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Mothers' experience in following up their newborns: a phenomenological study

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ABSTRACT:

Objective: To apprehend on the mothers' experience regarding the follow-up of their children by the primary care service after discharge from the maternity hospital. **Methods:** A qualitative research using Alfred Schütz's Social Phenomenology framework. 23 mothers took part in an interview at their homes in *Regional de Saúde*, Paraná, Brazil, in 2018. **Results:** Four categories emerged from the analysis of the participants' testimonies. The "reasons why" pointed out three: Understanding about the Network and the care process at discharge from maternity; First postpartum week: Home care network for newborns; Neonatal period: Child follow-up in primary care. As for the "reasons for", one emerged: Expectations for child care in the Network. **Conclusion:** The Network in the municipalities under study does not offer systematic monitoring for child health in the neonatal period, referring to exposure to the greatest risk of harms due to the restricted promotion and prevention actions.

Descriptors: Neonate; Child Care; Primary Health Care; Evaluation of Health Programs and Projects.

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INTRODUCTION

For the world public policies on child health, the neonatal period is identified as one of the most vulnerable and, although the goals of reducing mortality among children under five have been achieved, in recent years in Brazil, mortality from perinatal disorders and neonatal remains with the highest indexes[1].

According to a report by the Word Health Organization (WHO), 2.6 million newborns worldwide die annually, being that approximately 80% of those deaths could be prevented with basic care even during pregnancy. Among the 184 countries, Brazil, classified in the upper middle-income group, was considered the 28th worst, like Mexico, with 7.8 neonatal deaths per thousand live births. In relation to the infant mortality rates, Brazil is ranked in the 108th worse position[1].

Perinatal mortality is an indicator related to the inadequacy of obstetric and neonatal care. After the delivery and discharge from the maternity ward, neonatal survival is directly related to the quality of the services offered in the health care network, from primary care to the most complex ones[2]. To this end, it involves efficient flows, and protocols based on scientific and professional evidence with adequate training for resolving care, as well as parents oriented to identify danger signs and seek the health unit urgently[3].

It is worth mentioning that the longer survival of the child is also related to better living and health conditions; therefore, actions to promote healthy environments with a focus on family, community, and society must be guaranteed in the agendas of the public policies, as well as a reorganization of the health system and greater investment in the Primary Health Care service for qualifying the care provided[2]. In this sense, the health system started to be organized in a network to offer continuous, comprehensive, efficient, safe, and equitable care, including health and economic responsibilities, in order to meet the goals and what is proposed in the Sustainable Development Goals by 2030, including ending preventable deaths of newborns and children under 5 years old[4,5].

The organization of maternal and child care in the country took place in 2011, through *Rede Cegonha* and, in the state of Paraná, in 2012, through the *Mãe Paranaense* Network, in compliance with the nationally established guidelines that also agreed on the link and the guarantee of access to specialized outpatient care and hospital care[6,7]. The *Mãe Paranaense* Network, object of this research, consists of different levels of care, from the lowest to the highest complexity and, according to each one, is referred, respectively, to as usual risk and high risk.

For this purpose, after five years of implementing this Network in the Regional Health Units in Paraná, the present study sought to apprehend the mothers' experience regarding the follow-up of their children by the primary care service, after discharge from the maternity hospital, in order to understand, in the users' perspective, if the guidelines are being met regarding the monitoring of the child in the neonatal period.

Understanding care from the perspective of users allows identifying potential and possible weaknesses of the Network, which can serve as subsidies as a management and decision-making tool, both by the professionals and

by the managers who compose it, and thus meet the real maternal-child needs[8,9,10].

METHOD

For this study, the qualitative approach was based on the theoretical-methodological framework of Social Phenomenology by Alfred Schütz[11]. Schütz's methodology allows us to extract the meanings of the life world, as well as the "reasons why", the lived experiences, and the "reasons for", the expectations reflected in the social action of mothers who use the Health Services Network from the pregnancy cycle to the puerperal period, the latter contemplated by the mother-baby dyad.

The participants were women living in four municipalities (M) of the 17th Health Regional (*Regional de Saúde,* RS): M1, M2 and M3 (medium size) with one maternity each for Usual Risk (*Risco Habitual*, RH) delivery, a reference for another 11 municipalities, and M4 (large) with two maternity hospitals, one for reference RH, located in a municipality, and a maternity hospital for High Risk (*Alto Risco*, AR) that serves the 21 cities of the Health Regional and neighboring states, as well as users of the primary care service.

In order to obtain the core elements of the phenomenon, 23 mothers were interviewed with audio media recording at their homes by prior appointment via telephone[11]. The collection period ranged from March to September 2018.

A script with semi-structured questions extracted from the matrix proposed by the Network was used to answer the following concerns: The reasons why: "Have you already heard about the *Mãe Paranaense* Network Program? Tell me what you know about (What is it for you?)"; "Upon discharge from the hospital, after the birth of your child, did you receive any guidance on which health service to seek for continuing the child care? Comment"; "You received a visit from the health team in the first week of your child's life. Tell me about that visit"; "After being discharged from the maternity hospital, tell me about your follow-up and the baby at the health service in the first month after delivery". The reasons for: "What do you expect from the services, the public policies and programs aimed at caring for your baby?"; "What do you expect from your municipality/regional/state (politicians) regarding the care for your baby?"; "Would you like to talk about something that was not covered in this second stage of the interview?"

The mean interview time was 50 minutes, considering the interaction between the researcher and the participant. The testimonies were closed up by the convergence of the "reasons why" and the "reasons for", making it possible to create the type experienced in child care after implementing the Network[11].

For the analysis, the material was fully transcribed and then checked and organized by two researchers, following the six steps elaborated by theorists of Alfred Schütz's Social Phenomenology: attentive and careful reading of each statement to identify and understand the global meaning of social action; individual re-reading of the testimonies to identify common aspects that express the contents related to the "reasons why" and the "reasons for"; grouping the convergences of the testimonies to extract the concrete categories; analysis of the concrete categories to understand social action; from the set of

"reasons why" and "reasons for", the type experienced expressed in the concrete categories and discussed in the light of Social Phenomenology and of other referentials relevant to the object of study was constituted[12].

The identification of the participants was established by the letter M (Mother) followed by an Arabic number (nº) in the order of the statements, risk classification (RH and AR) and municipality size (M1, M2 and M3 – Medium Size; and M4 – Large), being indicated, for example: Mnº RH - M1 or M2 or M3 or M4 or Mnº AR - M4.

The research was authorized by the Health Secretariat of the State of Paraná, the Regional Health Board, and the Maternity Boards of each municipality, as well as approved by the Ethics Committee for Research with Human Beings of the State University of Londrina, CAAE: 67574517.1/1001.5231.

RESULTS

The interviewed mothers who use the health care network from prenatal care, delivery and up to follow-up of the child in the postpartum period were: 23 women, of whom 14 are classified as High Risk and 9, as Usual Risk. The age range varied between 15 and 37 years old, with more than half having attended high school, most lived with a partner, thirteen were primiparous, and ten multiparous. Regarding the type of delivery, 12 underwent normal delivery and 11, cesarean sections.

The typification of the interviewed mothers allowed organizing and analyzing the meanings of the speeches by extracting four categories that express the experience of discharge from maternity and follow-up of the newborn by the Primary Health Care service. Three categories emerged from the "reasons why": Understanding about the Network and the care process at discharge from maternity; First postpartum week: Home care network for newborns; Neonatal period: Child follow-up in primary care. As for the "reasons for why", one category emerged: Expectations for child care in the Network.

I. Understanding about the Network and the care process at discharge from maternity

This category points out the mothers' understanding of the *Mãe Paranaense* Network, as well as the counter-referral carried out by maternity professionals, both of Usual Risk and of High Risk, for the monitoring of the newborn in the primary health care service. It also deals with the guidelines provided by these professionals to the mothers regarding the continuity of care for their child.

It was learned from the speeches that little has been oriented in the health services about the Network. Two aspects are perceived: one, from the mothers who have never heard about the program and another, from those who have heard, but know little about it, as they only associate it with High Risk pregnancy and child monitoring.

> [...] So for me, what they said was that it would be for mothers who would only have a high risk of pregnancy, they would be referred. If it weren't for the high risk of pregnancy, I wouldn't be framed in the profile of the Mãe Paranaense [...] So that's how it is, the gynecologist evaluates you [...] then, for example, if you have something of high risk, such as diabetes, high blood pressure, some

> disease during pregnancy, then they send to the Mãe Paranaense, other than that [...] (M1 AR-M3).

> [...] I had already seen something on a placard at a health center, even in the booklets [...] It is about accompanying the mothers [...] from prenatal care [...] to a certain age of the child [...] (M7 RH-M3).

> [..] I heard about it at the hospital [...] they said it is for us to know more about the children [...] how to take care [...]. That's all I know [...] (M10 AR-M4).

> [...] Never heard about it [...] (M18 RH-M4).

In the women's speeches, it was apprehended that all the professionals from both types of maternity hospitals (RH and AR) make a counter-referral to the primary care service. However, there are differences in the way to convey the guidelines for discharge regarding the continuity of child care in the health unit. The ways to guide the professionals in AR maternity hospitals were through oral and written communication. In the case of RH maternity hospitals, guidance was provided only through written communication so that the mother could read the document provided at discharge.

> [...] they told me to take it to the health center being closest to my home [...] then they said: in any doubt you may read the paper, everything is said there, you just have to read [...] it was a lot of paper [...] (M6 AR-M3).

> [...] the woman gave me a notebook and said it was for the next exams and consultations [...] go to the clinic where everything was in paper [...] (M3 RH-M3).

> [...] I received guidelines, I don't remember which ones, there were many, I just remember that I had to [...] take her to the basic health unit. (M22-AR-M2).

As for the guidelines provided by the maternity professionals to the mothers, the speeches reveal that they were those related to scheduling the appointment with a physician or nurse and vaccination, especially BCG.

> [...] He said that she will have a follow-up until the sixth month that would be childcare, and that the doctor usually does it [...] or the nurse [...] they asked me to keep the vaccine up to date [...] (M1 AR-M3).

> They told me to look for the clinic where I had done the prenatal care [...] I would have to go there to do childcare and the first BCG vaccine [...] (M8 AR-M3).

> [...] He advised that the vaccinations and consultations were in the basic health unit (M13 RH-M4).

In the speeches of the mothers who delivered in an AR maternity, guidance on neonatal tests occurred both upon discharge and upon the baby's return at the maternity hospital after discharge; however, in RH maternities, they left with an appointment for some neonatal screening exams and an appointment

with a pediatrician. As for the "ear test" with change, they were referred to the service itself for the return and, later, indicated for follow-up in primary care.

> Yes, they indicated the heart test and consultation at 1 month after birth (M23 AR-M1).

> [...] She did all the exams, then the ear exam changed, I had to go back after three days to do it again, then they said I had to take all the papers to the clinic, to make her card [...] (M17 RH-M4).

Upon discharge, breastfeeding is guided by RH and AR maternity professionals, both in the general aspect and at the impossibility of breastfeeding the baby.

> [...] as she had no symptoms of anything, nor jaundice [...] what they talked about a lot was about breastfeeding, they explained it right to us [...] They called asking how the adaptation was (M16 RH-M4).

> [...] They taught the Heimlich maneuver, tried again to force breastfeeding, but it didn't work, then they passed a formula [...] they said to take the baby straight to the clinic [...] (M20 AR-M2).

II. First postpartum week: Home care network for newborns

In this category, it was possible to learn how the newborn's care was provided by the team of Basic Health Units in the municipalities in the first week of life, as well as home visits on the 5th day of life and the approach of the professionals.

The home visit was carried out in the medium and large municipalities by the health team in the first week of the newborn's life and, according to the maternal speeches, the professionals made a complete consultation identifying the environment, examined the baby, guided on hygiene and breastfeeding care and on danger signs, and checked the Children's Card, as well as scheduled the next appointments at the unit.

> The Community Health Agent and the nurse came. So, they came here, looked at the baby's room, and observed the hygiene conditions of the house. The nurse said: [...] keep the house clean [...] they taught me to bathe the baby, and then asked me to bathe the baby in front of them [...] they also asked me to see how I was breastfeeding, so I showed them [...] they looked at the baby's card. [...] In fact, I didn't even leave the house to make an appointment with a doctor, they even brought a medical appointment [...] with the pediatrician, the first consultation [...] (M1 AR-M3).

> The day I was discharged I got home, and they already came [...] they saw the card, and already made an appointment with the pediatrician [...] and they asked about the delivery [...] they advised if I needed help to breastfeed, they had a center for this and gave a little paper [...] (M4 RH-M3).

In the speeches of the mothers from a large municipality, transcribed below, it is verified

that the home visit was carried out; however, the consultation was not carried out, only a general assessment. In addition, the mothers were instructed to attend the unit to perform childcare.

> [...] three girls came, the "chief" nurse and another two nurses [...] She came to see if everything was fine with the baby and told me to come to the clinic to give her an injection [...] (M12 AR-M4).

> I arrived home one day, then two, three days later [...] the nurse at the clinic came [...] they asked for the card [...] he advised me to take him to do the childcare because as he was born underweight, he was classified as high risk [...] he said that for at least 15 to 20 days, the baby should be going to the clinic, because he was born very premature [...] they said to sunbathe him [...] (M10 AR-M4).

It is also observed in the speeches of the mothers from medium and large municipalities that those who received home visits were only by the CHA, to be called to take their child for vaccination or to seek care at the health unit. But, even though some women were classified as high-risk pregnancies and, consequently, their children should be assessed as such, at no time did they receive home visits from the professionals in the basic units.

> [...] No, not yet. I only got a call this time ago, I think my daughter should be some three months old [...] (M3 RH-M3).

> None [...] My daughter is seven months old and never [...] no one from the clinic came by and didn't even call [...] (M2 AR-M3).

> No, they only came here once [...] because of his vaccine, and because I was not taking him to the childcare [...] they asked me to take the baby to the clinic [...] He was already three months old or so [...] (M6 AR-M3).

III. Neonatal period: Child follow-up in primary care.

This category refers to the care of the neonate by the professionals from the health units and it was apprehended that there is no uniformity in the monitoring of the child considering the risk classification.

The mothers' speeches also point out that the baby's first consultation performed by the pediatrician at the basic health unit was complete both in terms of physical examination and guidelines. There was also the report of baby care at the Hospital, being, in this case, described by the mother as better when compared to the BHU. Even though the classification was high risk, it was extracted that the child was seen only once and that there were no subsequent consultations to monitor growth and development, but the mother used the service to keep the vaccination schedule up to date.

> At the clinic [...] I had an appointment with the pediatrician, then he had no more [...] I only took him there for vaccines and to weigh him [...] at the first consultation the pediatrician looked at everything [...] then he asked if I was breastfeeding

> and said that the weight was good [...] (M9 AR-M4).

> [...] In the first month it was good, they measured everything right, but at the hospital it was better, because he went there too; but at the clinic, the pediatrician is not very good [...] he doesn't weigh, doesn't measure, you have to keep asking, it's complicated, I'm already doing it privately (M15 AR-M4).

In other health units, the consultation was interspersed between physician and nurse, both for high risk and for usual risk, totaling two consultations in the first month of the baby's life. Subsequent appointments were also scheduled.

> The baby went through the consultation with the pediatrician. He did a thorough examination and said that everything was fine; then he already said that he would have to start monitoring in the childcare, advised on vaccine, and asked if the baby was breastfeeding [...] The pediatrician and the nurses also spoke about the sunbathing issue. He asked if I was having difficulty breastfeeding and I said no, that it was smooth [...] (M2 AR-M3).

> The baby had two appointments, one childcare and one with the nurse [...] they weighed, saw if the baby was growing right [...] I already left the clinic with the next appointment rescheduled (M4 RH-M3).

The consultation made by the nurse was pointed out by the mothers as complete, the physical examination and the guidelines, as well as the care by the nutritionist.

> I went to the health clinic once and was taken care by the nurse. He is very good. [...] he looked if the baby was a little yellow [...] he weighed the baby [...] said that everything was fine [...] but the baby never went to the doctor [...] (M6 AR-M3).

> [...] saw if everything was right [...] measured the baby, weighed the baby without clothes to know if she is at the ideal weight, then the nutritionist answered doubts about feeding for those who have the youngest baby, how to breastfeed [...] it is more to clarify doubts, we ask and she answers (M19 RH-M4).

IV. Maternal expectations for child care in the Network

The category refers to the "reasons for" and reveals what women expect in terms of baby care. In the speeches, we perceived that their expectation is to increase the number of pediatricians in the health units to monitor the newborn.

> [...] more pediatricians, that we many times go to places and there is no pediatrician (M17 RH-M4).

> [...] I hope that [...] there is more follow-up by the pediatrician, which is very little [...] it's more by the nurse [...] the pediatrician has to follow-up more than the nurse [...] (M10 AR-M4).

> [...] there has to be more pediatricians, because there is only one, then

> there is no way to appoint directly (M14 AR-M4).
>
> [...] Here at the clinic, there had to be more pediatricians, because there is only one, then there is no way to appoint directly and just [...] (M20 AR-M4).

Another point considered important by the mothers is that the professionals of the health units carry out home visits, make an active search, and provide guidance on baby care, especially for women who experience their first maternity.

> [...] needing more attention, more conversation [...] mainly with first--time mothers [...] (M5 RH-M3).
>
> […] more attention, communication and conversation [...] that the professionals go to the houses to ask what's going on [...] (M6 AR-M3).
>
> [...] always guide as much as possible, especially if you are a first-time mother who doesn't know much and probably has an aunt, grandmother, neighbor who will give you a lot of information and sometimes it's not right (M8 AR-M3).
>
> [...] Ah, as a first-time mother, they should come over here at home to visit [...] I hope that there may be more professionals [...] and that they may talk better with the mothers [...] (M21 AR-M2).

The expectation of the participants is that the services also have a nutritionist and group activities to approach breastfeeding.

> [...] that there may be nutritional monitoring [...] monitoring to see if parents are vaccinating their children [...] that they really go after [...] because there are some mothers who don't care (M19 RH-M4).
>
> [...] that there may be groups to explain breastfeeding (M2 AR-M3).

DISCUSSION

Women did not know about the *Mãe Paranaense* Network Program, which leads to the belief that the primary care professionals in medium and large municipalities have not been working on the theme with pregnant women during their prenatal care. This data is related to another research that found that pregnant women were unaware of the Network[13]. This fact shows that the mothers do not have access to information about their rights as recommended by the Network's guidelines.

According to the *Mãe Paranaense* Network Program Guide, the hospitals are responsible for guiding and directing the puerperal woman and the newborn to primary health care after discharge, that is, for the "First Week of Comprehensive Health", ensuring care continuity. This process is extremely important since it helps in monitoring the child[14] and, therefore, to detect and reduce any harms in the neonatal period. The researchers found that the guidelines were not carried out in full in the public hospitals[15]. The opposite occurred in this research, through which it can be seen that practically all the hospitals directed women to PHC; however, what stood out were the different forms of guidance of the professionals between the High Risk and Usual Risk hospitals.

Even if there is a counter-referral, it is clear that there is still a gap to be faced in this process because, in addition to being superficial, there is no uniformity in the transmitted guidelines. This gap expresses the experiences lived by the women since the baby's first week of life, a social action reflected in the inter-subjectivity that can only be understood through externalized actions, which constitute the basis of communication and of social relationships[11,16,17].

The PRMP guideline sets up the consultation or home visit until the fifth day after the birth, in order to reduce neonatal and puerperal harms[7]. However, a study identified that both in medium and large municipalities this action has been little performed, a fact related to another research that showed that not all the professionals visit at the recommended time[18].

It is noteworthy that the visit provides greater contact between the team and the mother-baby dyad for orientations aimed at individual and family needs, in order to stimulate and manage breastfeeding, update the vaccination calendar, schedule consultations, and guide hygiene care.

The first consultation of the newborn should preferably take place in the first week of life, as it is an appropriate time to stimulate and assist the family in the difficulties of exclusive breastfeeding, guide and perform immunizations, and verify the performance of neonatal screening to establish or reinforce the family support network[6].

In this study, what could be learned is that the monitoring of the child in the first month of life is taking place, but not always in the period stipulated by the ministerial and Network regulations. It is also clear that the main focus of this monitoring is the physical examination of the babies, while guidance on breastfeeding, disengagement maneuver, hygiene care, and care with the umbilical stump are insufficient.

One of the fundamental actions in the child's consultation is encouraging exclusive breastfeeding, but the testimonies showed few guidelines, differently from what was evidenced in another research[19].

The mothers' expectations revolve around having more physicians to accompany their child in the primary care service, but they also expect health care quality from the Network's professionals. These mothers have interests that are their own and that motivate and direct them to seek care in the health sectors[11,17]. Therefore, they expect that, during the neonatal and puerperal cycle, the health professionals provide comprehensive and equitable assistance in the different aspects, including in relation to the concept, in compliance with the ministerial objectives and guidelines of the networks/programs.

CONCLUSION

It was learned how the mothers interact with the Care Network for their children and express experiences that do not match what is recommended in the programmatic guidelines. Even though baby care has improved, still their needs are not fully met and, as their children do not receive adequate care according to the Network, the mothers' expectations revolve around increasing the number of physicians as a possibility for improving the service.

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