ORIGINAL ARTICLE

REVISTA ENFERMAGEM ATUAL IN DERME

THERAPEUTIC ITINERARY AND HEALTH CARE NETWORK FOR HIGH-RISK PREGNANT WOMEN IN THE AMAZON

ITINERARIO TERAPÉUTICO Y RED DE ATENCIÓN EN SALUD A MUJERES EMBARAZADAS DE ALTO RIESGO EN LA AMAZONÍA

ITINERÁRIO TERAPÊUTICO E DA REDE DE ATENÇÃO À SAÚDE DE GESTANTES DE ALTO RISCO NA AMAZÔNIA

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ABSTRACT
Objective: to analyze the Therapeutic Itinerary (TI) and the health care network from the perspective of high-risk pregnant women from the interior of the state of Amapá and from riverside areas treated at the maternity ward and referral clinic in the capital. **Method**: descriptive study with a qualitative approach, guided by the Coreq checklist. Semi-structured interviews were conducted with 12 high-risk pregnant women from the interior of the state and riverside areas. Data analysis was conducted with the help of the Iramuteq software, followed by Content Analysis. **Results**: two categories emerged: 1) therapeutic itineraries of pregnant women from riverside areas and interior areas, which describe the understanding and discovery of the condition of high-risk pregnancy, the paths taken from the discovery and their access to health services; 2) health care networks in the state from the perspective of the participants, who, in turn, highlight difficulties and desires for changes, such as availability of tests and medications, in addition to humanization and communication on the part of the professionals. **Final Considerations**: it was possible to get to know the ITs and realize that the reference public health services in the state are still very incipient to meet the real needs.
Keywords: Prenatal Care; High-Risk Pregnancy; Therapeutic Itinerary; Health of the Rural Population.

RESUMEN
Objetivo: Analizar el Itinerario Terapéutico (IT) y la red de atención médica desde la perspectiva de mujeres embarazadas de alto riesgo del interior del estado de Amapá y de zonas ribereñas, atendidas en la maternidad y la clínica de referencia de la capital. **Método:** Estudio descriptivo con enfoque cualitativo, guiado por la lista de verificación Coreq. Se realizaron entrevistas semiestructuradas a 12 mujeres embarazadas de alto riesgo del interior del estado y zonas ribereñas. El análisis de datos se realizó con el software Iramuteq, seguido de un análisis de contenido. **Resultados:** Se identificaron dos categorías: 1) Itinerarios terapéuticos de mujeres embarazadas de zonas ribereñas y del interior, que describen la comprensión y el descubrimiento de la condición de embarazo de alto riesgo, los caminos recorridos a partir de este descubrimiento y su acceso a los servicios de salud; 2) Redes de atención médica en el estado desde la perspectiva de las participantes, quienes, a su vez, destacan dificultades y deseos de cambio, como la disponibilidad de pruebas y medicamentos, además de la humanización y la comunicación por parte de los profesionales. **Consideraciones finales:** Se pudo conocer las TI y constatar que los servicios de salud pública de referencia en el estado aún son muy incipientes para atender las necesidades reales.
Palabras clave: Atención Prenatal; Embarazo de Alto Riesgo; Itinerario Terapéutico; Salud de la Población Rural.

RESUMO
Objetivo: analisar o Itinerário Terapêutico (IT) e a rede de atenção à saúde sob a ótica de gestantes de alto risco provenientes do interior do estado do Amapá e de áreas ribeirinhas atendidas na maternidade e no ambulatório de referência na capital. **Método:** estudo descritivo de abordagem qualitativa, norteado pelo *checklist* Coreq. Foram realizadas entrevistas semiestruturadas com 12 gestantes de alto risco oriundas do interior do estado e ribeirinhas. A análise dos dados foi conduzida com auxílio do *software* Iramuteq, seguida pela Análise de Conteúdo. **Resultados:** emergiram duas categorias: 1) itinerários terapêuticos de gestantes ribeirinhas e dos interiores, que descrevem o entendimento e a descoberta da condição de gestante de alto risco, os percursos trilhados a partir da descoberta e o seu acesso aos serviços de saúde; 2) redes de atenção à saúde no estado sob a ótica das participantes, que, por sua vez, evidenciam dificuldades e anseios por mudanças, como disponibilidade de exames e medicamentos, além de humanização e comunicação por parte dos profissionais. **Considerações Finais:** foi possível conhecer os ITs e perceber que os serviços públicos de saúde de referência do estado ainda são muito incipientes para o atendimento das reais necessidades.
Palavras-chave: Cuidado Pré-Natal; Gravidez de Alto Risco; Itinerário Terapêutico; Saúde da População Rural.

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INTRODUCTION

Pregnancy is a period of changes, adaptations and risks associated with the development of the fetus, and is a unique moment for the woman and her family. In view of this, prenatal care is an important tool in promoting and protecting the health of both the pregnant woman and the fetus, from the beginning of pregnancy, enabling prevention, screening, early intervention and treatment of risks and complications related to the pregnancy and childbirth cycle, since these are among the main causes of maternal mortality[1].

Although prenatal care is widely available in Brazil, its quality is still not considered satisfactory, given that access is not adequate in health services at all levels of care. It is worth noting that quality prenatal care offered during pregnancy and extended care during childbirth and the postpartum period contribute to reducing maternal mortality[2].

In view of this, women living in riverside communities and in the interior of the state with High-Risk Pregnancy (HRG) stand out, as they have different needs and difficulties (if not more complex) than those living in urban areas. Pregnant women living in riverside communities face obstacles in high-risk prenatal care, especially with regard to accessibility to health services, which can be influenced by several factors, such as: local availability of services, geographic and regional, socioeconomic and cultural barriers[3].

Considered among the "Forest Populations", riverside communities are made up of several family groups that live in wooden houses adapted to the flood and ebb systems of the rivers, commonly stilt houses, since they mostly live on the banks of rivers, lakes, creeks and swamps. Therefore, these communities are often isolated or considerably distant from the capitals, in addition to having little or restricted access to health and communication media[3].

Although there is a health network and policy that advocates adequate care for both prenatal care and for riverside and inland populations, such as the Rede Cegonha (RC) and the National Policy for Comprehensive Health of Rural, Forest and Water Populations (PNSIPCFA), its difficulties persist. The RC is configured as a component of the Health Care Networks (RAS), as the RC has expanded investments to improve care during labor and birth. It emerged in 2011 in the Unified Health System (SUS), to guarantee humanized care in prenatal care, childbirth, postpartum and child care[4]. Regarding the health of the Rural, Forest and Water Populations (PCFA), the federal government, with the aim of improving the health level of these populations, through actions and initiatives that aimed at access to health services, reducing health risks and improving health and quality of life indicators, instituted by Ordinance No. 2,866, of December 2, 2011, the National Policy for Comprehensive Health of Rural and Forest Populations (PNSIPCF)[5]. In order to care for pregnant women from riverside areas, there is a need to align health service

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strategies so that the principles advocated by the SUS can be ensured, especially comprehensive care. From this perspective, the RAS will be successful if the services offered that are responsible for the health of this population, together with health policies, form a dialectical relationship.

In this context, the means accessed by these pregnant women to treat and monitor their high-risk pregnancies may also differ from others, that is, their Therapeutic Itinerary (TI) will be traced based on their particularities. The TI comprises the path that the individual or community takes to resolve certain signs and symptoms of illness until their diagnostic outcome. This path encompasses the most diverse alternatives chosen by the individual, involving their symbolic, social and cultural aspects[6].

Furthermore, the study is justified by the literature, which shows that, worldwide, 95% of maternal deaths could be avoided if the provision of public and private health services were expanded, taking women's sexual and reproductive rights as a reference, ensuring respectful care for pregnancy and postpartum health[7].

In view of the problem presented, the following question arises: “What is the Therapeutic Itinerary followed by pregnant women living in riverside areas and in the interior of the state with indications for high-risk prenatal care?” In this sense, this study aimed to analyze the Therapeutic Itinerary and the health care network from the perspective of high-risk pregnant women from riverside areas and in the interior of the state of Amapá treated at the maternity ward and the reference outpatient clinic in the capital.

METHODS

This is a descriptive study with a qualitative approach using the semi-structured interview technique, conducted according to the Consolidated Criteria for Reporting Qualitative Research (Coreq)[8]. The sample consisted of 12 pregnant women aged between 20 and 45 years and with a gestational age between 17 and 38 weeks. The inclusion criteria were: pregnant women classified as high risk; living in the interior of Amapá or in riverside areas of the state or in nearby municipalities of the state of Pará (Breves, Afuá and Chaves); over 18 years of age and literate; agreement to participate in the interview and sign the Informed Consent Form (ICF), approved by the Ethics Committee of the Federal University of Amapá (Unifap/Macapá-AP) according to Opinion no. 3621991.

Data collection took place in 2019, at the state's reference maternity hospital and at the outpatient referral center for high-risk pregnancies in the state of Amapá. The semi-structured interview technique was used based on a semi-structured form with closed and open questions, with the closed questions related to the characterization of the pregnant women's profile based on sociodemographic, economic,

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gynecological and obstetric data, and the open questions addressed: the pregnant woman's understanding of GAR, her behavior upon discovering her condition as a high-risk pregnant woman, the existence (or not) of difficulties in high-risk prenatal care and the need (or not) for changes in the existing RAS in the state aimed at the condition of these women.

Throughout the interview, the researchers allowed free speech and, simultaneously, the outline of the conversation, seeking to keep the interview in tune with the research objectives. The approach initially involved an informal conversation with the pregnant woman in order to obtain truthful and complete answers, observing verbal and non-verbal communication. The interviewees' reports were recorded on a digital device and, to determine the number of participants, the saturation method was used, that is, when the answers begin to repeat themselves and become common, without presenting any new elements related to the questions on the form[9].

In the semi-structured form, four open questions were used to guide the interviews: 1) What do you know about pregnancies that require more care, which we call high-risk pregnancies? 2) What did/do you do when you discovered your high-risk pregnancy? 3) Did you have/do you have difficulties in following up on your high-risk prenatal care? Please comment; 4) Do you think something needs to change in the system of care for high-risk pregnancies? Please comment.

To support the analysis of the data in this research, the software Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires (Iramuteq) was used, which seeks to obtain classes formed by words that are associated with these classes. The interpretation of the data is supported by content analysis, which must have an organization as its starting point, and the different phases of the content analysis are organized around three poles: pre-analysis; exploration of the material; and treatment of the results: inference and interpretation through categorization[10].

This analysis indicated a convergence of empirical characteristics around five themes: a) high-risk pregnancy: understanding and discovery; b) path; c) access to health services; d) difficulties; e) desire for change. And, the themes, addressed in two categories: 1) Therapeutic Itineraries of pregnant women from riverside communities and from the interior of the state; and, 2) Health Care Networks in the state from the perspective of the participants.

RESULTS AND DISCUSSION

There was a predominance of pregnant women aged between 20 and 25 years (50%), brown skinned (91.7%), from Afuá (25%) and Ferreira Gomes (25%), with incomplete elementary education (75%), in a stable union (83.4%), living in wooden houses (66.7%), where between six and ten people live (66.7%), and whose main source of income comes from the Bolsa Família Social Benefit Program (75%).

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The sociodemographic and economic characterization data found in this study corroborate data from other studies with high-risk pregnant women, in which young women aged between 18 and 30 years – the ideal age range for reproduction –, brown skinned, with low education and no fixed income prevailed[1,11-13].

Correlating with the other data, such as education level and main source of income, it can be seen that these women have a greater relationship with rates of low education and lack of paid work. Studies show that the pilgrimage between health services is most commonly suffered by brown and black women, followed by white women with low levels of education. The problem of racial inequalities in the context of health is highlighted, characterized as a public health problem that is not restricted to Brazil, but that also affects several countries, especially with regard to biological differences, social disparities and ethnic discrimination[14].

However, the data from this research related to the level of education of pregnant women show that 75% of them have only incomplete elementary education, which constitutes a divergence when compared to other studies with high-risk pregnant women[12]. The divergence may be related to the different origins of the participants in this research, including pregnant women from the interior of Amapá and riverside areas, who find themselves in contexts with several difficulties, such as precarious access to public policies in the areas of education and health[5].

Regarding marital status, the data show that approximately 83.4% of participants were in a stable union, which is reinforced by other studies, which also showed the predominance of pregnant women with this same marital status. This characteristic is highlighted as one of the risk factors because, while the presence of a partner can offer emotional and financial support, on the other hand, situations of conflict or violence in the relationship can increase stress levels and negatively impact the well-being of the woman and the baby[12,15].

As for the gynecological and obstetric profile, there was a predominance of women with a gestational age between 30 and 41 weeks (66.7%), who received prenatal care in their locality (91.7%), with a history of one to five pregnancies - previous and current (41.7%), as well as births, in which 50% of them adopted natural childbirth (normal birth), performed in a hospital (50%); Furthermore, most pregnant women had not carried out sexual and reproductive planning (58.4%). These data are similar to those of other studies, such as the number of pregnancies, both previous and current, in which multigravidae pregnant women represented the majority[16]. Regarding the current time of pregnancy (at the time of the interviews), approximately 66.7% of pregnant women were between the 30th and 36th week of pregnancy.

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Also, approximately 66.7% of the study participants were in their second pregnancy at least. In this context, excluding first-time mothers, the data on the occurrence of complications in previous pregnancies remained balanced at 50% for both positive and negative responses, representing important numbers in the face of a risk condition. Similar results were noted in other findings of women with complications in previous pregnancies[12]. These data are significant, since they alert to the recurrence of RAG. Regarding previous pregnancies, 50% of the pregnant women reported a physiological birth.

With regard to the performance of previous Sexual and Reproductive Health Planning (SRH), the data again agree with data presented by other authors, since approximately 58.4% of the pregnant women had not previously performed SRH monitoring, in line with the results of another study[16]. These data can be compared to the number of pregnancies of the participants in this study, which range from 1 to 11 pregnancies; however, they are concentrated between 4 and 11 pregnancies (50%), which may mean obstacles such as difficulties in accessing them and lack of adequate guidance.

In the first category entitled "Therapeutic Itineraries of pregnant women from riverside communities and the interior of the state", the TIs are defined as the experiences of an individual in search of a solution to their health problem, that is, the path taken by a person through their choices to produce care from the most varied health services (and practices) to obtain assistance, treatment and cure for diseases and injuries. TIs begin with the diagnosis of the health problem, including the first symptoms, interventions sought and adopted until their resolution. Thus, TIs are studied with the aim of knowing and understanding these movements and resources accessed by these people[17,18].

The study and design of the TI is necessary for prenatal care, especially for GAR, which requires more care, as well as a greater number of consultations, whether in UBS or at more complex levels of the health system, in addition to exams to be performed, treatments, among others. Regarding the target audience of this research, the importance of identifying TIs is highlighted, essentially because they are vulnerable groups. Regarding the TIs outlined by the participants of this study, they will be addressed in the following aspects: understanding and discovery of the GAR condition, the paths taken from the discovery and their access to health services.

It was possible to notice that many participants had an idea about the meaning of GAR, however they were unaware of its causes, just as there were pregnant women who were confused about the concept of GAR. Such situations can be evidenced in the following reports:

> I had already heard about it, it's a risky pregnancy, right? I'm here

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> because of a urinary tract infection, just this infection. I didn't know it was serious (G1).

> Regarding high-risk pregnancy, what I understand from the name is “high risk”. So, both the mother and the baby are at risk, and it's a case for medical specialists, because the baby and the mother are at serious risk, even losing the baby (G3).

> To tell the truth, I have no idea what a risk is, but the difficulties we face, we think it's a risk, sometimes it becomes an even greater risk. I believe it's a risk for both, the child and the mother (G10).

Studies indicate that pregnant women's understanding of pregnancy and prenatal care, as well as their health status and the complications they are subject to, is little investigated, which is worrying, since weaknesses in the knowledge of high-risk pregnant women regarding their own conditions can be perceived. The data are corroborated by another study in which the participants had difficulty in translating the problem, its implications and alternatives for resolution, which reveals flaws in the guidance provided during prenatal care[19,20].

In this sense, the authors emphasize the need to intensify health education among pregnant women, in order to provide better assimilation and exchange of adequate knowledge about pregnancy, prenatal care and their health conditions, contributing to the promotion of self-care, active participation throughout the pregnancy-puerperal cycle, prevention of injuries, in addition to enabling the dissemination of this knowledge[21].

Regarding the discovery of the GAR condition by the participants, it was possible to identify that several pregnant women already imagined their condition based on close experiences (their own or not) and others discovered it due to the symptoms presented. In addition, they reported feelings related to their condition, such as fear, worry and despair. Regarding the discovery, the following reports can be observed:

> In fact, I thought I was high risk because I had seen my sister who had gotten pregnant. She is diabetic and was placed on the high risk list, and I thought mine was high risk too. I already knew I had diabetes; I found out when I was 9 years old, but I didn't have it under control properly. So I was only worried at first, but deep down, I already accepted it. I knew I was high risk. So it wasn't a shock to me (G3).

> I had a problem with swelling, so I went to three doctors, they gave me medicine, but it didn't work, so they told me to come to Macapá, because it would be better. I arrived and I'm being treated (G7).

Regarding thoughts and feelings upon discovering the GAR condition, these are evidenced in the following reports:

> When I found out I was pregnant at high risk, I was scared, mainly because it's not good for me or the baby. Then they [professionals] don't know if they're going to take my baby out early or not, so I'm scared (G6).

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> I just wanted to cry, because I knew it was going to be difficult, and then I started to worry because I have a 1-year-and-10-month-old baby and I'm immediately worried about her (G9).

> Until the morning, I wasn't feeling anything, but now that I'm sure I'm going to be here in the capital for a few more days, I'm starting to feel desperate, because we don't know what's going to happen from now on. I'm worried, because what am I doing here?! Because, every now and then, I have cramps, I'm not getting enough fluids and they don't want to take the baby out, they don't want to do anything, and they don't tell me either, so I'm left here not knowing if my son is okay or not (G10).

The reports reveal feelings such as fear, despair and concern, corroborating the results of other studies, in which the participants also revealed feelings of fear, anxiety, insecurity, shock, surprise and concern in the face of the unexpected and knowing that they are giving birth to a child in a situation of greater risk. Furthermore, these feelings are also associated with the sudden need to reorganize these women's lives, lack of resources due to financial hardship, lack of information, and the feeling of vulnerability regarding complications during childbirth, death and death of their child[20].

In view of this, there is a need for detailed and clear guidance for pregnant women regarding their doubts, concerns and health condition, which helps to dissipate fear and anguish, since they tend to feel safer because they do not remain in doubt and uncertainty about their health and that of their child in a risky situation[22].

Most pregnant women arrived in Macapá by boat or by car paid for with their own resources, others were taken by ambulance, and many of them did so alone, without any type of assistance. Some reported having undergone some prior treatment before going to Macapá. Regarding the paths taken by the pregnant women, three main ITs were identified: 1) the perception of symptoms followed by seeking care at the nearest hospital and referral to the referral maternity hospital; 2) prenatal care at the UBS, discovery of GAR and referral to the referral outpatient clinic for high-risk pregnancies; 3) prenatal care at the UBS, referral to the referral outpatient clinic, followed by referral to the maternity hospital. It was also possible to notice their efforts to reach the state capital in order to continue prenatal care, whether at the reference clinic or at the maternity hospital, as their reports reveal issues such as: borrowing money to pay for boat, bus or car tickets to the capital and accommodation at the homes of friends and family members living in Macapá, as can be seen in the following reports:

> In the municipality of Mazagão, where I am receiving my prenatal care, they did not accept me because I am diabetic, so I continued taking my diabetes medication and folic acid. Then they referred me to Capuchinhos (a referral clinic for GAR). There I started high-risk prenatal care, but my diabetes was very uncontrolled, so I was then

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> referred to the maternity ward. I have relatives who live here (Macapá). When I have an appointment scheduled, I come the day before and sleep at their house, and then I come for the appointment the next day, because it is difficult to come (G3).
>
> The professionals in the municipality of Afuá told me that they could not take care of me there, so they referred me to come directly to the maternity ward (Macapá). During the boat trip, I vomited a lot, I had tremors, and my vision and stomach became very bad. I was very stressed and forgetful. They asked me questions and I didn't know how to answer. I didn't recognize people. They talked to me and I just looked in the direction I was going because I couldn't see well. I didn't have any support. I came alone among strangers, but I came. I was feeling sick and ended up in the ICU (G7).

The Explanatory Models, proposed by Arthur Kleinman in 1978, aim to understand the TIs and divide the Health Care System into three subsystems: family, popular (folk) and professional. These subsystems are not exclusive, but overlap. The family involves self-medication and advice from family and friends; the popular refers to unrecognized practices and specialists, such as healers and traditional healers; and the professional refers to Western medicine and formalized health services[6,18].

In this context, it was observed that the professional subsystem was predominant in their ITS, contrary to what was expected, since these are women belonging to traditional population groups, who are commonly very connected to their cultural and ancestral customs.

Regarding the efforts to reach the capital and, consequently, to health services, it is worth highlighting one of the components of the RC: the Logistics, Health Transport and Regulation System, which concerns the guarantee of the pregnant woman's connection to the reference unit and safe transport, which, through the reports obtained, is partially functional, since it does not include all participants in their prenatal care[23].

In view of this, this component of the RC stands out, since it constitutes a RAS, which, like the other RAS, must be associated with health actions and policies, in order to enable quality access to health services for the most varied population groups, and, in this case, for women from the interior of the state and riverside areas. In view of this, the PNSIPCFA stands out, which, among its objectives, proposes: guaranteeing access to health services with resolution, quality and humanization, including all levels of complexity of health care. Thus, it can be inferred that the implementation of the PNSIPCFA, associated with the RC, would enable improvements in the accessibility of prenatal care for these populations, since it would take into account their particularities and vulnerabilities[5].

Regarding access to public health services, the reports demonstrated the difficulty of access, and the phenomenon of pregnant women going through the services could be

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identified in the reports, especially in relation to the outpatient referral center for high-risk pregnancies in the state. The main difficulties in access reported were related to scheduling and rescheduling appointments. As can be seen in the following statement:

> I started my prenatal care in the city of Mazagão. I received two referrals from the general practitioner, because the obstetrician was on vacation, but the high-risk outpatient clinic in the capital required a report from a doctor specializing in obstetrics. So, I was only seen after the third referral, when he (the gynecologist) returned from vacation. I scheduled the first appointment, but I was not seen because the doctors were in training, so they rescheduled me for another day. At the first appointment at the outpatient clinic, I was referred to the maternity ward because the exams were very abnormal (G3).

From the reports, it is clear that pregnant women have difficulty accessing more complex health services, such as outpatient clinics for high-risk pregnancies, a phenomenon known as peregrination, which is a serious public health problem and is directly related to obstacles to the quality of obstetric care, the reduction of maternal mortality levels and women's health indicators in Brazil[24].

Pilgrimages, associated with the reproductive process in public health services, are considered obstetric violence, since they are related to the annulment of rights, due to the precariousness of the services offered, causing pregnant women to have to travel long distances in search of care. Furthermore, to ensure accessibility to health services, they must allow their resources to be easily accessed by users, since accessibility is directly related to the principles of Comprehensiveness and Equity, which govern the guidelines of the SUS. The SUS must guarantee accessible and effective services to the population, taking into account their singularities[25,26].

In the second category, entitled “Health Care Networks in the State from the Participants’ Perspective”, it is clear that the participants’ perspective on the RAS is based on difficulties and a desire for change. The predominance of weaknesses in socioeconomic aspects was observed, as verified by the concern about carrying out exams, which are not being carried out in full by the state’s public health services, as well as the availability of medicines, materials for carrying out simple, although essential, tests, such as capillary blood glucose, in addition to the difficulty in paying for transportation to get to the health services.

In addition, other weaknesses were highlighted, such as: insufficient number of professionals for prenatal care in the place of origin, distance from health services, inadequate boat for the journey, pilgrimage to health services, entry of male companions into health services, as well as lack of adequate conditions for companions to stay and overcrowding in wards, generating concern about waiting for beds.

> There (Perimetral Norte/AP) I had no problems, I was able to go to

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> the appointments, but from the beginning, all my exams were paid for. In Macapá, I had problems, because on the first of the month I had an appointment, but I didn't go because I didn't have the money, now I only have to go next month. And when you get here, nothing is resolved, so you have to go back, and then we come just to spend money (G8).

> If they ask me to do the exam, I can't do it. The money I brought to Macapá was only R$50.00, and there's no point asking my relatives for money because they would have to bring it in person, since I don't have a bank account, and they would have to pay for transportation to come (G10).

The data obtained regarding the main adversities of the participants corroborate other studies that highlight the difficulties faced by riverside women in accessing health services, due to geographical barriers, which lead to an unequal and exclusionary reality for these women, since the democratization of access to health is flawed. In this context, in order to reduce such inequities and improve the quality of life of these populations, the Ministry of Health created actions to promote health equity, such as the Riverside Family Health Strategy teams and the Fluvial UBS. However, reports indicate that these actions do not work satisfactorily:

> Oh, I've already been to one of those in the interior (UBS Fluvial), every year I go there, this year I've already been there but now I'm only going next year. There they give medicine, they do these exams, but only every year (G6).

In addition to geographical difficulties, other adversities reported by pregnant women have also been observed in other studies, such as unavailability of medication, dissatisfaction with prenatal care, inadequate facilities and poor care. It is worth noting that all of these implications have direct or indirect repercussions on the health of both the pregnant woman and the fetus. Socioeconomic difficulties stand out in the reports, corroborating the results of other studies in which pregnant women also faced obstacles in undergoing tests; however, the difficulties were mainly related to delays in results, misinformation and lack of quality services[27,28].

The problem becomes even more serious when one realizes that the same was reported by the majority of pregnant women, and when compared with their socioeconomic profile, in which approximately 75% of them have as their main source of income the Bolsa Família, a federal government social benefit program aimed at people with greater socioeconomic vulnerability. Thus, it is possible to imagine the scale of the problem for these pregnant women when they are faced with the responsibility of public health services for costs that are not their responsibility, since these should, in fact, be provided by the public health network.

Studies show that not performing tests such as ultrasound during pregnancy does not mean omission or diminish the quality of prenatal care. However, from the moment the professional requests the test, the health network must be able to perform the service for the

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pregnant woman, otherwise it is proven that the municipality is not complying with what is recommended by the SUS. In addition, the proposal in the RC regarding access to tests during prenatal care (normal and high risk) and access to their results in a timely manner is highlighted[29].

In view of this, there is a lack of respect for the principles of Equity and Comprehensiveness, as there is a notable lack of resources in health services, which highlights the need for changes in prenatal care in order to promote dignity, health, well-being, comfort and safety for pregnant women, reducing maternal and perinatal mortality rates[28].

All pregnant women reported the need for changes, although some were unable to explain their contexts. On the other hand, many of them pointed out this need in several aspects, especially regarding humanization and communication within health services, in addition to the lack of provision of exams, forcing them to pay for the service in the private network. In addition, they reported the desire for priority in scheduling appointments for pregnant women who come from the interior of the state and from riverside areas, as well as a specific boat to bring them safely to the capital for prenatal care, and adequate conditions for companions to remain in health services. This can be seen in the following reports:

> Look... several things need to change, because we are in the maternity ward because we have to be, but the people who work here are very ignorant. Sometimes, when we ask a question, they don't answer, and when they do, they do it in a rude way, and when they do certain tests in the ward, they make us feel embarrassed (exposure) (G3).

> The way they (professionals) treat us and how we can access the tests needs to change. Because we come from our city with hope, because the doctor said that they do all the tests here in the maternity ward, but when I get here I have to pay to do them (privately)! So what's the point of coming from there to here? Regarding the care, they should have come here to explain my situation, but no one explains anything (G10).

The reports reveal the extent to which the participants perceive the failures of humanization and communication on the part of professionals towards pregnant women, elements that are so capable of being solved and yet visibly cause them stress.

It is a fact that, for health professionals, the main concerns are related to the risk to life, and it is common for biopsychosocial aspects to be secondary. However, there must be concern about the complexity of the factors that disturb the general well-being of pregnant women, since trivializing the need for information further reinforces their insecurities. In this sense, studies indicate that humanized behaviors of health professionals, such as providing opportunities for the exposure and clarification of doubts and concerns and providing detailed guidance regarding diagnosis and therapeutic

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interventions, are capable of alleviating feelings of fear, anxiety and despair, generating greater security and assisting in the process of coping with their risk condition[20, 25].

A humanized approach must be present at all times, especially when the pregnant woman is diagnosed or discovers that she has GAR, as this will influence the way she will deal with the situation from then on, as it is an important factor in the pregnant woman's adherence to the health service and her continued care, making the results more lasting and significant[30]. In view of this, the existence of an integrated health care network for these women, so that they are seen as complex human beings with several aspects to be taken into account, is essential so that the pregnant woman has the possibility, not only of diagnosis, but also of dignified and quality prenatal care. Professionals involved in prenatal care, especially in high-risk pregnancies, need to get closer to the pregnant women and their realities so that they can help them cope with this new situation, since it has both personal and family implications for them[20].

FINAL CONSIDERATIONS

Through this study, it was possible to identify the ITs of pregnant women from riverside communities and the interior of the state for high-risk prenatal care, which were characterized predominantly by the professional subsystem of Arthur Kleinman's Explanatory Models, since their first choice, as well as the continuation of their paths, is through public health services, even though these cannot fully meet their real needs.

From the perspective of the participants, it is concluded that the policies and RAS aimed at high-risk prenatal care and PCFA are flawed by not meeting their singularities, needs and most basic desires, such as the availability of medicines and full performance of the requested exams within the public health services themselves. Or, even the provision of care based on humanization and communication for pregnant women who feel distressed, worried and afraid when faced with a GAR situation.

Therefore, there is a clear need to adapt health policies and RC in the state of Amapá to high-risk prenatal care for these women, as well as to coordinate RC, as a RAS, with specific health policies and policies to promote equity and comprehensiveness in health, such as PNSIPCFA, since this seeks, within the particularities of PCFA, solutions to their health-related problems. In addition, it is important to emphasize that it is essential to raise awareness among professionals in public health services about humanized care for clients, especially those who find themselves in more complicated and stressful situations, as in the case of GAR, in order to offer quality care, valuing these pregnant women in all their aspects.

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Nothing to declare.

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