

## THE DAILY LIFE OF PREGNANT WOMEN: NURSING PROMOTING BEING HEALTHY

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**ABSTRACT:** This is a qualitative, exploratory-descriptive study, grounded on the everyday life and interpretative sociology. The aim of the study was to understand the everyday life of pregnant women and their families, based on prenatal care. The study was conducted in a health center in southern Brazil, and it involved ten pregnant women. Data were collected by means of semi-structured interviews, using the intrafamilial genogram and ecomap, between March and May of 2011. Data analysis involved: preliminary analysis, ordering, key links, coding and categorization. The results show that the everyday life of pregnant women involves biological changes and emotional experiences that generate a need for changing their pace of life, whose implementation depends on social changes, requiring a support network that may contribute to promote health during pregnancy.

**DESCRIPTORS:** Pregnant women. Family nursing. Health promotion. Activities of daily living. Prenatal care.

## O QUOTIDIANO DE GESTANTES: A ENFERMAGEM PROMOVENDO O SER SAUDÁVEL

**RESUMO:** Trata-se de uma pesquisa qualitativa, exploratório-descritiva, fundamentada na Sociologia Compreensiva e do Quotidiano. Buscou-se compreender o cotidiano das gestantes, no contexto familiar, a partir do pré-natal. A pesquisa foi realizada em Centro de Saúde do Sul do Brasil, com dez gestantes. A coleta de dados deu-se através de entrevistas semiestruturadas, utilizando o genograma intrafamiliar e ecomapa, entre março e maio de 2011. A análise de dados envolveu: análise preliminar, ordenação, ligações-chave, codificação e categorização. Os resultados mostram que o cotidiano das gestantes envolve modificações de ordem biológica e vivências de ordem emocional que geram uma necessidade de modificações no ritmo de vida, cuja concretização depende de modificações de ordem social, demandando uma rede de apoio que pode contribuir para a promoção da saúde na gestação.

**DESCRIPTORIOS:** Gestantes. Enfermagem familiar. Promoção da saúde. Atividades cotidianas. Cuidado pré-natal.

## LO COTIDIANO DE MUJERES EMBARAZADAS: LA ENFERMERÍA PROMOVRIENDO EL SER SALUDABLE

**RESUMEN:** Se trata de un estudio cualitativo, exploratorio-descriptivo, basado en la Sociología Compreensiva y el Cotidiano. Hemos tratado de entender el cotidiano de las mujeres en el ámbito familiar, desde el período prenatal. La investigación se realizó en un Centro de Salud en el sur de Brasil, con diez mujeres embarazadas. La recogida de datos fue a través de entrevistas semi-estructuradas utilizando el Genograma Intra-familiar y Eco-mapa, entre marzo y mayo de 2011. El análisis de los datos: análisis preliminar, clasificación, palabras clave, codificación y categorización. Los resultados muestran que la vida cotidiana de las mujeres embarazadas implica la modificación de algunas experiencias biológicas y emocionales que generan una necesidad de cambios en el ritmo de la vida, cuya implementación depende de cambios de orden social, que requieren una red de apoyo que pueden contribuir a la promoción de salud durante el embarazo.

**DESCRIPTORIOS:** Mujeres embarazadas. Enfermería de la familia. Promoción de la salud. Actividades cotidianas. Atención prenatal.

## INTRODUCTION

The moment of pregnancy, in the process of a forming family, is a time when critical and vital situations are faced, because, during pregnancy and the puerperal period, there is a transformation and expansion of the marital system to a parental one.<sup>1</sup> This can generate a process of disorganization and conflict, and it could cause suffering, therefore demanding performance of the healthcare team to reorganize the time of the pregnant woman and her family, helping them to adapt their pace of life, and promoting the organization and rearrangements that may be needed in the family and in work, thus forming a support network.

In addition, prenatal care is the first step towards humane childbirth and to reduce the rates of maternal and perinatal morbidity and mortality, which are closely related to the quality of care that is provided by healthcare professionals, especially at the level of primary care. In addition, it must permeate actions related not only to biological aspects, but also to psychosocial aspects, with educational, preventive and promotional activities in health.<sup>2</sup> It is worth noting that the empathy of pregnant women with professionals and the service itself contributes to adherence to consultations and comprehensive care.<sup>3</sup>

The aim of this study was to understand the daily lives of pregnant women within the family context, based on prenatal care, in order to contribute to a better performance of healthcare and nursing professionals, understanding the everyday as the way of living of human beings, expressed in their daily lives, through their interactions, beliefs, values, images and symbols, which build their living process, in a movement of being healthy and getting sick, punctuating the life-cycle.<sup>4</sup>

## METHOD

This is a qualitative, exploratory-descriptive study, grounded on the everyday life and interpretative sociology,<sup>5</sup> in its intertwining with the health-disease process, involving the life cycle of the family.<sup>1</sup> The research took the guidelines of the Ministry of Health<sup>2</sup> and the Municipal Health Department of Florianópolis<sup>6</sup> as starting point, which emphasize the importance of notions such as sensitivity, understanding, way of life, potential and birth process, from which we can refer to the notions of sensible reason, understanding, everyday life, potency,<sup>5</sup> and family life

cycle<sup>1</sup>, along with notions of limits, the imaginary and the ethics of aesthetics,<sup>5</sup> thus uniting the literature on prenatal care with our theoretical and methodological framework, reinforcing the qualitative approach.

The study setting was the Health Center of Lagoa da Conceição (Florianópolis, Santa Catarina, Brazil). Ten pregnant women participated in the research. The selection criteria for the women interviewed were: being pregnant; being residents of the area covered by the health center of the research site; performing prenatal care in this health unit; accepting the invitation to participate in the research carried out during prenatal consultations or meetings of the group of pregnant women. At the time of the survey, 13 women were carrying out prenatal care at this health center, however only ten women agreed to participate.

The invitation to participate in the study was always performed at the end of the consultations, so as to prevent any association between the care received and their participation. The Informed Consent Form (ICF) was read and signed by the interviewees before the start of the interviews, clarifying the research objectives, their form of participation in it, its voluntary nature, the assurance of confidentiality, the non-binding to the delivery of care from health services and the tools that would be used. After agreement, the participants signed the ICF in duplicate, in accordance with the recommendations of resolution no. 196/96 of the National Health Council.<sup>7</sup> The research proposal was approved by the Human Research Ethics Committee of the Federal University of Santa Catarina (certificate n. 1774, process n. 1774, cover sheet n. 402219). Codenames were used in order to guarantee anonymity of the participants and confidentiality of the information.

Data collection was carried out by the authors, together with the pregnant women, using semi-structured questionnaires with open guiding questions, namely: 1) What is your daily life like? Tell us about it; 2) Tell us about your pregnancy, how was/has it been going for you (planning, craving/acceptance by you and your family, joys, worries, anxiety, etc.); 3) What does pregnancy mean to you?; 4) When did you start your prenatal care?; 5) What facilitated/contributed/helped so you could get your prenatal care/at that moment?; 6) What complicated/prevented/hindered the start of your prenatal care? The third person

technique was also used, in which the pregnant woman was asked to speak about a subject, and not just about her specific experiences. This strategy aimed to enable feelings, difficulties, barriers or issues that they could not reveal, so they could also come to the fore. The interviews (lasting on average 60-90 minutes) were previously scheduled, after conducting the nursing consultation, preferably in households (seven interviews), but also within the group space of pregnant women (one), at the health center (one) and in the workplace of the interviewee (one) between March and May of 2011. In eight of the ten interviews, the intra-family genogram tools and the map of extra-family interactions or ecomap were used, whose data contributed to the contextualization of the pregnant women, in their households and their extended social network. Two patients chose not to develop these two instruments, referring to the lack of time, with one of them being late for work. The interviews were recorded and transcribed in full, contributing to further analysis. After all the interviews, the data obtained were recorded in field diaries,<sup>8</sup> including interaction, theoretical, methodological and reflective notes, which contributed to the composition of the analysis and discussion of results, recording reflections and insights occurring at the time of the interviews or shortly after them.

The data from interviews and from the field diaries were analyzed based on assumptions of qualitative field research,<sup>9</sup> involving: preliminary analysis, ordering, key links, coding and categorization (identifying categories), with the objective being the common thread. Throughout the research process, we aimed to unite the women interviewed with our sensitive outlook, trying to understand the daily life of these pregnant women, perceived and described by them in the prenatal process. Thus, everyday life emerged and led to the identification of categories, with its properties and characteristics, as well as how these relate to each other, as shown in figure 1.

## RESULTS AND DISCUSSION

### Sociodemographic profile

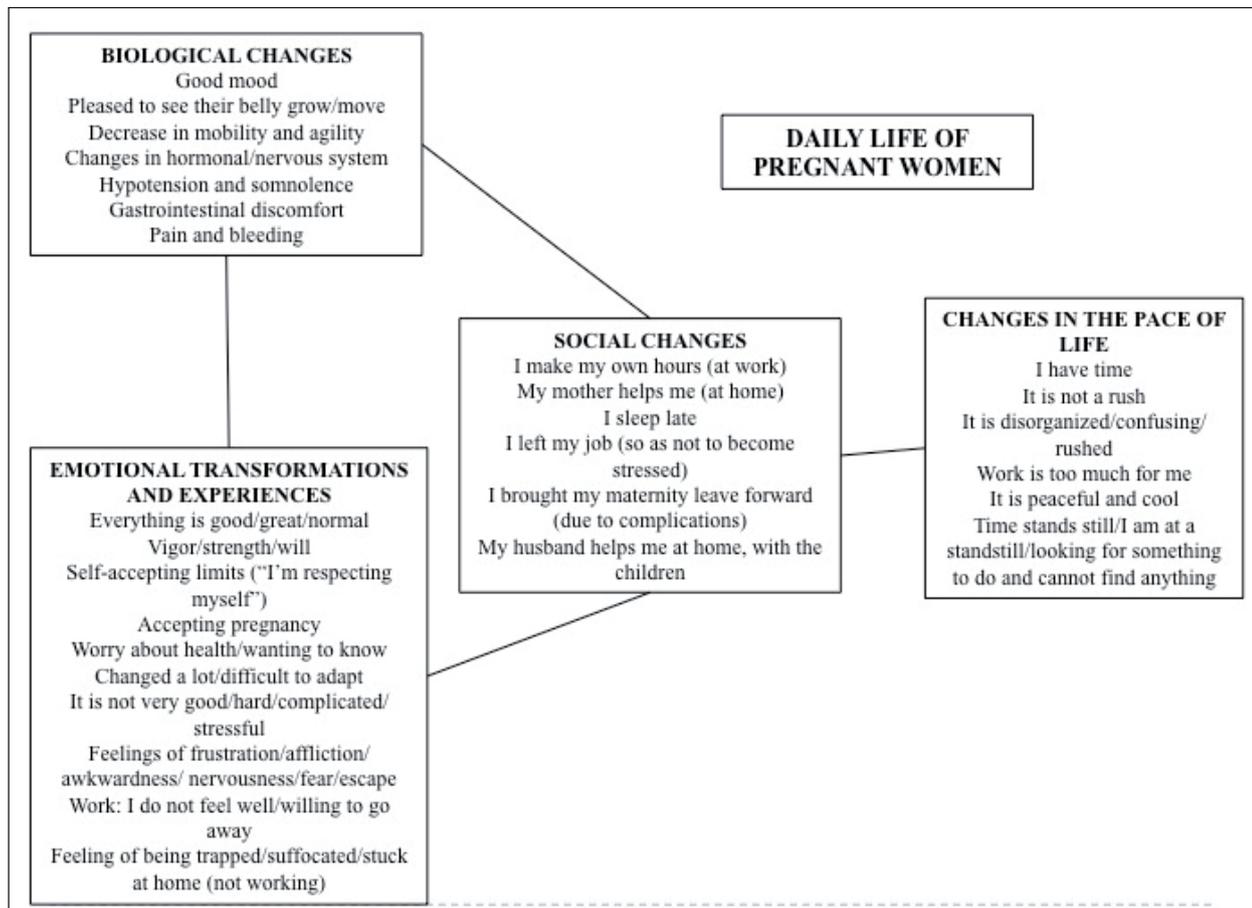
The observation of the sociodemographic profile of the pregnant women who participated in the study shows, in relation to age, a distribution in the age group 20-35 years, with five corresponding to the range of 26-30 years; as

regards the level of education, six had secondary education (complete or incomplete), three had higher education (complete or incomplete) and one had primary education (incomplete); regarding occupation, we classified them within the following major occupational groups, according to the Brazilian classification of occupations:<sup>10</sup> five interviewees belong to the group of "service workers, commercial salespeople in shops and markets" (confectioner, clerk and salesperson); one as "professionals in the arts and sciences" (naturologist); one as "senior member of the government, leaders of public interest organizations and of companies and managers" (entrepreneur); and three as "others" (housework and maid). All participants lived in urban areas and, as regards their origin, one of the interviewees was born in Santa Catarina and nine in other states.

Their marital status and affective situation (as regards the bond of a couple) was also identified. Regarding marital status, eight declared themselves single, one married and one in common-law marriage, legally formalized. However, seven of the interviewees had an affective couple relationship, despite having no civil bond, in other words, being legally unmarried, i.e., they had partners who they referred to as a boyfriend, husband or future spouse. Thus, those who had partners, with or without a legal bond, totaled nine of the women interviewed, although some referred to their affective relationship as an insecure condition. Only one woman declared herself as single, with no partner, describing the pregnancy as unplanned but desired, considering herself independent and able to care for the baby on her own, characterizing a "single parenthood".<sup>11</sup> In addition, seven lived together with their partners and three lived alone or with other relatives, such as brothers, sisters, sons, daughters, father, mother, brothers- or sisters-in-law, father-in-law, mother-in-law, stepmother, goddaughter and uncle.

### The daily lives of pregnant women: biological, emotional and social changes and pace of life

Daily life was identified as involving the following categories: biological changes; emotional changes; social changes and changes in pace of life, as observed in figure 1.



**Figure 1 - Schematic overview of the daily lives of pregnant women in the family context from the prenatal period**

Biological changes refer to the gravidic changes and discomforts expected in low-risk pregnancies, or even obstetric complications in those at high risk, bringing together emotional transformations and experiences, i.e., in the way of feeling about this period of the family life cycle, generating a trend and a need for changes in the pace of life that, in order to occur, require also social changes. The categories that involve biological, emotional, social changes and changes in the pace of life, were discussed in an integrated manner, reflecting on their implications for the healthcare staff and nurses in promoting the health of the pregnant woman, considering her family background.

**Biological and emotional changes**

The daily lives of pregnant women and their families are, therefore, a mixture of feelings and emotions, made of reality and dreams, love and rejection; shared by being together daily, in family life, composing the ethics of aesthetics, which precisely constitutes emotions that are shared

and experienced in common. As such, the ethics of aesthetics is defined as being opposed to socially established crippling morality. It would be a kind of morality without restrictions, without boundaries, limits or barriers, with the desire to be together prevailing, the feeling of belonging to germinated micro-groups.<sup>12</sup> However, when the opposite occurs, primarily the lack of support from a partner or the family presupposes an experience of insecurity and loneliness.<sup>13</sup>

This collective sharing also refers to networks of support, and which are not restricted to the practical structure and logistics of rearranging the material conditions of survival (job, income, household chores, time availability, healthcare services), even though this structure is of paramount importance, but also networks of emotional support, guidelines, exchange of experiences, embracement, sensitive listening, encouragement and stimulation. Friends, family and health professionals, especially nurses, play a fundamental role in the establishment of this

network, contributing decisively to empower women and to a healthy and pleasurable experience during pregnancy, which can be called, perhaps, actual care.

When speaking of ambivalent feelings, such as love and rejection, for instance, and reflecting on the contrast of the ethics of aesthetics to socially established castrating morality, we cannot fail to address the construction of the myth of maternal love<sup>14</sup> as unconditional love. It is a reflection that depends, to a large extent, on the vision we have of women's health care, sexual and reproductive rights and, daring to expand further discussion, of what we mean by being a woman. In a sexist, patriarchal, heteronormative society, too often, women are viewed merely as potential mothers, or baby machines. The condition of mothers or pregnant women is seen as natural, implicit to the condition of womanhood.

Such a way of seeing ourselves, and of being seen, implies social negligence and violence in the various spheres of the life of every woman, including the care she receives, or fails to receive, from healthcare services. There is often an assumption that all women indiscriminately, especially if adult and married, have motherhood as a dream and a life project, even those who became pregnant in an unplanned and perhaps unwanted way. We are imbued, in our daily lives, with this socially established crippling morality, still feeling unable to share this morality without limits, restrictions, boundaries or barriers. The result is that, in general, we let precious opportunities to conduct health education, especially education for sexual health, pass us by. Often, feeling we are helpless and awkward, not knowing what to say about an abortion suffered or about not accepting a pregnancy, we do not let ourselves intervene in situations of risk, neglecting the planning of preconception, postpartum depression or so many other delicate situations that arise in our consultations.

In this list of everyday situations of social negligence or violence, maybe we can also include naturalization and the consequent trivialization of morbidity and mortality during pregnancy. In this sense, it advocates for improvements in reproductive health, considering this a challenge, since risk situations mainly affect women with poor access to health services. This fact requires prenatal and labor care services of quality, effective social control with expansion and qualification of Maternal Mortality Committees and mobilizing health managers, health professionals and society in the

promotion of public policies that seek to reduce maternal mortality.<sup>15</sup>

Patriarchal thinking, as previously seen, feeds prejudice, takes place in cultural oppression and manifests itself in the quality of the healthcare services offered to women. This patriarchal morality is related to the historical construction of the myth of maternal love: "when you go through the history of maternal attitudes, the belief arises that maternal instinct is a myth. We cannot find any universal and necessary conduct of the mother. Instead, we see the extreme variability of their feelings, according to their culture, ambitions and frustrations. How, then, can we not come to the conclusion, even if it seems cruel, that maternal love is only a feeling and, as such, essentially contingent? This feeling may or may not exist; be and then disappear; show itself as strong or fragile. Preferring a child or surrendering to all. Everything depends on the mother, on her story and history. No, there is no universal law on the subject that escapes natural determinism. Maternal love is not inherent in women. It is additional".<sup>14:366</sup>

Thus, the feeling of not desiring pregnancy and children is understandable and human. However, due to the social construction of such a myth, the woman bearing it seems "wrong". "Instead of instinct, would it not be better to talk about a fabulous social pressure so that women can only feel fulfilled in motherhood? [...] Since a woman could be a mother, it was deduced that not only should she be a mother, but that she should only be a mother and that only in motherhood could she find happiness".<sup>14:355</sup>

### *Social changes and changes in the pace of life*

From the biological changes and the emotional transformations and experiences, the experience of time itself transforms, takes a slower pace, demanding a slowdown or moderation in the pace of life. When circumstances disregard these trends, forcing the maintenance of a fast pace, especially in the workplace, a hard, difficult character is painted in daily life, generally associated with work overload or excessive working hours.

The realization of this tendency or the need to change the pace of life (slowdown or moderation), depends, therefore, on the occurrence of rearrangements in family organization and in work, which enable the adaptation of everyday life to the new experience of time, transfigured from changes to organic rhythms. In other words,

making necessary social changes as well, involving rearrangements in the support network, and the very existence of such a support network so that the pace of life can adapt to the present situation. As sometimes these rearrangements do not occur or do not occur satisfactorily, pregnant women are unable to adapt their lifestyle to their new organic and emotional rhythms.

On the issue of social changes and changes in the pace of life, and the experience of pregnancy as pleasurable or as a source of suffering, it seems interesting to note that negative feelings are present, both among pregnant women who work outside the home, and among those who do not work; as well as positive feelings, indicating that working outside the home may be an element of stress and overload on the one hand; or professional, personal and social stimulation on the other. Of the ten women interviewed, five had a job outside the home at the time of the interview; of these, three talked of daily life with expressions such as: having time and/or peace and quiet, and two, that it is rushed and/or disorganized. Five were not working outside the home at that moment and, of these, three believed that their lifestyle was peaceful, whereas the other two thought time had stopped, or felt suffocated, because they looked for something to do but could not find anything.

The demands on women, in many instances, are greater than those on men. In their daily lives, women are torn between dedication and raising children, having simultaneously to comply with house chores and work, and at the same time they are required to look after their body. On the other hand, in some situations, there is a resistance to the ideal mother model, as the case of a woman who has an active social life: who works outside the home, who conciliates their job with many responsibilities inside and outside the home, who leaves the children with nannies some of the time, sometimes having to redo or resume an emotional life after a break.

Women will thus be induced to make choices, sometimes abdicating their needs as a woman, mother, wife, professional, to meet another need imposed on them. It goes against the social imaginary widely reproduced in magazines and media: supermoms of slender silhouette, that can go to the gym three times a week, with healthy kids and without problems, triumphant in all areas, with happy marriages, good jobs and without losing their smile. With these models imposed, and their difficult implementation in reality, this generates,

in most women, a sense of guilt and the feeling that they are not fulfilling their role as mothers, as it is difficult to perform the juggling required to attain it. In our society, immediate gratification is prioritized, and a child is not seen as enjoyment or something immediate.

Thus, the claims of the women interviewed that their pace of life during pregnancy was quiet or peaceful balance out in frequency and intensity with expressions that it is rushed, stressful, difficult or disorganized. Even those respondents who started their answers with positive terms, then had mixed, intense feelings, sometimes negative, expressing ambivalent experiences and demonstrating, perhaps, that the initial response (peaceful, for example) could express the response that was believed to be the expected or the correct response. Subsequently, throughout the conversation, deeper and more complex feelings started coming out and complementing the initial response.

### **The healthcare and nursing staff in the promotion of health of pregnant women: the prescription of time**

Descriptions of concern and discomfort lead us to an important aspect that stood out in a few statements: the disorganization and reorganization of time and the pace of life during pregnancy. The moment of generating the children in the training process of a family could be considered an example of critical confrontation. This phase proved to be vital for the construction of the nuclear family. Throughout this period, which begins during pregnancy, the transformation and the consequent expansion of the marital system to the parental one occurs. At this time, the feelings of mothering and fathering are respectively awakened in the woman and the man. However, this process of learning to play new roles and assuming the role of mother and father do not always occur in a balanced and appropriate manner between the couple so they can meet the adaptations required by the arrival of the new being. In this sense, the issue of the health and illness of individuals showed that the process of being healthy and getting sick are related to sociocultural and environmental issues, as well as biological issues and the interactions established with the space where they live. Hence the need to understand people's daily lives, how they experience them and face the adversities that arise in their day-to-day lives and in the process of building them.<sup>16-17</sup>

This process of disorganization and conflict can cause pain, discomfort and distress and, due to this, terms like grief, frustration and complicated also came out in the interviews. The reorganization of time and the pace of life become necessary and, often, the performance of the healthcare professional and the supporting nurse (cherishing), promoting health education (empowering), can be instrumental in promoting a healthy and pleasurable experience during pregnancy. Actions in health education are also designed as a form of exchanging experiments, knowledge and experiences that also lead to the construction and reconstruction of knowledge from a process of identification among individuals involved during the process of health care, a basic premise to empowerment.<sup>18-19</sup>

It means focusing care on daily life, a therapeutic intervention to rethink and reorganize family and work arrangements in order to promote being healthy, by prescribing time, with time being necessary to rethink the way we live our daily lives, interactions, beliefs, values, images, meanings and symbols. In seeking favorable environments for the promotion of health in families in which men, women and children interact, bringing their imagery, to a world where work has been transfigured, perhaps health and education professionals need to prescribe time.

## FINAL CONSIDERATIONS

Understanding the daily lives of pregnant women, within the family context, from the prenatal period, has showed us that the intense transformations of pregnancy are already elements that generate ambivalent, contradictory, paradoxical feelings and experiences, seemingly in the disharmony between the desired rhythms (establishing) and imposed rhythms (established) can be seen as a factor of illness or, at least, a less enjoyable experience of pregnancy.

However, we must understand that this necessary prescription of time can be found as being devoid of therapeutic value if it does not take into account the limitations that may arise for the rearrangement of family organization and work in the daily life of each of the women attended. As discussed earlier, beyond the experience of marital conflict in relation to unequal divisions of tasks (gender relations), the media also exerts a powerful influence on women and families, with its patriarchal and capitalist logic that impels women to assume a triple workday (work, home, and children). Therefore, if our therapeutic inter-

vention does not take into account such limits, if an exchange with the pregnant woman is not composed with sensitive listening, and embracement, it can become merely prescriptive, i.e., with difficult compliance. We would be breaking ties, rather than building them, and intensifying anxieties, rather than alleviating them.

After all, since we are leaning on everyday life, we involve ourselves into habits and relationships and therefore in dynamics that were built and consolidated over a lifetime and, therefore, require significant powers (internal forces) for their transformation. In other words, the change of family dynamics, through a process of deconstruction and reconstruction of the meanings of motherhood and fatherhood, of fathering and mothering, from what is imagined about models and gender relations, does not constitute an isolated, individual or simple process. It is, rather, a necessary and profound transformation in social relations, a process of global, social and complex character, which we may not be able to handle, completely, if our operations are purely restricted to the space of the clinic and the clinical conduct.

Therefore, the relationship among the professional, the pregnant woman and the family needs, in as many spaces as possible, to also assume its social character and its transformational powers. It is necessary to contribute daily to the deconstruction and reconstruction of models of gender and relationships arising from it, not forgetting, either, to cover other social issues that may interfere with the pace of life and social transformations, such as: skin color, class, sexual orientation. In other words, we could say that, besides the inner forces already mentioned, the potencies for these transformations are also expressed by social forces, often dormant in the healthcare professionals' relationships with the users of the Brazilian Unified Health System. Once again, the social micro and macro are related, as well as the individual, the collective, and the family, stressing the multidimensionality and complexity of living, i.e., everyday life. The strengthening of ties and the awakening of these transformational powers can exert significant influence on how the process of adherence to the prenatal period occurs, not only in relation to its early occurrence, but its periodicity, plenitude of actions and broad coverage.

Given the limitations of this research, conducted with a small number of pregnant women (due to the selection criteria of the participants) and in only one health unit, in future studies, we

suggest the participant observation of pregnant women in their day-to-day lives including data collection with other family members.

Since it deals with a social reality, it becomes urgent to deepen the discussion on the daily lives of pregnant women and their families in new studies. It is necessary to reflect on the role of healthcare professionals, specifically nursing, in the care for pregnant women and their families, involving their everyday lives, their way of living, considering the dynamics of life in society, in contemporary times, highlighting the intersubjective and ethnocultural dimension, when considering the multidimensionality and complexity of human beings.

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