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Original article

HEALTH CARE FOR WOMEN IN THE PREGNANCY-PUERPERIUM CYCLE: EVALUATION OF ACCESSIBILITY IN PRIMARY CARE

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ABSTRACT: This study aimed to analyze accessibility to the health service of women in the pregnancy-puerperium cycle, in the perception of the female service users. To this end, an exploratory, descriptive study was undertaken, with a qualitative approach, using a semistructured interview for data collection. The population was made up of women who had been, or were, in the pregnancy-puerperium cyclein January 2012 – April 2014. The criteria of saturation was adopted for defining the sample, which reached the number of 29 interviewees. The thematic categorical technique was adopted for analysis of the data. The results showed the existence of various geographical, economic, sociocultural and organizational barriers in the assistance to women in the pregnancy cycleand in the postpartum period. It is possible to note the need for organizational changes which would be reflected in improvement in the quality of the care.
DESCRIPTORS: Accessibility of Health Services; Pregnant women; Postpartum Period.

ASSISTÊNCIA À SAÚDE DA MULHER NO CICLO GRAVÍDICO-PUERPERAL: AVALIAÇÃO DA ACESSIBILIDADE NA ATENÇÃO BÁSICA

RESUMO: Objetivou-se analisar a acessibilidade ao serviço de saúde da mulher no ciclo gravídico puerperal na percepção das usuárias. Para tanto, foi realizado um estudo exploratório, descritivo, de abordagem qualitativa, utilizando-se entrevista semiestruturada para coleta de dados. A composição da população foi de mulheres que estiveram ou estavam em período gravídico ou puerperal no período de janeiro de 2012 a abril de 2014. O critério de saturação foi adotado para definir a amostra, que alcançou 29 entrevistadas. Adotou-se para análise dos dados, a técnica categorial temática. Os resultados mostraram a existência de diversas barreiras geográficas, econômicas, socioculturais e organizacionais na assistência à mulher no ciclo gravídico e período pós-parto. Percebeu-se a necessidade de mudanças organizacionais de modo que reflita na melhoria da qualidade na assistência.
DESCRITORES: Acesso aos Serviços de Saúde; Gestantes; Período Pós-Parto.

ASISTENCIA A LA SALUD DE LA MUJER EN EL CICLO GRAVÍDICO-PUERPERAL: EVALUACIÓN DE LA ACCESIBILIDAD EN LA ATENCIÓN BÁSICA

RESUMEN: Estudio cuyo objetivo fue analizar la accesibilidad al servicio de salud de la mujer en el ciclo gravídico puerperal en la percepción de las usuarias. Para eso, se realizó un estudio exploratorio, descriptivo, de abordaje cualitativo, utilizándose entrevista semiestructurada en la obtención de datos. La composición de la población fue de mujeres que estuvieron o estaban en periodo gravídico o puerperal de enero de 2012 a abril de 2014. El criterio de saturación fue adoptado para definir la muestra, que tuvo 29 entrevistadas. Fue utilizada, para análisis de los datos, la técnica categorial temática. Los resultados mostraron la existencia de distintas barreras geográficas, económicas, socioculturales y organizacionales en la asistencia a la mujer en el ciclo gravídico y periodo posparto. Fue constatada la necesidad de cambios organizacionales que reflexionen en la mejoría de la cualidad en la asistencia.
DESCRIPTORES: Acceso a los Servicios de Salus; Gestantes; Periodo Posparto.

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INTRODUCTION

Women make up more than half of the Brazilian population and are the principal users of Brazil's Unified Health System (SUS)[1]. They make up, therefore, a social segment which is fundamental for health policies, requiring the SUS to take a view extended to includethis part of the population, given that various social, economic and cultural factors – in addition to the historical inequalities of power between men and women – entail a strong impact on their health conditions[2].

In relation to attendance to pregnant women, emphasis should be placed on the importance of the woman, the newborn and the family receiving appropriate care during the pregnancy, labor, birth and the postpartum and neonatal period. The care must be based not only in clinical procedures, but in a set of actions such as health promotion, embracement and the establishment of a bond, among other technologies, so as to develop the woman's autonomy for her self-care[3].

In order to improve the care for the pregnant woman and the newborn, actions must be planned taking into account the identification of risk factors related to maternal and neonatal mortality, as this situation is an important indicator which reflects the socioeconomic and reproductive conditions – and, principally, those related to the prenatal care, to the birth, and to the newborns[4].

In this regard, in 2011, the Brazilian Ministry of Health launched its Stork Network (*Rede Cegonha*) strategy, which aimed: to foster the implementation of a new model of healthcare for women and children, focusing on care in labor, birth, and on the growth and development of the child from zero to 24 months[5].

The evaluation of the actions in health is a potent tool for the strengthening of the services for managers, professionals and service users. The evaluations of the quality of the services provided have transformed into a broad dimension of studies/research, due to the need to analyze the various contrasts found in the health institutions. To this end, there are various systems, both Brazilian and international, which undertake the task of assessing and issuing objective opinions on the quality of the services provided[6]. In this evaluative perspective, one axis of analysis can be based on accessibility.

Accessibility is understood as the extent to which the characteristics of the health resources match the needs of the population in the process of seeking health care. It results from a combination of factors with distinct dimensions, which are classified geographically, organizationally, socioculturally and economically[7].

In this regard, it is understood that accessibility to the health services must encompass both the characteristics of the service, in relation to the offering of attendance at compatible times, with the availability of prepared professionals; embracement; the conditions of the service user in relation to the locale where she lives, the time she has available, her purchasing power, habits and customs and the relation between these[8]; besides efficacious treatment in the prenatal period, and the undertaking and receiving, in the required time,of laboratory tests and imaging examinations[7]. However, it may be noted that these actions have not actually been undertaken in practice, making the quality of the care unsatisfactory[8].

In the current context, the issue of insufficient accessibility for gestational care entails maternal-child vulnerability. At the same time, it makes both the gestational period and the puerperal period disarticulated and fragmented. In this regard, the question arose: how does the dimension of the accessibility of the female service user in the pregnancy and puerperal periodin the health services in primary care occur?

This being the case, this study aimed to analyze the accessibility to the health service of the woman in the pregnancy-puerperium cycle, in the perception of the female service users.

METHODOLOGY

This work was undertaken based on the research project titled "Accessibility to the service in the pregnancy-puerperium cycle: An evaluation of the care provided to women in primary care", linked to the National Program for the Reorientation of Professional Training in Health (PRÓ-Saúde) articulated to the Work Education Program for Health (PET-Saúde), of the Federal University of Campina Grande (UFCG) between 2012 and 2014, as stipulated under Decree N. 24, of December 15th 2011, of the Ministry of Health, through the Department of Management of Work and Education in Health (SGTES).

The study has an exploratory and descriptive design, with a qualitative approach. It was undertaken in the municipality of Lagoa Seca, in the state of Paraíba (PB), in two Family Health Strategy (ESF) units, which have teams from the PRÓ/PET-Saúde.

The population was made up of women who had been or were in the pregnancy or puerperal periodin January 2012 – April 2014, identified through research undertaken in the record books of each Family Health Unit (USF). Subsequent to this research, lots were drawn, undertaken randomly within the representative population in order to obtain a sequenceof the participants.

The following were applied as inclusion criteria: women who undertook prenatal consultations in the units participating in the study in the above-mentioned period, there being limitations based on age, skin color/race, or permanent or temporary physical disability. The exclusion criteria adopted in this study was residence incompatible with the area of coverage of the selected USF.

Data collection was characterized by semistructured interviews. The criteria of saturation was adopted for defining the significant quantity for the study.The criteria of saturation can be understood through the researcher's knowledge of the study scenario, of the internal logic of the collectivity, and perceiving the intensity of the information necessary for her work[9].

The interviews took place in October – December 2014. In order to undertake these, the researchers went to the participants' homes. As a guide, they used a script made up of open questions, addressing the following issues: Accessibility – Quality in the Health services; Accessibility – Geographical and Organizational dimensions; Accessibility – Sociocultural and Economic dimensions.

An MP3 device was used for recording the interviews. Considering the evaluation of saturation, a total of 29 interviewees was reached. The mean duration was approximately 10 minutes. The dialogues were transcribed and organized. The material arising from the collection was analyzed in accordance with content analysis of the thematic categorical type[10].

The study was approved in April 2014 by the Research Ethics Committee of the Alcides Carneiro Teaching Hospital, under Opinion N. 869,561. The participants' privacy was prioritized during the collection and tabulation of the data, and expositionof the interviews, preserving anonymity and the confidentiality of the data; the interviewees were represented using the names of precious stones.

RESULTS

Based on the analysis of the data, a central category was obtained titled "Commentsregarding quality and accessibility in the SUS", which expresses the representations on the knowledge regarding quality, accessibility, and the difficulties met in the service by these women. These difficulties led to the composition of the other categories: The path to the unit: time and distance as obstacles; Costs which arose: financial difficulties which emerge during the prenatal period; Female Service Users V. Services: the sociocultural dimension of accessibility and The (dis-)organization of the service as a factor which is prejudicial to the care.

The commentsregarding quality and accessibility in the SUS

Regarding the quality attributed to the SUS's health services, the majority of the female service users

did not attribute positive qualities (9), while others consider them to be normal (7) and the minority (6) attributed the services' quality as good due to the fact that they managed to access the service.

Referent to the negative attributions, one can note from the accounts that the use of the service occurs inefficaciously, with medical attendance, medication and tests lacking.

Health in the SUSdoesn't have quality, it is very bad. It is the worst health in the world, the person needs things and can't get them, so they say they are going to resolve matters and do not resolve anything. (Coral)

I don't think that the attendances of the SUS have quality, because a lot of things are lacking: you go to the doctor and that they don't have the medications, often they don't even have files where they can make notes on the consultation, I think that the attendance is not good. (Lemon Quartz)

In evaluating the service as normal, the female service users associated good quality with the issue of attendance being available whenever they need it; however, for them, the quality is not good, due to the lack ofsupplies.

You don't find quality in all the SUS services, a lot of things are lacking, there is a lack of medications, or regarding the test which the person requests but which is not approved. (Zircon)

The SUS only has quality in some things, because you can't always get hold of things. (Topaz)

For good evaluation, the findings were shown to be related exclusively to the offering of medical attendance, medications, tests and embracement; that is, in the women's perception, quality in the health service is to find available what one seeks.

[...] This is how you need to be attended, to have tests, like, ultrasound, for these things to be easier, you know? [...]. (Amber)

[...] For it to be good, you have to have everything; have a male physician, a female physician, and to converse [...]. (Emerald)

Good attendance is to have a doctor available. (Amazonite)

When asked about what accessibility is, half of the women asserted that they did not know, while those who knew of the term restricted their answers to the fact of having access to the services.

No, I don't know what this is. (Coral)

No, I don't understand what that is, no. (Rhodonite)

It is the person going from their house to the clinic.(Silk)

It is having access, you know? To what you need. (Amber)

In reference to the difficulties found in seeking attendance in the health services/units, one encounters identification of the dimensions of accessibility, evidencing the geographical, economic, sociocultural and organizational dimensions.

The distancefrom where I live [...]. (Amazonite)

Sometimes when the person needs something that is too expensive, the time, the delay, and they don't give the things that the person wants, sometimes you ask for something this year, and you only get it next year. (Ruby)

The person needs things and can't get them, they just make promises, but don't do anything good for health. (Coral)

Many professionals who treat us badly [...]. (Agate)

They don't want to attend us [...]. (Zircon)

Often it is the bureaucracy, and what's more [...] it is the bureaucracy that impedes what happens, you know? (Amber)

The doctors which the service doesn't have, the delay for arranging appointments. (Topaz)

The Path to the unit: time and distance as obstacles

It was ascertained that the majority of the women recognized the distance between their residence and the health service as a barrier:

It is a long way, but even so I come on foot, and it is half an hour from my house to here. (Silk)

It is distant, for sure. I think that I go by bus and I also have to go by bus and often on foot, you know? (Lemon Quartz)

Indeed, it does exist, because it is very far to go to the PSF, I have to catch two buses. (Coral)

The distance exists. Because when I need to go, I can't go on foot. (Rhodonite)

Some women assert that as a result of the distance from the USF, it is faster to seek attendance in the urgent and emergency services:

[...] The person doesn't always have the money to go there (to the USF), so when they really need attendance, it is better – and closer – to go to the hospital. (Coral)

[...] It is so far, the people go to the hospital, because it is closer to here. (Crystal)

Costs which arose: financial difficulties which emerged during the prenatal period

When asked about the financial situation, the women mentioned greater difficulty for undertaking tests, as shown in the following accounts:

I paid for all the ultrasounds, woman, and in addition to paying for this, I paid for me and my sister to go to Campina [the neighboring city] for the imaging examinations, so, you know, I borrowed the money. (Crystal)

It was a little difficult because we don't have a fixed income, we don't have a family structure for everything we need to have enough money. Through the city government, I could only get one ultrasound, I had to pay for the others [...]. (Amazonite)

So we were short of money, but we managed. All the ultrasounds, there were lots of them. When I wanted things faster, I paid for them. (Amber)

I was short of moneybecause I always paid [for ultrasounds and tests], I don't like asking for anything through the SUS, I think it is too slow. (Fluorite)

Other women mentioned the travel to the health service as an economic barrier:

[...] Just paying for the tickets to go and do the prenatal consultation [...]. (Kyanite)

[...] so having to pay for a taxi to go to the maternity unit, and come home afterwards, was very hard [...]. (Coral)

Female Service Users V. Services: the sociocultural dimension of accessibility

In this category, sociocultural barriers were identified in the attendance to the birth:

There are many professionals who treat us badly [...]. (Agate)

[...] The female doctor humiliated me a lot, she was making jokes at me because I was screaming from the pain, and her standing there saying that these people have three children and still shout like this. (Crystal)

People who have studied say some things that we don't understand. It is all lies to take us in, and we believe

it at the time and go home believing that they will resolve issues. (Emerald)

They leave the person suffering there, and don't care. (Turquoise)

The (dis)-organization of the service as a factor which is prejudicial to the care

Some women identified an organizational barrier in the waiting time for the consultations:

We wait a lot, do you understand me? We arrive early, and it takes a long time to be attended. (Amber)

So, they take too long to arrive. They arrive from 08:30 to 09:00, so you leave home early, and they are slow to begin the attendance. (Crystal)*

The only bad thing is their schedule, they ask you to arrive early, and are slow to attend you. (Zircon)

The working hours are the hard bit, because the staff are slow to start. (Tournaline)

In relation to attendance in the birth, the majority said that they were attended well and that they succeeded in having the baby without major problems. However, certain of the women's reports reveal the need to travel around looking for a maternity unit, which reflects an organizational barrier:

I went straight to the maternity unit, but there wasn't a space there, you know? Because it was full there, so they sent me off to[hospital], but they were slow to see me, you know? If I hadn't gone there so fast, I would've had the baby on the way, it is only bad because of this, you know? (Dolomite)

I was supposed to have the baby at [hospital], but I didn't manage to be attended there, and I went to the UPA [Emergency Department]. (Agate)

Another organizational problem identified was the professionals not undertaking the visit in the puerperal period. The majority of the non-pregnant female service users interviewed said that no home visit was undertaken by the professionals who undertook the prenatal care; most of the visits were undertaken by community health workers.

● DISCUSSIONS

In the female service users' view, the quality of the attendance is directly linked to the guarantee of access; therefore, when this use is denied, when there is scarcity of supplies, or when attendance is stopped,there is poor evaluation on the part of those who use the services.

The majority of the patients and family members have little knowledge on the technical domain of the quality, leading them to have their opinions reflected by cultural aspects and representations that a good service is that which has available attendances with prescriptions of medications, tests, and other procedures[11].

There is low satisfaction of the service users in relation to the system's failure to resolve problems – such as lack of medications, few spaces for attendance, and delays in arranging tests and consultations with specialists[12].

One can see in the perception of the largest number of the female service users, that quality is attributed to the service through the simple fact of being attended. One can also note the valorization of the figure of the physician as the principal component in the USF.

One finds a reductionist view of the family health team on the part of the service users, centered on the medical professional, showing unawareness of the role of the other members of the team, and placing emphasis on the diagnostic and curativist actions[13].

*It is necessary to arrive extremely early in the morning to enter a queue; hence there is often a long wait between arriving at the unit and being seen by a member of staff. Translator's note.

One fact which calls attention in the study is that the number of women who knew the meaning of accessibility was equal to that of women who did not know how to respond. This finding may be related to these service users' level of education, as those who did not know how to respond had a low educational level.

The guarantee of universal access in the SUS results from the recognition of possiblebarriers to accessibility linked to the population's needs and characteristics[14]. This recognition is important as it may drive changes in the governmental spheres, eliminating or attenuating these barriers, given that difficulties in access are the reasons cited most for not undertaking the prenatal care[15].

The time spent traveling, determined by the distance traveled, is one of the principal difficulties in the users' access to the health services, as it constitutes a resistance imposed by the geographical space on the users' trajectories, moving from place to another, to theservices[16].

It is noted that the distance between the women's residences and the USF configures a barrier to access, above all for those women who live in the rural zone. One study undertaken in a health district of the municipality of Salvador, in the state of Bahia, in 2009, showed that people who lived in the most distant areas present increased social vulnerability, and, consequently, a worse health situation, aggravating factors being related to the geographical obstacles to obtaining access to the services[17].

Furthermore, the search for access leads the service users to the urgent and emergency services. It was noted that the female service users ceased to use the gateway to the SUS as a result of the municipality's organizational and geographical problems. One study indicated that the demand for attendance in emergency care unitsoccurs due to there being a shorter waiting time and ease in attendance there, due to the organization of flowand the model of care centered on the doctor[18].

The geographical obstacles mentioned, and the disorganized arranging of the service in the municipality, with weakness in the mapping of the areas of coverage of the USF studied, shows a lack of transport available for undertaking home visits, and the absence of an 'anchor unit' forthe unit for assisting those who live the furthest away, and who do not have the resources for attending.

It was observed that the majority of the women who reported financial difficulties in the gestational period related these to the costs of the ultrasound examinations (USG). However, the Ministry of Health statesthat, although this is a procedure undertaken routinely, there is as yet no scientific demonstration that this has any effectiveness in reducing perinatal morbidity and mortality or maternal morbidity or mortality in the prenatal period for low-risk births[19].

The financial resources necessary for paying the transport costs represent a barrier to access for the service users. Even though the SUS is a free and universal system, it is the Brazilian families which are the most well-to-do financially that spend most on health, reflecting an inequality in health expenses with detrimental effectsfor those who are poorest[16].

The financial difficulties constitute an obstacle for the service users; however, meetingthe expenses in health situations is the way to seek resolution for their problems. Bearing in mind that they face slow responses to these, the service users seek alternatives, such as: going to other establishments at the same level of care, or of greater complexity, self-medicating, and private care. As a result, one can perceive a health services – service users relationship which offers, materially, the minimum for survival, and denies them citizenship in healthcare, reaffirming an excluding model of care[20].

Referent to the findings of the sociocultural dimension, in this study, it was noted that these support a study undertaken in maternity units in São Paulo, in 2008, which identified deeply disrespectful forms of treatment in the reports of mistreatmentand that people were left to 'suffer' without staff concerning themselves about this[21]. The health services face various economic and structural difficultiesand underlie the poor treatment experienced by the female service users; in this way, the sociocultural aspects are reflected in the discriminatory practice[22].

Regarding the organizational accessibility, this is understood as the facilities offered by the service which favor the service users' attendance[23]. Where obstacles exist, these refer to the delay in obtaining consultations, such as for arranging a consultation, the waiting time to be seen and/or for undertaking laboratory tests[7].

One study showed that the waiting time for consultations is a striking characteristic in prenatal care, and that the long wait causes the women tiredness, stress and hunger[24]. This indicates that often the services are structured and organized to attend their own needs, establishing arrival times which are most suited to the professionals' work, without being concerned with the service users' actual needs, as well as failing to take into account their commitments in their private lives[22].

Another difficulty found in this study was the women's need to travel from unit to unit looking for a maternity unit in which to give birth, related to the lack of linksbetween the prenatal and birth departments. This fact was also the result of a study undertaken in two public maternity hospitals in the urban area of São Luiz, in the state of Maranhão,in2007, when approximately half of the participants had to go to more than one maternity unit to achieve access, which exemplifies the lack of continuity of the care in the pregnancy-puerperal cycle, as well as the lack of integration of the health units which provide care during the prenatal period and the establishments for birth, leading to the failure to offer excellence and safety to the patients[25].

The puerperal visit is important for providing guidance on breast-feeding and care with the newborn, to assess the mother's interaction with the newborn, to identify situations of risk or complications, and to provide guidance on family planning[19]. The absence of the visits may reflect the organization of the USF teams, asthese do not find/prioritize time for leaving the health units and going to the female service users' homes.

CONCLUSION

As an inclusive and integral policy, the SUS seeks to establish,based on strategic actions, the engagement of universal access to the health services, making it possible to overcome historical shortfalls in the offering of care in the various scenarioswhich surround, and continue to permeate, women's health – in particular that of pregnant women and women who have recently given birth, at all the levels of complexity of the health system.

The programs and strategies with a focus on women's health, an example being the Stork Network, address – at least in the theoretical field – the principle needs linked directly or indirectly to the pregnancy-puerperal period. The reality, in this study, denotes major drawbacks in practice, which inviabilize comprehensive health care for the pregnant and puerperal women and go against the theoretical precepts such as the putting into effectof the care network which ensures access, embracement, and capacity to resolve health issues.

The representations of the accessibility to the service, which are based on the women's perception, demonstrate that the barriers in general combine and converge on the organizational barrier, as each difficulty related to the distance, to the waiting time, and to not being able to undertake tests reflects the municipality's organizational lack of preparation.

In this regard, it is essential to understand and consider the service users' participation and evaluation as an integral part of the SUS, in order to seek to break barriers and to seek quality in the services provided, as these women's opinion constitutes an important indicator of the health services' quality.Emphasis is placed on the importance of change regarding the management and professional practices such that the inclusion of the understanding of the social determinants may be reflected in a praxis which recognizes the barriers to accessibility existing in the USF, and that strategies may therefore be developed for minimizing these or even eliminating them from the scenario analyzed.

This study provides supportfor the development of others, having as the scenario: the other levels of care; broadening of the representative focus to themanagement and health professional, using the prerogatives of the faces of the organization, the forming of partnerships, and networkingwhich results in the reflection on the need and structuring for quality care.

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