RESEARCH | PESQUISA

Women's perception of prenatal and delivery care in cases of neonatal death

Percepção das mulheres sobre a assistência pré-natal e parto nos casos de neonatos que evoluíram para o óbito

Percepción de las mujeres sobre asistencia prenatal y parto en casos de recién nacidos que han evolucionado para óbito

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Abstract

Objective: To analyze women's perception of care in prenatal and delivery care in cases of neonatal death. **Method:** A qualitative study was carried out with women whose children died in the neonatal period. Data were collected through open-ended interviews and analyzed according to the thematic analysis technique. **Results:** The professional-patient relationship in which there is dialogue is associated with good prenatal experience for women. Guidelines and information about health are seen as a positive aspect to achieve quality of care. The difficulty of access to exams and the lack of preparation of women for childbirth appear as negative aspects for care. **Conclusions:** Negative health care factors are reflected in a biographical way on these women. **Implications for practice:** Include results that can serve as a warning for professionals who provide care for pregnant and parturient women.

Keywords: Death; Prenatal Care; Prenatal; Parturition; Quality of Health Care.

Resumo

Objetivo: Analisar a percepção de mulheres sobre a assistência prestada a elas no pré-natal e parto em casos em que o recém-nascido evoluiu para o óbito. **Método:** Estudo qualitativo realizado com mulheres cujo filho evoluiu para o óbito no período neonatal. Os dados foram coletados por meio de entrevistas abertas e analisados de acordo com a técnica de análise temática. **Resultados:** A relação profissional-paciente, na qual há diálogo, está associada à boa experiência do pré-natal para as mulheres. Orientações e informações sobre saúde são vistas como um diferencial para o alcance da qualidade. A dificuldade de acesso aos exames e a falta de preparo da mulher para o parto surgem como aspectos negativos da atenção. **Conclusões:** Fatores negativos da assistência refletem-se de modo biográfico para estas mulheres. **Implicações para a prática:** Os resultados poderão servir de alerta para os profissionais que atuam na assistência à gestante e à parturiente.

Palavras-chave: Óbito; Assistência pré-natal; Pré-natal; Parto; Qualidade da Assistência à Saúde.

Resumen

Objetivo: Analizar la percepción de las mujeres sobre la asistencia prenatal y el parto en casos en que el recién nacido ha evolucionado para óbito. **Metodo:** Estudio cualitativo realizado con mujeres cuyo hijo se murió en el período neonatal. Los datos fueron recogidos a través de entrevistas abiertas y analizados según la técnica de análisis temática. **Resultados:** La relación profesional-paciente, en que hay diálogo, se asocia con una buena experiencia prenatal para las mujeres. Las directrices y la información sobre la salud se consideran un diferencial para lograr la calidad. La dificultad de acceso a los exámenes y la falta de preparación de la mujer para el parto son aspectos negativos. **Conclusiones:** Los factores negativos de la asistencia se reflejan en una forma biográfica para estas mujeres. **Implicaciones para la práctica:** Los resultados pueden servir como alerta para los profesionales que trabajan en el cuidado de mujeres embarazadas y parturientas.

Palabras clave: Óbito; Asistencia Prenatal; Prenatal; Parto; Calidad de la Atención a la Salud.

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INTRODUCTION

Neonatal mortality, a component of the child mortality rate, indicates the health conditions of a population. High mortality rates in the early neonatal period reflect the quality of obstetric services and newborn care during this period of life.[1-5] Child mortality rates in Brazil remain high, when compared to more developed countries, although there has been a decreasing trend in such indicator in this country.[6]

Among the factors associated with perinatal death is prenatal and delivery care. Prenatal care has improved in Brazil, with an increasing number of women having six or more consultations. However, the quality of such care has been insufficient. Likewise, the number of deaths occurring during the intrapartum period shows the potential to prevent these deaths and the need to improve health care.[6]

One of the factors that contribute to the quality of prenatal and delivery care for women is the humanization of health services, including the personal and professional commitment of workers in this area. Health promotion and prevention actions in obstetric care are associated with women's empowerment, who must be considered as individuals with rights characterized by a unique family and cultural history.[7] However, there are still barriers to the humanization of care for pregnant women in Brazil as a whole. This puts in perspective the distance between the routine practice of services and the recommendations for improvements suggested by studies and political and governmental authorities in the area.

Aiming to consider women as unique individuals with rights during prenatal and delivery care, one needs to appreciate their experiences and how they perceive the experience of being cared for in health services providing such care. The following factors contributed to the good experience of pregnant women seeking health services: the participation of a companion during the entire process; the availability of exams and consultations; the acquisition of clear and safe information about health status; the respect for the particularities of each pregnant woman and their cultural and subjective aspects; the availability of health care services in case of birth complications and reception in maternity hospitals.[3,4,7-11]

Considering the lack of studies that assess prenatal and delivery care in the perspective of women whose newborns died, the present study aimed to analyze women's perception of quality of prenatal and delivery care in the cases when newborns died.

METHODS

An exploratory study with qualitative data analysis was performed. This approach enabled researchers to enter the universe of individuals with their values, beliefs and expectations and to increase their contextualized experience in a single and distinct reality.[12]

This study was conducted in the city of Cuiabá, Mato Grosso state, Mid-Western Brazil. This is part of a larger research project that analyzed neonatal mortality with an emphasis on the perspective of mothers who experienced, during pregnancy and birth, the need for care in cases of complications and who could narrate experiences that included the way professionals and services were organized to provide services to them. In this perspective, participants were mothers of children who were born weighing less than 2,500 grams and who died during the neonatal period in 2013.

In the city of Cuiabá, public prenatal care is provided in 65 Family Health Units, 21 health centers and six policlinics. The delivery care network managed by the "*Sistema Único de Saúde*" (SUS - Unified Health System) is comprised of two registered private philanthropic hospitals and one public federal university hospital. Follow-up of high-risk pregnancies is provided by these three hospitals. Additionally, this capital city has five hospitals in the private health network that include outpatient clinics to follow pregnant women and maternity hospitals.

It should be emphasized that mothers participating in this study had a follow-up of their pregnancy in the city's primary health units, private consultation rooms and outpatient clinics for high-risk pregnancies. The majority of deliveries occurred in maternity hospitals registered with the SUS.

Participants were selected from the identification of neonatal deaths occurred in the city of Cuiabá, Mid-Western Brazil, in 2013, through Death Certificates (DC) and the observation of their respective Birth Certificates (BC). These data were collected by researchers in the City of Cuiabá Department of Health between September and November 2014.

After identifying 69 deaths of low-weight neonates occurred in 2013, participants were sought according to the criteria used in the primary research project: newborn weight at birth higher than 500g; newborn survival time of at least 72 hours after birth (for mothers to have sufficient time to experience their child's hospitalization); mothers living in Cuiabá with an available and current full address. Interviews were conducted as women were identified and subsequently transcribed and analyzed, observing whether the research objectives were met or not. With eight interviews, there were sufficient data to respond to the objectives, ending the field work.

Data collection occurred through open-ended interviews performed at home between November and December 2014 in a meeting with each participant that lasted from 35 to 60 minutes each. Interviews were conducted and participants were encouraged to report freely, according to the following question: "How was the prenatal and delivery care for you?". Interviews were recorded and transcribed right after they were conducted for data analysis concomitant with the field work.

With the transcriptions of all interviews and analysis of results according to the principles of qualitative data analysis, a thematic content analysis technique,[11] the most significant units

of meaning found in the data were identified, thus defining the themes that emerged as results from this study: the dialogue; professionals' availability and approach as qualifier of prenatal and delivery care; the quality of instructions provided by professionals; the concern for the availability of medical services to care for complications; the importance of the nursing team; the period of time before receiving information about their and the newborn's health status; prenatal care as inadequate preparation for delivery; and the presence of a companion as a facilitator during the birth experience. Study authors chose to present the themes grouped for the different moments of service provided to pregnant women: prenatal care and delivery care. This decision was made aiming to contribute to a clear identification of the understanding obtained from such different moments. In this sense, the units of meaning, grouped in themes, were organized into two groups of results: Prenatal care in the perspective of women whose neonates died and Delivery care in the perspective of women whose neonates died.

This study is part of a larger research project approved by the Júlio Muller Hospital Research Ethics Committee under official opinion 968/CEPHUJM issued on October 9th 2010. During all stages, ethical research aspects were respected, in accordance with Resolution 466/2012. Before interviews were performed, women received information about the study and those who agreed to participate signed an Informed Consent Form. Aiming to maintain participants' anonymity, they were identified by the letter I, followed by the number of interview (I1, I2, I3 etc.).

RESULTS

Prenatal care in the perspective of women whose neonates died

In some cases, the quality of prenatal care is associated with the professional-patient relationship in which there is dialogue with explanations about procedures, exams and instructions. The following can be mentioned in this respect:

> *[...] the doctor explained things well and said everything I needed to care for. I was really calm [...] I was often in touch with the doctor and he asked how I was. Everything was fine. [...] He always explained that the baby could stay in the ICU and have some problem, it could take longer or not, so things were clear. (I1)*

However, there were cases when the mothers considered the lack of guidance to be the cause of neonatal death, as observed below:

> *[...] it wasn't good, because I didn't receive instructions as I should have. [...] If he had instructed me, if he had given me a certificate, put me to rest, I wouldn't have lost my child. (I6)*

Women consider the unavailability of physicians to be one of the factors that affect the quality of prenatal care:

> *I thought it was so-so, I think the doctor and nurses should've done more follow-up, because we only saw each other once a month. There was so much to say, especially for first-time mothers. (I2)*

The longitudinal follow-up of pregnant women by a single professional during prenatal care is mentioned in interviews as a factor that plays a role in quality. This follow-up expected by some women was also harmed in the case of prenatal care in a university hospital, due to the change of interns at each consultation:

> *I thought it was a bit complicated because [...] every month it was someone different [...] people didn't know what I had and what my daughter had. They'd read the paper and make assumptions [...] At the end of a consultation, the doctor stamped and signed the paper as if he'd seen me [...] I thought this was a disregard. (I8)*

The way professionals approach pregnant women, with conversations, guidance and the ability to listen to them, was described in the interviews as a positive experience during prenatal care, especially among primiparous mothers. In addition, instructions about breastfeeding care are also viewed positively by some of the participants:

> *To know new things. Because I didn't know much about breastfeeding, how to clean my nipples, how babies have to go for the areola on the nipples. (I2)*

Guidance on the development of pregnancy is valued in cases of hospitalization due to complications, indicating that pregnant women expect dialogue and instructions during both routine prenatal care consultations and hospitalizations. Quick, mechanical and procedure-based consultations that prevented them from asking questions were not valued, as described below:

> *The doctor only looked at us like this... She'd look at the medical records and exams, she'd never wait for us to say something and would let us go right away. [...] It wasn't like that with the nurse. The nurse is patient, she'd look at us, talk to us and give some instructions. (I2)*
>
> *There wasn't any follow-up, no talks, because it was a pregnancy. [...] doctors barely look at you. You say what you have and they start writing the prescription. (I3)*

The importance of health professionals' preparing pregnant women by clarifying their questions and informing about possible complications during prenatal care was revealed:

[...] prenatal care is very important, even for your preparation. For example, if you don't know that your child has something [...] sometimes, you're not prepared psychologically or logistically to receive this child. (I1)

Prenatal care helped a lot, because we see everything there. We check the heart every month, we check the blood pressure and weight and see if they're not obese, we check their diet. We certainly need prenatal care to have a healthy child. (I4)

[...] it's very important. Because all exams are performed to know if a child will have possible problems or not. However, in many cases, what I see is negligence towards prenatal care. (I7)

Some of the participants in this study view prenatal care as a required preparation for the remaining steps, delivery care and post-natal care, although the failures contributing to neonatal death were attributed to it. They indicated that prenatal care was not capable of preparing them for delivery, in addition to failing to diagnose complications such as urinary infections. In some cases, premature birth was understood as the consequence of poorly performed prenatal care:

[...] very bad. Because I had prenatal care [...] I had the exams and nothing showed, but I had urinary infection, which also contributed to the premature birth [...]. (I3)

[...] I think lack of adequate instructions during prenatal care was the reason for my child's death. [...] In my opinion, some information was missing. (I6)

[...] You can find out everything through prenatal care [...] After it all happened [...] and she died, the doctor said that if this had been diagnosed before, I would've needed an abortion, I'd have to get her out, because she was going to be born with these malformations, so they thought it would've been better to remove her [...] I wouldn't let them do it. (I8)

Other mothers associated the quality of prenatal care with the access to health services, consultations and diagnostic exams:

[...] what I liked best was the ultrasound. To see my baby, to see the photos, that was what I most liked. (I6)

The delay between the requests for exams, diagnoses and treatment was negative in some of the experiences analyzed, apart from the poor assessment of exam results, when certain complications passed unnoticed:

I had urinary infection [...] I only went to see the other results a month later to find out how this infection was. (I2)

I had no follow-up at all. I had the exams done and not even the doctor detected the infection, which aggravated my situation. (I3)

[...] if prenatal care had been adequate, there wouldn't be so many children born with health problems... But if there was follow-up, talks for the pregnant women, then there wouldn't be so many problems. (I7)

Delivery care in the perspective of women whose neonates died

Delivery care was reported to be of good quality by some participants. However, unlike prenatal care where the role of physicians stands out, the quality of hospitalization during delivery was associated with the work of the nursing team. Nurses who communicate and explain the procedures contribute to reducing concern about hospitalization and delivery and improving quality of care. Dialogue with explanations about one's health status was valued in some of the interviews, while lack of dialogue caused concern and dissatisfaction with the health care received:

They treated me very well, there was always a nurse who talked to me, changed the serum, [...] they stay there and they talk to me and give me advice. (I2)

No, they only said it was normal, that labor pain was normal, that was it, there was no talking. (I7)

The negative assessment of delivery care can be due to the public services provided. As they are part of the Unified Health System, the team might not be performing adequately, as observed in the delay to inform patients and make decisions about the delivery, apart from the performance of professionals who do not consider the uniqueness of each case, thus affecting quality of care:

[...] they don't pay any attention to mothers and pregnant women coming through the SUS, they simply ignore them. (I3)

I was on my knees, like this, with my legs folded on the chair, trying to stand the back pain [...] Then, she [nurse] came and said: 'This one? This is not pain!' [...]. (I8)

Some reports show the delay to inform about the recommended care, causing women to judge this as a flaw of the health team. This delay and the lack of information also cause mothers to think that complications could have been prevented if care had been provided in a more efficient way:

if they had done all the procedures required and if they had done a C-section, my child would be here with me. (I3)

> *It took them too long to deliver the child... It took too long, it was past the birth time. (I6)*

In the present study, some women reported that the experience of the delivery can be smooth when family members are present. The moments prior to delivery, during hospitalization, are when pregnant women feel the need to stay close to someone from their family, who can offer support. Thus, the absence of such family member can cause delivery to be stressful, affecting quality of care:

> *During the day, there was always someone with me and they also cared for me and helped me bathe. It was smooth and everything was fine during hospitalization. (I1)*

> *[...] it was when I began to feel labor pain there and talk to them [...] I asked them if my husband and aunt could stay with me and they said no because it was crowded there. [...] After delivery, my aunt, who was a bit nervous, went there and said that they were irresponsible. (I7)*

Another aspect that affected quality of care, as reported by some participants in this study, was the lack of support to deal with complications of both mothers and children. The availability of professionals in the maternity ward was also inadequate in some of the situations experienced by participants. For one of the mothers, the lack of specialized professionals was only discovered when she went to the hospital in labor and her follow-up was thus affected. The lack of beds in the neonatal ICU was also reported as a problem for neonates in some cases, having enough influence to cause death according to mothers:

> *[...] I arrived there and there were no gynecologists. I stayed in the ambulance, waiting to receive care. They took me to another hospital when I already had very strong contractions [...] (I6)*

> *[...] it's important to have our baby in a place with adequate conditions for this. It'd be ideal if there were conditions to receive mothers as well. (I1)*

> *[...] he'd need to be in an ICU as fast as possible and they couldn't find one. [...] In my opinion, this lack of ICUs when he needed one was what caused his death. (I7)*

DISCUSSION

Other studies have already evidenced that a good service, based on active listening and adequate professional performance, enables the association between user and health service, increasing pregnant women's satisfaction with prenatal care.[7,8,13-15] The women interviewed in the present study mentioned the clarification of questions as a positive factor for the quality of prenatal care, as observed in other studies.[13,14] The presence of dialogue and instructions on health care led to a more adequate follow-up of pregnancy. Health care that includes safety through the transmission of information about mother's and child health has also been described in other studies.[16] The bond between pregnant women and nurses is an aspect that enables more humanized care.[7]

Pregnant women's empathy for health professionals has an influence on adherence to consultations and comprehensive care.[15] Professionals' awareness of the fears and anxieties of pregnant women promotes their bond with these women, which can help to prevent problems.[8] A study performed in Southern Brazil indicated that respect for pregnant women's beliefs and singularities strengthens this bond and helps professionals to meet their actual demands for primary care.[7]

Studies have shown that professional guidance provided during prenatal care consultations is precarious, although such consultations are understood as privileged space for pregnant women to receive instructions about pregnancy and delivery.[3,4] The following instructions were the ones least received by pregnant women: maternal breastfeeding, recommended maternity hospital at the moment of delivery, the right to have a companion, information about delivery and the use of contraceptives after delivery, puerperal consultations and instructions on types of delivery.[3,4] The results found here show that lack of guidance during prenatal care touches on two important aspects associated with quality of care. The first aspect is the professional-patient relationship, which can be disqualified by mothers when their questions are not answered. The second refers to the low number of consultations or even the low quality of such consultations, thus harming the preparation of pregnant women at the moment of delivery.

Exams performed to follow mothers' and children's health status are essential for good prenatal care. This finding has been described in another study, where mothers had to consider exams as essential for the follow-up of pregnancy.[13] However, there is also evidence that the delay in the delivery of requested exam results was a negative aspect in prenatal care.[16]

Researchers found that, although the exams recommended for prenatal care are frequently requested, there are no records of their results in medical records.[3] Urine exams, for example, were indicated as one of the least recorded, in agreement with participants' complaints about not having been diagnosed with urinary infection, even though such exam was performed. On the other hand, a study showed a low number of requests for laboratory exams in the first consultation, although these are recognizably essential to prevent, identify and correct abnormalities during pregnancy.[4] Easy access to preventive laboratory exams contribute to the resolvability of prenatal care actions and it is reported as a factor that strengthens the bond between pregnant women and health services.[7]

In the present study, the number of consultations performed during pregnancy was shown to be one of the elements that hindered a better assessment of prenatal care for mothers. The

beginning of prenatal care depends, among other factors, on the service's capacity to be available and one's access to this service.[16] Pregnant women with a lower number of consultations during prenatal care follow-up showed less adequate exams, vaccination, instructions on delivery and breastfeeding.[3]

Lack of follow-up of pregnancy, according to what is recommended by the Policy on Humanization of Labor and Birth, was reported by some mothers in this study, including fewer than six consultations, as shown by other studies on quality of prenatal care.[3,4,15] Maximization of opportunities to take action in each consultation is more important than the number of such consultations, so that prenatal care can have positive effects on pregnancy and make a connection with pregnant women, enabling the expansion of care beyond reproductive health.

Thus, it was evident that a positive qualitative assessment of prenatal care is associated with professionals who talk about pregnancy and obstetric and neonatal care that may take place and those who are available to answer questions and receive mothers, even out of the monthly routine consultations, listening to their concerns and questions. It should be noted that mothers complained about not being prepared for childbirth, nor receiving instructions and support to cope with the complications that may arise during pregnancy and delivery.

The decision of pregnant women to have the follow-up during prenatal care is supported by factors such as: the availability of access to services, the availability of exams to confirm pregnancy, quality of care in public health services, health team's empathy, and the establishment of bonds with health professionals.[15:261]

Prenatal care as preparation for delivery was viewed as unsatisfactory in other studies that focused on the perspective of pregnant women. Information about delivery provide safety and prevent women from having misconceptions about birth, emphasizing that communication between professionals and pregnant women need to be prioritized during the follow-up of pregnancy.[17] Additionally, a study performed in Japan, one of the countries with the lowest child mortality rates in the world, indicates that primary care before birth needs to be improved to be more efficient to prevent avoidable neonatal deaths.[18] In primary care, the identification of twin pregnancy, fetal distress, fetal growth restriction, and early referral of pregnant women to specialized centers are recommendations to prevent neonatal deaths. Primary care like this is associated with the prevention of neonatal deaths, when compared to an increase in neonatal care after birth.[18]

The way professionals receive pregnant women at the moment of birth can cause them to feel dissatisfied, as observed in the interviews. In this sense, the medical team's disregard for maternal pain is a factor that negatively influences this moment.[9] Lack of information during the delivery process and harmful malpractice known by women cause them to become distrustful of the treatment received. This makes the medical team become more neglectful, not informing patients about the procedures to be performed and disregarding communication as a protective factor for a successful delivery.[10] A study performed in Nepal points out that the negligence of physicians and nurses and mothers' lack of knowledge about symptoms and signs of danger are considered by them as reasons for the death of their babies.[19] Without the technical knowledge about their own health status and that of their child, maternal assumptions about the low quality of preparation received during prenatal care are only made after the occurrence of complications.

Participants' dissatisfaction with delivery care was associated with the lack of professionals, uncommunicative and impatient staff, lack of a family companion and the neglect for maternal pain. This situation is strongly associated with interpersonal relationships, even in Brazil, where humanization of birth is a legal guarantee. However, this still needs to be more incorporated into delivery care services.

The emotional support that pregnant women receive from the health team is connected to the well-being of those who have lost newborns. This is essential for women who need to continue visiting the hospital in case of twin births, when one of the children has survived, and who depend on hospital care.[20]

The presence of a companion at the moment of delivery brings comfort and safety, apart from being a special moment for this family member, as observed in the literature.[9] Studies show that, for health professionals, giving women the opportunity to choose a companion for delivery means to provide humanized care.[10,21,22] However, current evidence shows that there are still women who are not accompanied at any moment of the birth process. This situation can be changed by encouraging a companion to be present.[11,17,23]

The nursing team has been described by other studies as the main factor for humanized delivery care.[9,17] During interviews, humanized care, guidance and dialogue aimed at answering pregnant women's questions are found to be actions associated with the nursing team when they are hospitalized for delivery. Nursing instructions aroused a feeling a comfort and encouraged women in the birth process.[9] Nonetheless, in cases of neonatal death, nurses who shared the family's routine of anguish faced death as a difficult moment, although their own bond with their family helps them to cope with the pain.[24]

The death of a newborn is an emotional and traumatizing experience for parents. The loss of a baby triggers strong feelings of grief in parents and family members, as well as nurses, physicians and other professionals who have a hard time accepting death, as they are prepared to save lives.[25]

The present study revealed the mothers' judgment about the differences in health care between public and private hospitals and their concern for the availability of services in maternity hospitals to care for mothers and newborns. A study on public *versus* private health services showed that the pregnant women cared for in the private sector began their prenatal care earlier on and had a higher number of consultations and exams such as ultrasounds. In contrast, pregnant women in the public sector had a higher number of urine exams and serology for syphilis and their diet was more frequently supplemented with ferrous

sulfate, thus indicating differences between public and private services and the advantages of women cared for in the private sector. These advantages could be associated with their better socioeconomic conditions, such as the possibility of purchasing ultrasound exams.[26]

An alarming factor pointed out by participants in this study was the availability of maternity services that provide support to parturient women and newborns. In this sense, there were negative reports on mothers being separated from their children due to the need for intensive care. Access to the services offered by maternity hospitals occurs in different ways in Brazil and the Mid-Western region, the setting of the present study, is indicated as one with great problems of geographic distribution of maternity hospitals, which are centered on the state capitals.[27] Moreover, the highest neonatal mortality rates are associated with births in hospitals without neonatal ICU.[11]

The "Rede Cegonha" (Stork Network)[28] aims to improve health care for women and their newborns, guaranteeing access, resolvability and quality of prenatal, delivery and neonatal care. This network is expected to contribute to the reduction in neonatal deaths in the city of Cuiabá, Mid-Western Brazil. However, it is still undergoing a process of implementation in this city.

CONCLUSIONS

The present study showed factors that contribute positively and negatively to the quality of prenatal and delivery care in the perspective of women whose newborns died. Many findings on the experiences reported corroborate the previously published literature on aspects requiring incentive to improve quality, such as the presence of a companion during delivery, reception of pregnant women, humanization of professional care, greater availability of neonatal beds, and perinatal services. The communication between health professionals and pregnant women as a source of comfort, safety and strength of their bond, so that the experiences of pregnancy and delivery are more satisfying for women, should be emphasized.

The qualitative approach of this study on quality of prenatal care showed how negative factors for health care biographically reflect on women, apart from evidencing the coldness and neglect of certain professionals when caring for pregnant women. Certain dimensions of health care stood out in the results and should be explored in new studies, as they are associated with quality of prenatal and delivery care, such as: delay to perform exams and obtain their results; flaws in the diagnosis and control of pregnancy-related pathologies, such as urinary infection; diagnosis of relevant health conditions in due time, such as fetal distress and restriction in intrauterine growth; professional-patient relationship, especially when patients' complaints are not heard or valued; insufficient attention given and lack of bond and humanization in the service; lack of basic guidance such as signs of risk and where and when to search for health care; difficulties to understand and follow the instructions received; and different levels of satisfaction among pregnant women, associated with the distinct postures of professionals.

The perspective of listening to individuals who are cared for, which requires attention from health services, increases knowledge about prenatal and delivery care. Furthermore, the results can be a warning for professionals providing care for pregnant and parturient women, apart from being used in health education.

One of the limitations of the present study was the fact that the results only showed the perceptions of one of those involved in the health care process. Thus, more qualitative research on the professionals' and managers' perspective of this theme should be performed. However, the perspective of listening to individuals being cared for, which requires attention from health services, raises knowledge in the area of prenatal and delivery care.

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