activity; and five are unemployed. All have an education degree reduced, between incomplete elementary school (four) and the high school incomplete (five) and complete (three). Four of them are pregnant for the first time. Among the multiparous women, three have previous negative experiences of pregnancy, with the death of their partner, with pathologies and the child's death.

The medical problem they have, the lack of information about their own health, the difficulty to move with possible independence, fears, tensions and other feelings interlace with other limitations of women's lives - the difficulty of reconciling the care of home, family and themselves, cultural and socioeconomic conditions in deficit, lack of broad support from health services and other social services.

Looking at these problems from the angle of the vulnerabilities, and overcoming the unique risk reasoning implies identifying the aspects and the conditions that can compromise the health of women and, recognizing the interweaving between them, and that they both affect their physical and emotional health, as limited their possibilities of decision-making and care about themselves.

The vulnerability concept embraces different dimensions of experiences relating to requirements, to the health care services[15] and social protection. It refers to the totality of hinged of individualized aspects and characteristics of the contexts and social relations, which determine the first ones[2,15].

Promoters of vulnerabilities include, besides poverty, victimization, fragilities, insecurities, contingencies, unprotection, that people/families face in their trajectory of life, by social, economic and political constraints. It is where people live that needs, potential and mechanisms for social protection and unprotection manifests. This is in their living spaces answers to their needs are given, or not[16]. Although these aspects have not been dealt in this study, from the perspective of the vulnerabilities, in addition to seize medical problems and needs expressed, in this case, for women with higher risk, gestational must also identify the resources that they access where they live, i.e. the safety and access to rights they possess.

Thus, for operationalizing assistance practices in this perspective, it is necessary to establish another look and other social contexts, governed by extended health practices, individual and collective, that allow health services approach the diverse set of problems on which lie the health needs[15] of women. The quality of their life is not only a reflection of choices, feelings and perceptions, but also a result of the political and social situations they imposed.

It is important that pre-natal professionals approach the reality of life for women with a pregnancy diagnosed at greatest risk, seizing and understanding not only the implications of the new situation for their life and the lives of their family, but also the conditions that have to manage it and the resulting susceptibilities they produce.

Relief of medical occurrences as prenatal care object

Although the women in the study report non-medical events of their lives - of affective, cultural and social order - influencing in their health and care, they do not relate directly to the professional practices of prenatal services. These are appreciated, especially based on the actions of control of the medical problems that they have. Thus, they oppose the perspective of prioritized risk in the assistance received.

Pregnancy with aggravations is a concrete experience, accompanied by difficulties, needs and sufferings that are expressed in their bodies and special medical care are essential to their resilience. Thus, based on the medical problems experienced in the existing care alternatives and in their effects, known or expected, women build that reference and act based on it.

The diagnosis of gestational higher risk associated with a given medical problem is embedded by women like what translates their needs on health services. Thus, they recognize the specialized prenatal care space as appropriate.

> *Yes, for sure (agreeing with the medical diagnosis and referral to specialized service), because of fear that I had in my first pregnancy; the risk, which I also run now; because of hyperthyroidism. So, I agreed to do this monitoring more closely, in the hospital [...] (Rosa, 33 years old, G2, P1, hyperthyroidism).*

In general, women are satisfied with the assistance received, both on FHS and referral service. Their judging criteria of both are essentially the same and include relational aspects, routine procedures, access to information/explanations in assistance and easy access to services.

In prenatal, women assess whether they are "well treated" by workers and if they obtained explanations they consider important, regarding the reasons for the referral to specialized services, their health conditions, and of the son, of the findings of the examinations, and explanations to the questions and inquiries.

> *[...] They (FHS team) treated me very well, they informed me also very well [...] She (doctor of the FHS), explained to me why I was coming (to the specialized service), it was important that I came, because of the baby. So I was well informed, she explained it to me right (Dália, 31 years old, G6, P4, A1, diabetes and pre-existing and current hypertension).*

> *They (the specialized service workers) are good, both the girl who stays here (reception) as to who measures the pressure; are very nice, the doctors are pretty friendly with us [...] (Girassol, 27 years old, G4, P3, twin pregnancy).*

They appreciate the prenatal care protocol procedures such as the collection of information/complaints, the control of blood pressure and weight, the assessment of gravid abdomen, auscultation of the baby, the laboratory tests. In addition, they enjoy the proximity of the service and service agility.

> *I went to the consultations, there she weighed me, did the tests, asked how I was, looking at the baby's heart, looked at my belly, talked with me [...] I thought it was good, because it was close to home, so it was good [...] In the health center I have more friends than professionals, I know everybody, since the girl who cleans to the guard. So, they're all good people, I have nothing to complain about anyone, since the vaccine I took the exam I needed to do, the referrals of exams that I needed to do and there (FHS), the girls (FHS receptionist) do the appointment for me, the girls there are really good (Girassol, 27 years old, G4, P3, twin pregnancy).*

In the specialized prenatal, access to resources that the FHS does not have are highlighted, certain diagnostic tests, the assistance in any day or time and the immediate hospitalization, if necessary.

> *I like more here (specialized services), because it has more resources, the health center has almost no recourse. Here is a great hospital, so it has more resources [...] For example, my colleague got the disease of the cat and she is pregnant, then she will do that morphological ultrasound, she says it's overpriced, and she got it here [...] Even among the health center professionals always say if you have a bleeding you run to the hospital [...]. So, here is best (Flor-de-Lis, 29 years old, G2, P1, visually impaired, neonatal death previous history and current hypertension).*

Women give preference to specialized service, for its ability and agility of research and intervention in gestational problems. The monitoring of both services is considered expendable, although some of them remain systematic contacts with the two of them, by the importance given to the bond built with the professionals of the FHS.

In health care, they highlight medical practices recommended regular consultations: going regularly to the consultations, carrying out the examinations prescribed, use of drug therapy and adoption of recommended behaviors (food, activity and rest, among others).

> *I am taking ferrous sulfate, and eating too many beans, beets. It's not that I'm anemic now, before I get pregnant I always had anemia. When we get pregnant, the immunity always gets lower, then we need to eat more and take medicine (Violeta, 17 years old, primiparous, irregular vaginal bleeding).*

Several factors intertwined, internal contribute to the perceptions and practices of women -linked to experiences, sensations and feelings - and external, such as the social groups to which they belong; the environments in which they live; exposure to certain problems[17].

The judging criteria of prenatal services used are fruits of the way women perceive, among other aspects, that for them, based on actions, resources, and answers them obtain, in contact with the scientific reading, reinterpreted by other readings and educational opportunities and critical exercise of rights.

The meanings given to the health and the solutions that women admit have close relationship with the characteristics of the practices prevalent in health. In these, the phenomenon is health related, above all, for the proper functioning of the body; organic separating the people of their living environment, their experiences, social events and are valued, in particular clinical preventive-curative control actions.

The demand is socially constructed and is related to the profile of health services offer and how the care production is processed and the relationships between professionals and users[18]. They influence then in women understand exhibits, weaknesses and needs, and how they can be faced. Thus, the criteria adopted by them have close correlation with what is prioritized in reproductive health care in the biomedical model, with the interrelations presented in it, and with its historical boundaries (for example, around the access to services/health actions).

This does not mean that women reading about what is going on with them and about the care of which always need to converge with traditional reading/professional services. Perceptions about

health problems, their causes and care form, too, from a symbolic field that pregnant women share in their midst sociocultural, from which form their own references. That is, the medical approach of the situation for women is reinterpreted from other references. Thus, there is disagreement in the professional diagnosis, although it is not out of the recognition of the experience of the aggravation.

> *For me, I think it's a low risk (her own pregnancy). But, because of epilepsy, I have a problem, the nurse at the clinic preferred to refer me (Margarida, 19 years old, primiparous, picture an epileptic prior and current pregnancy).*

Although the women in the study expect prenatal services traditional medical actions of health care, in the same way that adopted them, also move in seeking resources for their other needs. In this sense, there is in the family (nuclear and extended) and on social network community and important sources of care, in affective sphere, work and finances.

Their families help them in daily activities and in emotional and financial issues. They welcome and help them in household chores, in the care of the other children, in financial difficulties, and in the follow-up to the specialized service.

Women also trigger other endorsements of their network of relationships - the help of friends, people around them, co-workers, members of the religious institution who assist them, as well as faith.

> *I ask God to help me, because I think not everyone is prepared to be a mother. I think it is God who enables us to be a mother [...]. The Sisters of the Church also are reassuring to me, my friends, all give me support (Flor-de-Lis, 29 years old, G2, P1, visually impaired, neonatal death history and current hypertension).*
>
> *I live in rente house, the house's owner, because I am new, there is that concern to know how it is, if I'm right, if I need something, if I'm doing well (Margarida, 19 years old, primiparous, prior and current epileptic framework).*

The less extensive and strengthened the family and community social network, the more vulnerable the woman could be. The same occurs when health services/professionals alienated the comprehensiveness and specificity of the needs with implications on the health of women and fail to integrate actively network actions.

Health services and, in particular, the FHS should engage in dialogue and exchange with that peculiar network. When necessary, it should be triggered and supported by its potential. When the health service work articulately with her, it extends the approach focused only on reproductive risks.

Local health services can act through actions of health education for pregnant women, the family and community organizing support groups and investing in the consolidation of specific networks that support the pregnant woman[8]. In these actions, risks and vulnerabilities can be better understood, also the various actions necessary care and the family and community ties strengthened. The basis of these actions must include how women organize their life experiences, health and care, how they feel and give meaning to them; their exposure to promoters of vulnerabilities and confronting the potential adverse situations that they own.

It is important that professionals recognize the potential present in the active role of women in the health care gestational. The work of teams of health should support them to develop and the ability to think in social and cultural context, to look with more autonomy, demanding the whole health and appropriating the rights they have.

CONCLUSION

Listen to women who experience a higher risk pregnancy enables to grasp and understand, from their peculiar experiences, the experience of medical and non-medical events to which they are exposed, and that can generate or actually generates vulnerabilities, to consider in good prenatal care.

In the reports of their experiences of pregnancy, women express various personal aspects, intersubjective, family, social and institutional entwined, with consequences or possible harmful consequences to their health, their son and family. Nevertheless, in their relation with health services, they appreciated above all the traditional resources and actions depending on the prenatal control of medical problems. However, they have in the family and local social support network an important support for the living and medical events that affect their health and care practices.

The study contributes to the recognition of important results in FHS and prenatal specialist service, since they do practices targeted to medical problems. Although the research does not highlight the diversity and potential vulnerabilities of life of participants, as well as the various sources that define, it shows that the recognition and understanding of it are important to building actions that can answer the needs of comprehensive care.

New studies should explore what makes and what strengthens pregnant women and, in particular, how these aspects can be seized and boarded in prenatal care, through individual and collective actions. Including the perspective of vulnerabilities in those studies can produce creative operating ways to the apprehension and interpretation of the social determinants of women's health in the prenatal clinic, as well as to act on them.

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