

## Guidelines on high-risk prenatal delivery in health services

Orientações sobre parto no pré-natal de alto risco nos serviços de saúde

Orientación sobre el parto prenatal de alto riesgo en los servicios de salud

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**Abstract: Objective:** to unveil the guidance received on childbirth during high-risk prenatal care in health services in the light of Social Representations Theory. **Method:** an exploratory descriptive study with qualitative approach, with the Social Representations Theory as a methodological theoretical framework. Data collection occurred between October 2017 and January 2018, in a maternity hospital in northern Paraná, during the hospitalization of 20 puerperal women. Semi-structured interviews and thematic content analysis were used. **Results:** the category emerged: *Knowledge developed in the face of health guidelines for pregnant women*. The central nucleus was configured in care directed to women's health and their empowerment in the pregnancy-puerperal cycle. **Conclusion:** health guidelines were similar at both levels of care, being directed to fetal health and well-being. Risk situations to newborns were identified in the emergency room that could result in premature cesarean delivery and complications to the conceptus.

**Descriptors:** Pregnancy, high-risk; Health services; Prenatal care; Health education; Women's health

**Resumo: Objetivo:** desvelar as orientações recebidas sobre parto durante o pré-natal de alto risco nos serviços de saúde à luz da teoria das representações sociais. **Método:** estudo descritivo exploratório com abordagem qualitativa, tendo a Teoria das Representações Sociais como referencial teórico metodológico. A coleta de dados ocorreu entre outubro de 2017 e janeiro de 2018, em uma maternidade do norte do Paraná, durante a internação de 20 puérperas. Utilizou-se entrevista semiestruturada e análise de conteúdo temática. **Resultados:** emergiu-se a categoria:

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conhecimento elaborado frente as orientações em saúde para gestantes. O núcleo central configurou-se no cuidado direcionado à saúde da mulher e seu empoderamento no ciclo gravídico-puerperal. **Conclusão:** orientações em saúde foram similares nos dois níveis assistenciais, sendo direcionadas à saúde e bem-estar fetal. Foram identificadas situações de risco ao bebê nas urgências que poderiam resultar em um parto cesáreo prematuro e complicações ao concepto.

**Descritores:** Gravidez de alto risco; Serviços de saúde; Cuidado pré-natal; Educação em saúde, Saúde da mulher

**Resumen: Objetivo:** dar a conocer las pautas recibidas sobre el parto durante la atención prenatal de alto riesgo en los servicios de salud a la luz de la teoría de las representaciones sociales. **Método:** estudio exploratorio descriptivo con abordaje cualitativo, con la Teoría de las Representaciones Sociales como marco teórico y metodológico. La recolección de datos se llevó a cabo entre octubre de 2017 y enero de 2018, en una maternidad del norte de Paraná, durante la hospitalización de 20 madres. Se utilizaron entrevistas semiestructuradas y análisis de contenido temático. **Resultados:** surgió la categoría: *Conocimientos elaborados frente a guías de salud para gestantes*. El núcleo central se configuró en la atención dirigida a la salud de la mujer y su empoderamiento en el ciclo embarazo-puerperal. **Conclusión:** las pautas de salud fueron similares en los dos niveles de atención, dirigidas a la salud y el bienestar fetal. Se identificaron situaciones de riesgo para el bebé en emergencias que podrían resultar en un parto por cesárea prematuro y complicaciones para el feto.

**Descriptores:** Embarazo de alto riesgo; Servicios de salud; Atención prenatal; Educación en salud; Salud de la mujer

## Introduction

Pregnancy is a physiological phenomenon that involves dynamic, physical, social and emotional changes. However, the gestational period can result in risks for both women and the fetus, just as the very characteristic of women can be more likely to have unfavorable outcomes, being considered high-risk pregnant women.<sup>1</sup>

Prenatal care stands out as an essential factor for women's health in the pregnancy-puerperal cycle. Practices performed properly during this follow-up result in better maternal and perinatal outcomes. An inadequate performance of care has been related to high rates of maternal and child morbidity and mortality.<sup>2</sup>

According to the Ministry of Health recommendations, prenatal care should start with welcoming conducts, with the development of educational and preventive actions, without unnecessary interventions, with early detection of pathologies and situations of pregnancy risk. Pregnant women have the right to establish a link between the place of prenatal care and the

institution that will deliver, from basic outpatient care to high-risk hospital care, in addition to ensuring easy access to quality services.<sup>3</sup>

The Brazilian National Humanization Policy (PNH – *Política Nacional de Humanização*) has proposed methodologies for care and management of existing health programs and strategies, providing for the inclusion of all social actors involved in this process. The *Rede Cegonha* (freely translated as Stork network) health program proposes a care network that guarantees humanized and quality care to women at birth.<sup>4</sup>

In recent years, Brazil has made important progress related to programs for women's health in the puerperal pregnancy cycle. However, there are gaps in pregnancy care to be filled, such as persistence of lack of a comprehensive view on women's health, which results in the fragmentation of information or care during prenatal care.<sup>5</sup>

In Brazil, between 2009 and 2013, there were 8,470 maternal deaths, with a maternal mortality ratio of 58.55 deaths per 100,000 live births, due to some cause related to pregnancy and childbirth. However, 95% of these deaths could be avoided if they had received adequate care.<sup>6</sup>

Health education, with guidance on care and hygiene, food, body modifications, sexual activity, physical activity, childbirth, newborn care, and breastfeeding, is important for pregnant women. However, in a recent study, it is observed that most women do not receive this type of information.<sup>7</sup>

A hospital-based survey with 23,894 women between 2011 and 2012 revealed that differences, according to the type of health service, public or private, were not observed after adjusting maternal characteristics. The lack of difference reveals that, by choosing a minimum global adequacy criterion, public and private services would demonstrate the same degree of adequacy if they met patients with similar social and economic characteristics.<sup>8</sup>

The knowledge of common sense about prenatal care in private services suggests that this care often does not follow the Ministry of Health recommendations regarding the number of appointments and what should be oriented during prenatal care. It is noteworthy that the

multidisciplinary team in this type of service exists; however, referral by obstetrician or direct search by patients only when there is an indication.

There is a gap in professional practice regarding essential guidelines, so that high-risk pregnant women are prepared to face the delivery. In this regard, there is a need to understand the guidance received on this moment in high-risk prenatal care in different health services to contribute to the period of birth, which may result in favorable or not favorable outcomes. The present study aimed to reveal the guidelines received on childbirth during high-risk prenatal care in health services in light of Social Representations Theory.

We have used the Social Representations Theory because of its characteristic in relation to the search for knowledge developed in the phenomenon “guidelines for childbirth”, in which the high-risk women social group can aim to understand birth during prenatal care.

## Method

This is a descriptive exploratory study with a qualitative approach, with the Social Representations Theory as a methodological theoretical framework.<sup>9</sup> Social representation aims to integrate a social phenomenon, which is not part of everyday life and which can reflect on the fear and anxiety of individuals and groups. However, as the conceptual framework is incorporated, it becomes familiar and is reworked, resulting in a new form of knowledge for a social group, called common sense knowledge.<sup>10</sup>

Social representation is defined as a set of concepts, phrases and explanations originating in daily life during the course of interpersonal communications. In this regard, representations are social phenomena understood from their production context, i.e., from the symbolic and ideological functions they serve and the forms of communication where they circulate.<sup>9</sup>

From pregnancy to delivery, women may face doubts and anxieties. In this sense, the social representation built during pregnancy can reflect on the re-elaboration of these concepts until delivery, bringing the elaboration of the women's own knowledge.

The study was carried out in a maternity hospital in a philanthropic hospital in northern Paraná State, from October 2017 to January 2018. The maternity hospital had a 46-bed rooming-in system, 13 (28%) of which were intended only for high-risk pregnancies. risk, linked to the Brazilian Health System (SUS – *Sistema Único de Saúde*). The rest other 33 beds were intended for general medical care (health insurance or private service) and deliveries used for both normal and high risk.

Women with a minimum age of 18 years, with a live newborn and having one of the criteria for high-risk pregnancies, according to the *Rede Mãe Paranaense* (freely translated as Paraná Mother Network) guidelines have been included.<sup>11</sup> Sedated or mechanically ventilated mothers have been excluded.

To select participants, we sought parity of the sample regarding the public service and service participants, reaching both publics. Thus, choosing the participants took place previously according to the inclusion criteria and parity for the two services.

The data were collected by the researcher herself, who has a master's degree in obstetrics, occupying a supervisory position in the maternity under study. A pilot test was carried out with three mothers, and the semi-structured form was adequate. Socioeconomic and demographic characteristics, marital status, education, occupation status, age and health insurance were identified. Afterwards, an interview was conducted with the guiding question: during prenatal care, did you receive guidance on your delivery? The data saturation criterion was used.<sup>12</sup> When necessary, the researcher used the following sub-questions to obtain further clarification: how was the orientation? Could you talk more about orienteering? Was there talk about childbirth during prenatal care?

Each interview lasted, on average, sixty minutes, which was given due to the researcher being a supervisor at the maternity under study, where the nursing team was organized to support newborn care. All interviews took place during hospitalization at an opportune time defined by the mothers, after twenty-four hours postpartum, in a reserved place, with only the puerperal and interviewer present.

A voice recorder was used, and the interviews were transcribed daily after data collection. There was correction in the transcription of Portuguese and language vices, not compromising statement meaning. Next, data interpretation was performed by thematic content analysis, outlined by pre-analysis, material exploration, and treatment of results.<sup>13</sup>

Statements were identified from one to twenty, being coded according to the service in which they were attended: PSUS (for pregnant women who performed prenatal care in public service) and PRI (for pregnant women who performed prenatal care in private/health insurance service), in order to maintain participant confidentiality. There was no refusal among study respondents.

This study followed the ethical recommendations of Resolution 466/2012 of the Brazilian National Health Commission, being approved by the Research Ethics Committee Involving Human Beings of *Universidade Estadual de Londrina* (REC/UEL) on October 9, 2017, under Opinion 2,323,783 and CAAE (*Certificado de Apresentação para Apreciação Ética* - Certificate of Presentation for Ethical Consideration) 78643417400005231. Participants were previously informed, through the Informed Consent Form, about the objectives and benefits of the research for health services, starting the interviews upon acceptance and signature of the term.

## Results

Based on the Social Representations Theory, analysis of the guidelines received during prenatal care, both in public and private health services, revealed that women received information directed to fetal health and well-being as well as identification of risk situations for

their babies, evidenced as emergencies that could lead to premature cesarean delivery and complications for the fetus. On the other hand, some statements revealed that the guidelines received did not meet the needs of pregnant women; thus, they looked for information on other sources on the internet.

Twenty postpartum women, twelve users of public health and eight from the private service participated in the study. Three participants attended prenatal care at the two health insurance services. Two completed prenatal care in private service and one woman performed all prenatal care in health insurance service, but delivery was performed in public service. These three mothers were considered to be private service users. Among the interviewees, seven women underwent prenatal care at the specialized service for high-risk pregnant women, and continued their follow-up in Primary Health Care. The rest were attended only by the Basic Health Unit, but were classified as high-risk pregnant women by the unit who followed them up.

The criteria for the high-risk prenatal care of the study participants were having chronic hypertension, gestational diabetes mellitus, hypothyroidism, premature labor, premature amniorrhexis, intrauterine growth retardation, oligodramnia, bariatric surgery and obesity. As for the way of delivery of the participants, seven were vaginal delivery, six of them from the public service and one from the private service and thirteen cesarean sections, six of which were from public health and seven from the private service. Demographic socioeconomic characterization occurred with women from 18 to 40 years of age. Thirteen had completed high school, ten had some kind of occupation and seventeen had a partner.

From the guiding question During prenatal care, did you receive guidance on your delivery?, It can be revealed that the central nucleus was configured in women health care and their empowerment in the pregnancy-puerperal cycle. Knowledge developed in the face of health guidelines for pregnant women resulted in the thematic category after statement analysis.

### Knowledge developed in the face of health guidelines for pregnant women

In this category, when women were asked about the guidelines received during prenatal care about the time of delivery, the responses revealed different aspects addressed by professionals, including risks for babies, delivery, and information on hospitalization. Some statements showed a lack of information that would supply the pregnant women's curiosity about how their birth would actually be. Differences were also noticed, determined by the system in which the pregnant women were attended, being a public and private health service.

During high-risk prenatal follow-up in public service, there were guidelines on the risks of the last month and how to proceed if signs or symptoms described in the prenatal appointment occur, such as increased blood pressure and the possibility of ligation, in surgical delivery case.

*Yes, at the high-risk clinic she said that she was going to be cesarean, due to the pressure, and that I had to do a tubal ligation [...]. If my pressure kept changing the way it changed all the time, then, in the last month, I could have pre-eclampsia. (PSUS2)*

Some women public service users were informed about routes of delivery, receiving guidance on the time of labor, the rate of contractions and pain. Prematurity and gestational diabetes were also addressed during appointments as possible complications that would prevent the vaginal delivery route.

*From the middle, more or less, prenatal care, from the fourth appointment we started talking about childbirth and he said that it is painful, he spoke more or less the time that the rhythm of contractions would last, it depended on the evolution that I it would have. He said that depending on whether I had gestational diabetes, my baby could be born prematurely. (PSUS17)*

The guidelines received by women who attended private service were similar to those received in public service regarding the justification for risk of prematurity, time of



hospitalization and routes of delivery. It was noted the concern of the health insurance professional to guide the woman about hospitalization bureaucratic procedures.

*I received guidance [...] he guided me, gave me all the paperwork [...] in case the water bag broke, I was not supposed to run out, because the baby could arrive at any time, and I was supposed to arrive here at hospital and tell the physician [...] I have health insurance and everything. He said that childbirth would be at such an hour and that hospitalization would be a little earlier [...]. As he always had a high percentage, he was always a child with size larger than expected, he said, "look it will hurt a lot". (PRI8)*

It was also noticed that the woman seen in the private service had the opportunity to visit the maternity hospital before delivery and choose the pediatric physician who would welcome the newborn. There was concern about breastfeeding in the first moment of life, favoring preventive measures for a possible premature birth.

*Yes, I did. The guidelines were as follows, for example [...], that my option for childbirth would be normal birth, but the physician made it clear that maybe there would be complications that would not be possible; that we couldn't focus only on normal delivery, so that when the time came, I didn't have that expectation, that frustration, that fear, so much so that when pre-eclampsia happened and I came to the hospital and I had to go through Caesarean. It was all so fast, and yet, he kept me calm, kept me safe, and he explained everything to me. I even met the maternity before giving birth. (PRI10)*

*We talked because I was concerned about the pediatrician's care, the question of the choice of the professional to follow, the issue of breastfeeding in the baby's first moment of life [...]. He always made it clear about the risk of prematurity, so much so that throughout the prenatal period, he adopted some preventive measures regarding the possibility of prematurity. (PRI20)*

Pelvic presentation, fetal distress, obstetric history of one or more cesarean surgeries and interpregnancy interval less than one year, were the reasons mentioned by women to justify the indication for operative delivery. Through the statements, it was evident that women accepted the indication of delivery without questioning or doubts.

*I received guidance [...] he said that, as I had already had a cesarean delivery, it was better that I have a cesarean delivery again, and this second pregnancy had an aggravation, he was sitting, so [...]. (PRI8)*

*She already said, in the beginning, that it would be cesarean, because I already have two cesareans, and the other is less than 1 year old. At the last, she just said, “we will already schedule your cesarean section” [...]. And that if I tried, it would be dangerous for me and the baby. (PSUS14)*

It was revealed in the statements of women that they did not receive sufficient and timely guidance on delivery, such as not knowing the way of delivery until the day before it.

*No, like that, we didn't know what it was going to be [...]. If it could be normal, or [...] as it was walking [...] yesterday even though it was decided [...]. That was going to be cesarean. (PRI1)*

*I never spoke of the birth itself; in fact, the last, penultimate appointment I had with my physician, we were going to talk about the delivery[...] but it just happened before, so it ended up being a cesarean section, but I always researched, always sought, always I took a look, like this [...]. I even told the physician that I wanted an explanation about the delivery, but she said that we would talk next time, and it turned out that [...] [laughs]. (PRI5)*

*They didn't say anything, no. I think because I already had others, then [...]. They just asked if we were okay, if we weren't bleeding, those routine questions that the physician talked about. (PSUS18)*

*During prenatal care, it was not mentioned, because at the last appointment I had with him, I asked if it was going to be cesarean or normal, he said he would expect normal because I already had one [...]. We*

*are curious and will search the internet, then I saw that there could be hemorrhage, there could be things and he could have spoken [...]. So, I searched for many things on the internet. (PSUS19)*

Lack of communication among professionals who assist prenatal care for maternal problems was marked in the statements above, where patients become spokespersons for their disease. Non-information caused the search for knowledge by own means through the internet, which was used to solve doubts and curiosities.

## **Discussion**

Faced with such interpretations, one can understand the potential that social representation has to create and transform reality, as it has the function of expressing the way individuals perceive and understand a certain object. Thus, it can be considered that social representation is a guide for action, as it guides actions and relationships between subjects participating in the same reality.

This study assessed the guidelines on the time of delivery in high-risk prenatal care at a maternity hospital in a philanthropic hospital in northern Paraná, unveiling gaps on this topic in this scenario. The findings point to a similar prenatal care of the public and private service, showing weaknesses and potentialities that encompass both health insurances.

In a national study on the adequacy of prenatal care conducted with public and private service patients, no differences were observed between them after adjustments in maternal characteristics; thus, the similarity of services was achieved for prenatal care adequacy.<sup>8</sup>

A survey carried out across the national territory, including pregnant women of habitual risk and high risk (25%) identified the deficiency of information during prenatal care regarding preparing women for childbirth, which prioritized guidelines on risk signs, thus intensifying the biomedical characteristic of maternal care.<sup>14</sup>

For the participants in this study, all classified as high-risk pregnant women, information about warning signs is important and should be mentioned throughout the prenatal period. This fact was justified by the fact that these women have a greater possibility of complications. It is noteworthy that when effectively guided, they can readily identify the risk signs and thus seek referral services more quickly.

Guidelines for the delivery time were revealed, with the possibility of vaginal or cesarean delivery, but information on the routes of delivery with indications, contraindications and risks inherent to each of them was not available. It is noticed that professionals influence them to choose cesarean surgery, mainly justified by the risks inherent in high-risk pregnancy.

A survey conducted in a municipality in Paraná, with results similar to the present study, observed a reality that for every four births, three were due to cesarean delivery; as for frequencies, 65.3% of cesarean sections were performed at SUS and 97.8% in supplementary health. Cesarean section is no longer a surgical procedure aimed at perinatal results and has become a consumer product. Rates are lower among women with less purchasing power and increase as financial resources are greater.<sup>15</sup>

Among the factors associated with vaginal and surgical delivery, it is evident that the chance of having a cesarean section triples among women who want this procedure; in the private service, the chances are 18 times higher for its performance. Among multiparous women, both for women with prenatal care in SUS and in private service, history of previous operative delivery increases the chance of having a new cesarean section by 11 times.<sup>16</sup>

In this same research, it was identified that women assisted in supplementary health have greater decision-making power regarding the possibility of choosing the professional and team that will provide the assistance as well as location and date of birth through elective cesarean section. The convenience in scheduling the birth of the child and avoiding labor pain

were the reasons mentioned as justification for the performance of the scheduled cesarean section.<sup>16</sup>

Fact also observed in a study in the municipality of Vale do Taquari, São Paulo, where it was verified that women with previous cesarean delivery, reported that the reason for choosing this way of delivery was due to medical indication. Women who chose vaginal delivery were influenced by family members (43%); however, physicians (31%) were the ones who contributed the most to the choice for cesarean delivery. It was also observed that women were not prepared for vaginal delivery because they did not receive information that would reduce their fears and were not informed about the complications of cesarean delivery for them and their babies.<sup>17</sup>

The results found in this study do not differ from those found in other studies<sup>15-16</sup>. Women are often convinced for cesarean delivery as the best option. The high-risk diagnosis cannot be decisive for the outcome of cesarean delivery. Professionals who conduct prenatal care should encourage openness to clarify women's doubts and concerns about the way of delivery at any time during prenatal care.

It was observed that the postponement of explanations about childbirth was present during prenatal appointments. Such fact can intensify women's doubts, in which they are not able to meet their uncertainties at the time of their need; this can make women use other means of information.

Guidelines on cesarean delivery were seen as a strategy to prevent fetal injuries. However, it can be inferred that this route is often prescribed even with stable health conditions for the woman and the fetus. It is important to rescue indications for cesarean delivery and the possibilities for vaginal delivery in high-risk pregnancies, so that it is an effective strategy for preventing diseases and not used routinely.

Contraindications for inducing labor in high-risk pregnancies and, consequently, indication for cesarean delivery are acute fetal distress; recurrent segmental scar (two or more);

urgent situations; anomalous fetal presentations; absolute cephalopelvic disproportion; placenta previa; presence of a previous corporal uterine incision; invasive cervical carcinoma; cord prolapse; active genital herpes; obstruction of the birth canal.<sup>1</sup>

Caesarean section, when properly indicated, reduces maternal and perinatal morbidity and mortality, but it should be noted that its risks are greater than vaginal delivery. Its indiscriminate practice, in addition to the consumption of health system resources, violates the exercise of women's sexual and reproductive rights.<sup>18</sup>

Non-encouragement to vaginal delivery is strongly observed in prenatal care, offered by the private service, since the follow-up is performed exclusively by the physician. Meanwhile, at SUS, in many municipalities, appointments are alternated between physician and nurse. It is important to break the social paradigm about cesarean section.<sup>16</sup>

A cohort study, which assessed the repercussions between pregnancy risk and type of delivery, concluded that caesarean section did not directly influence maternal outcome, but increased the chances of an unfavorable neonatal outcome.<sup>19</sup>

It is noteworthy the scarcity of material found on the association between risk pregnancy and delivery. It can be inferred that insufficient scientific evidence on the subject may impair the professionals' actions during follow-up and prenatal care. Information on the mode of delivery during high-risk pregnancy should be a considerable practice for improving maternal and neonatal care. Pregnancy is a favorable moment for breaking paradigms, by establishing the bond between professional, pregnant woman and family.

The present study revealed that when pregnant women do not feel sufficiently oriented about their doubts, they resort to other sources of information, such as using the internet to resolve their doubts. This is a tool used by pregnant women to clarify doubts, regarding the content sought, not targeting the woman's own health, but fetal health and well-being.<sup>20</sup>

The study participants sought information about the routes of delivery, to explain the reality that surrounded them during the gestational period in order to create social representations. The interpretation of reality provides social knowledge; however, for this process to happen during pregnancy, it is necessary to create spaces and explore its elaboration. Professionals who perform high-risk prenatal care, when they do not advise on the phenomenon of childbirth, generate impossibilities or difficulties for creating knowledge of daily life.

The pregnancy phenomenon can prevent women from perceiving themselves as beings who also need care, as much as babies, and imaging tests are recognized as substitutes for professional guidance. Professionals who follow high-risk prenatal care should include pregnant women for their own care, favoring women's understanding of the importance of their own health.

Thus, empowering high-risk pregnant women through prenatal care professionals is important for them to perceive themselves as essential people in the pregnancy process. Women should receive guidance on self-care, promotion and prevention of injuries, for their own well-being. Thus, the health service can encourage and guide as to appropriate care during their pregnancy.

Women's empowerment is initiated through educational actions, with the objective of developing attitudes, skills and self-knowledge so that women can assume decisions and responsibilities with their health. During prenatal care, labor, delivery and birth, it is possible for pregnant women to establish a power of decision about their delivery. These dimensions are related to the choice of the place where the baby will be born, the companion, the professional who should assist them, the non-invasive technologies of care applied to the process of gestating, giving birth and being born.<sup>21</sup>

In this regard, the birth plan is a resource that should be inserted to encourage pregnant women, which is still unknown by health professionals, hospitals and maternity hospitals, preventing its use from happening.<sup>22</sup> It is noteworthy that when pregnant women are attended to their individual needs, spaces for knowledge organized are created from the events of daily

life that occur according to the exploration of the psychosocial process, reflecting in the position of pregnant women regarding their own care and ease of communication with professionals.

Maternity hospital visit is an action that is still in the process of being implemented; however, if well implanted, it can bring greater security and comfort to women, for the opportunity to know the place where their children will be born. According to Law 11.634, of December 27, 2007, every pregnant woman assisted by SUS has the right to prior maternity knowledge and connection in which she will be delivered and where she will be attended in cases of pregnancy complications.<sup>23</sup>

It should be noted that guidelines received during prenatal care for delivery should be directed towards clarifying doubts, in addition to information relevant to pregnancy-puerperal cycle. Through Social Representations Theory, the needs for information on childbirth in high-risk prenatal care are identified and the possibility of enhancing the pregnant women's cognitive process, aiming at the elaborated knowledge.

Professional and pregnant woman bond provides subsidies for pregnancy to be a moment of construction of an educational process. Thus, knowledge about their health will be constructed at each visit, favoring more positive maternal-fetal outcomes and improving quality of care.

Performance in only one of the maternity hospitals in the city and with a group of women during the research period stands out as one of the limitations of this study; this restricts analysis of prenatal care offered in general, considering that there are quite different realities in health units, high-risk outpatient clinics and physician's offices. However, the results revealed important aspects for high-risk pregnancy care.

## Conclusion



When analyzing the perception of postpartum women who were followed up as high-risk pregnant women in public and private health in the light of Social Representations Theory, it was revealed that the guidelines received were directed to fetal health and well-being and identification of risk situations for babies, evidenced in emergencies that could result in premature cesarean delivery and complications to the fetus. There was a similarity in the orientations received in the two types of health services as well as a gap in the re-elaboration of the pregnant women's way of knowing about delivery. The essential guidelines for childbirth were not provided in the social group of high-risk pregnant women, resulting in the need to seek learning about the events of daily life.

The need is reinforced, in both health services, to improve educational activities, aiming at improving the quality of prenatal care for high-risk pregnant women; implement specific protocols that cover prenatal care in its entirety; seek to prepare women for hospitalization, for labor and delivery, regardless of the place where it is performed.

It is considered that including the social representations of puerperal women in assessing the guidelines received during appointment in high-risk prenatal care will be a way to adopt measures that ensure quality of care in the puerperal pregnancy cycle. It is suggested to carry out further studies on guidelines for high-risk prenatal care, with different methodological designs, seeking a better understanding, favoring improvements to prenatal care for pregnant women with high-risk diagnosis.

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Conception and planning of the research project, gathering, analysis and interpretation of data, writing and critical review.

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Analysis and interpretation of data, writing and critical review.

### **3 - Mariana Haddad Rodrigues**

Analysis and interpretation of data, writing and critical review.

### **4 - Rosângela Aparecida Pimenta Ferrari**

Writing and critical review.

### **5 - Deise Serafim**

Contributions: Writing and critical review.

### **6 - Alexandrina Aparecida Maciel Cardelli**

Conception and planning of the research project, analysis and interpretation of data, writing and critical review.

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