ISSN: 2230-9926

Available online at http://www.journalijdr.com

IJDR

International Journal of Development Research
Vol. 09, Issue, 02, pp.25707-25712, February, 2019

ORIGINAL RESEARCH ARTICLE OPEN ACCESS

NURSING PERSPECTIVES ON PERINATAL MORTALITY: CONTEXTUALIZATION AND CARE

***Laryssa De Col Dalazoana Baier, Márcia Regina Carletto, Ana Paula Xavier Ravelli, Clóris Regina Blanski Grden and Pollyanna Kássia de Oliveira Borges**

Nursing and Public Health Department, State University of Ponta Grossa, Ponta Grossa, Paraná, Brazil

ARTICLE INFO

Article History:
Received 17th November, 2018
Received in revised form
26th December, 2018
Accepted 07th January, 2019
Published online 27th February, 2019

Key Words:
Nursing,
Content analysis,
Perinatal mortality.

ABSTRACT

Perinatal mortality is one of the serious problems that afflict public and private health in Brazil. Its impact is differentiated in each region, but the mortality rate is a general cause of concern and calls for the need to investigate its causes and ways of minimizing it. This study aimed to identify the attitudes of nurses regarding perinatal death and understand the perspective of nurses on the possibilities of reducing perinatal death. In order to achieve this goal, it was necessary to understand the nurse's role in tertiary care and in the multiprofessional team in reducing perinatal death, identify the theoretical position regarding the topic, and verify if theory and practice are allied in the analysis of the data collected. After a bibliographical, qualitative, and basic review and using interviews, the technique of content analysis based on the work of Bardin was used. We interviewed 19 nurses who worked in hospital care; of these 17 were obstetrical nurses and 2 neonatologist nurses. Registry Units were selected and, from this, context units were enumerated and verified. It was possible to perceive as results that the majority of the nurses were aware of the weaknesses of the health system, the lack of multiprofessional and interdisciplinary work, the scarcity of resources invested in physical, human and technological structure, among other items. It was also emphasized that there is still a lack of capacity for the practice of Public Policy protocols as well as the relative lack of knowledge of many of its bases and the fragility of multiprofessional work.

Citation: Laryssa De Col Dalazoana Baier, Márcia Regina Carletto, Ana Paula Xavier Ravelli, et al., 2019. "Nursing perspectives on perinatal mortality: contextualization and care", *International Journal of Development Research*, 9, (02), 25707-25712.

INTRODUCTION

Perinatal death can be defined as the death of a newborn with up to seven days of life, starting at 22 weeks of gestation (Malta and Duarte, 2007). This indicator reflects the quality of care provided to the pregnant woman, the fetus and the newborn, and tends to be higher among the poorest. For Fonseca and Coutinho (2014), on average, 7.6 million perinatal deaths occur worldwide every year. Of this percentage, 98% of the deaths happen in underdeveloped countries and 57% are fetal deaths. Consultation of the national database of deaths shows that in 1996 perinatal mortality was 25.6/1000 births; 10 years later the rate was reduced to 19.92/1000, and in 2016, it was 17.22/1000 (DATASUS, 2019). Thus, it is necessary to investigate the specificities of the local risk factors for perinatal death. In Paraná, a state in southern Brazil and the site where the research was carried out, this indicator was not very different from the rest of Brazil. In 1996, perinatal mortality was 22.4/1000 births; in 2006, it was 16.54/1000, and, finally, in the year 2016, dropped to 12.87/1000 (DATASUS, 2019). Perinatal mortality can be classified, according to the causes, into preventable and non-preventable deaths. In the first case, the problems leading to death could have been solved with better care, laboratory tests, search of information, among other factors. In the second case, there are diagnosed cases of serious formation problems, such as brain pathologies, malformation of vital organs, among other causes. Pereira *et al.* (2016) indicate that some causes have been reduced, but asphyxia, prematurity and fetal malformation still remain frequent. "New" situations include congenital syphilis, respiratory distress, bacterial septicemia, neonatal aspiration syndrome, chromosomal anomalies and anencephaly. Among the public policies implemented in recent years to reduce perinatal mortality, we highlight the Stork Network (BRASIL, 2011) and the Mãe Paranaense Network Program (PARANÁ, 2013). In general, the Mãe Paranaense Network is the

****Corresponding author:*** **Laryssa De Col Dalazoana Baier**
Nursing and Public Health Department, State University of Ponta Grossa, Ponta Grossa, Paraná, Brazil.

expression of the national policy (Stork Network) in the state of Paraná, Brazil, with the necessary peculiarities to meet the demands of the state. This network aims to organize aspects of care to the mother-child binomial since prenatal care until the end of the first year of life. The Program embraces the pregnant woman in the space of Health Units, performs all pregnancy monitoring, with up to 17 prenatal exams, carries out the classification of gestational risk, promotes specialized care, guarantees that the delivery take place according to the established risk classification, among other actions (PARANÁ, 2017). The situation in Paraná is still worrying, though, because preventable deaths happen, and actions are still necessary for a better quality of care. The actions of nurses in this process, according to França and Lansky (2016), are multiple and have different results. In theory, the authors point out the need to be closer to what is suggested in public policies and the reality of nurses. In practice, not everyone knows the public policies or is aware of their guidelines. Therefore, the need for training is fundamental, as well as the qualitative enhancement of services. In order for public policies to reach the greatest number of women, a change in the nurses' perspective is necessary, so that they focus on their activities and successfully complete the planning and care procedures that they have to face. The qualification and training processes can improve the perspective of nursing, and the work of multiprofessional teams is fundamental. In a healthcare team, nurses are professionals who work providing direct care to women, they stay longer with the mother-child binomial, and they are directly related to health education. Thus, the discourses emanating from nurses on perinatal mortality can tell much about the working conditions in which they act, how they exercise their skills in the work process, and what impacts perinatal deaths have on the experience of care provision. The question that guided this research was: how do nurses see perinatal death? Based on this question, the research was carried out to identify the attitudes of nurses regarding perinatal death, and to understand their perspective about the possibilities of reducing perinatal death.

MATERIALS AND METHODS

This was a qualitative study, carried out with 19 nurses who worked in the hospitals of the city of Ponta Grossa - Paraná, Brazil. The research was carried out in the maternity units of the municipality that attended pregnant women in gestational risk classification (habitual, intermediate or high risk) proposed by the Mãe Paranaense Network Program. Data was collected through interviews with the nurses responsible for the maternity sector at each shift. For the structured interviews of managers and nurses, an opinion-triggering tool was used, according to indication of Nicolini (2012). This tool was an updated report on the subject. This report was used to initiate a dialogue to reach the objectives established in this study, in which 9 pre-established key questions were made, with the possibility of others questions that were being made along the interview. The semi structured research instrument was tested with residents of the first year of residency in obstetric nursing, specifically a total of 4 resident nurses, in order to verify if the questions would be able to direct the achievement of the previously proposed objectives. Adjustments were made in the instrument and, after this step, the data were collected with the target population of the research. The 19 participating nurses, all female, were contacted via telephone and the interviews were previously scheduled. The interviews were carried out at their places of work, in their residency work, according to their availability. The organization and analysis of qualitative data was done through Content Analysis (BARDIN, 2004), a research technique that works with words, allowing in a practical and objective way the production of inferences from the content of the communication of a text replicable to its social context. In the content analysis, text is a means of expression of the subject where the analyst seeks to categorize the units of text (words or phrases) that are repeated, inferring an expression that represents them (CAREGNATO, 2006). All subjects were informed about the objectives, risks, and benefits of the research. Their information was collected through spontaneous acceptance and agreement in the Informed Consent Form. This research was approved by the Research Ethics Committee with Human Beings of the Higher Education Center of Campos Gerais under protocol n° 1,617,353/2016.

RESULTS AND DISCUSSION

The interviews were carried out with nurses, all graduated, who worked directly in tertiary care for pregnant women in labor, delivery and postpartum. Of the total of 19 nurses, 17 had specialization in obstetrics and 2 in neonatology. After the complete transcription and analysis of the speeches, we found 8 units of records and 28 units of context. In this article we will cover 3 units of record and 11 units of context. Table 1 shows the units of record found in the interviews, as well as their units of context.

Table 1. Units of record and units of context emerging from the interviews with nurses. Paraná, Brazil, 2018

UNITS OF RECORD	UNITS OF CONTEXT
1. Contextualizing perinatal deaths	1.1 Impossibility of action: Unavoidable cases
	1.2 Culpability of subjects
	1.3 It is the mother's fault
	1.4 Primary Care is to blame
	1.5 Perinatal deaths are not part of the hospital's current reality
2. Technical training	2.1 Training from the Public Policy of the state
	2.2 The meeting is annual
	2.3 Qualification is not for everyone
	2.4 Knowing the protocols
3. Assistence that works	3.1 Actions carried out
	3.2 There are no changes

Source: the Author

Contextualizing Perinatal deaths

When asked about what the nurses thought about perinatal deaths, they said they felt helpless before the inevitability of many of the cases or that they do not feel co-responsible for the situation, as shown below.

Impossibility of action: unavoidable cases: The impossibility of action was one of the aspects mentioned in the interviews. Regarding this impotence, one of the nurses reported:

> N.02 - The only cases that happened were those who were extremely preterm, really? But perhaps in the gestation something happened, they were born before time because of some intercurrence, something that could have been avoided?

In the speech of the interviewee, extremely preterm infants are mentioned, those who arrive at the hospital with some intercurrence and whose situation could only be anticipated by previous actions. However, due to numerous situations, this possibility was not investigated and the situation became

unavoidable. On this topic, França *et al.* (2016) argue that prematurity of children is a recurrent cause of perinatal mortality in Brazil. This factor raises the number of stillborn children and has regional differences. In the North of the country, the authors found that mortality related to prematurity is higher than in the South and Midwest. However, in the view of the authors, it is still difficult to confirm the accuracy of these numbers because the data are analyzed based on the International Statistical Classification of Diseases and Related Health Problems (CID), which means that there is a suppression of certain particularities. In their view, "the birth of preterm infants and death from this cause is largely preventable by improved timely access and qualification of prenatal care" (FRANÇA *et al.,* 2016). Thus, preterm birth is associated with prevention factors such as previous examinations and consultations, which does not appear to be an increase in perinatal mortality, which is associated with the lack of follow-up, on the part of the mother and the Health Unit. Thus, it is evident that subjects should not be blamed unilaterally; it is necessary to analyze what could be done in each context. "Low birth weight, prematurity, gender of the newborn and sociocultural characteristics of the pregnant women were the main risk conditions found for neonatal deaths" (DE PAULA JUNIOR *et al.,* 2017, p.29). Both France (2016) and De Paula Junior (2017) propose that neonatal care should be discussed so that the rate of premature infants could be reduced, based on solutions which contemplate regional aspects but that can also be applied at the national level. In the interviewee's speech, prematurity is highlighted as something problematic, while the avoidability of death was also acknowledged, since she works in a hospital where she attends high risk and extreme prematurity is directly associated with this problem. The theoretical discourse and the discourse expressed by the source are in line with each other, which her local speech to be also the picture of a broader and more complex scenario.

Culpability of subjects: Regarding guilt, from the perspective of the nurses, the mother has part of the responsibility of perinatal mortality and, at other times, the guilt was on the precariousness of basic care.

It is the mother's fault: Regarding the mother, some interviewees pointed out that there is a lack of interest or commitment: "*There is a clear part of responsibility of the mother who does not reach the health unit*." In these situations, when the request for examination is made, the mothers miss the consultations, the examinations, or they return to investigate situations after the initial diagnosis. In another interview, the responsibility of the mother was mentioned once again by the nurse. The details obtained in this speech complement the previous discourse, because the causes pointed out are no longer associated only with the lack of commitment or interest of the mother, but also to lack of assistance in the Health Unit and the difficulty of meeting the physician, and such circumstances become attenuating for birth. She emphasized:

> N.14 - There is a clear part of responsibility of the mother who does not reach the health unit, who cannot have assistance or does not really go to the clinic. All this will influence the time of birth and after birth that influence indirectly.

For Lopes (2018), maternal mourning is considered one of the worst processes that the human being can face. Mortality is seen as something unexpected, causing problems of a different order. However, the author shows that some patients take the risk and others are unaware of the consequences of not having consultations and examinations or even of the need to seek the Health Unit to check the conditions of the fetus. "In order to reduce avoidable deaths, prenatal care should be started as early as possible in order to care for and prevent complications that may lead to death" (LOPES, 2018). In this case, the discourse of the first and second interviews was confirmed; there is no way to treat the mother's role homogeneously. Each case needs a particular analysis of physical and social conditions. It is important that there be preventive care and, in case of perinatal mortality, the ability to offer support or advise about the interruption of gestation.

Primary health care is to blame: Regarding primary care, the interviewees stressed that urinary infections and late prenatal care may be determinant for perinatal death: "... *especially urinary tract infections, I think it is not taken seriously...*". Both problems are associated with lack of perception of the mother, linked to non-attendance to the Health Unit to investigate the conditions. Eclampsia and placental detachment appeared in the reports in an equally important way, and the lack of bond between the Health Unit and the patients was stressed, because issues that could be easily solved are only noticeable when the patient arrives at the Hospital and her card is analyzed.

> N.07- I think so, primary care has the blame. You see when the woman who has a urinary tract infection arrives; I think that this problem is not taken seriously as it should be, either by the doctors who are in the PSF1 doing the prenatal care, or by the patients themselves; because we do not see their adherence.

> N.03 – The most frequent here are cases of urinary tract infection; there are a lot of these cases; placental detachment I do not think it reaches 4%. I do not have access to these rates, but I believe that it does not reach that much. Eclampsia we have many cases as well.

Based on the above reports, it is perceived that there is a bad stratification of the relationship between the Primary Care Unit and patient care. Such distancing favors the possibility of avoidable cases becoming more complex in resolution, and increasing the severity of the existing cases, prompting intercurrences of more serious degrees. In the view of Borbolato and Cardoso (2015), the lack of primary care can lead to further problems such as eclampsia, urinary tract infection, placental detachment, and late prenatal care. Failure to fill in the information on the patient record is also a problem; its right completion could make it easier to obtain information for a more accurate diagnosis. Scabelo Galavote *et al.* (2016) emphasize that nurses are important in primary care because their role is to perform prenatal care, recognize changes, contribute to the solution of problems that come up, and be co-responsible for the qualitative care. The authors point out that "the organization of the work process in PHC is fundamental so that the team can advance in guaranteeing both the universality of access and the comprehensiveness of care and improvement of well-being and of the work itself" (SCABELO GALAVOTE, 2016). It is also important that the nurses know the demands of the primary care unit, as well as the technological supports to facilitate and advance the work in a satisfactory way to the patients. Therefore, the nurses' work in PHC can help to prevent deaths, either in the perinatal

period or in other diverse circumstances. Both primary and tertiary care must be co-responsibility for finding solutions in a joint manner, as well as new options for the current situation.

This does not happen in my hospital: Another aspect highlighted in the interviews was that some nurses pointed to perinatal mortality as non-existent in their routines. The justification that the problem does not affect the reality in which they operate can be explained by the fact that the questioning about perinatal mortality can also mean the questioning of the efficiency of the nursing work. For Oliveira (2014), questioning about work may represent a threat. This may have led to the denial of the fact in the responses. It is also possible that the interviewees did not witness the perinatal mortality in the working hospitals, which does not mean the absence of numbers, but rather the lack of perception of the nurses in the report.

Thus, the answers that permeated this discourse can be perceived as follows:

> N.15 - Not today. Because I think we have a multidisciplinary team today, so that we work as a team; doctors, nurses in the disposal of nutritionists, we have pediatricians, we have a social worker, so we work totally according to the patient, in management according to the pregnant woman.

Based on this response, it is argued that the predominant factor highlighted was the occurrence of few words, short answers, or justifications associated to the health diagnosis. In one case, the fact that perinatal mortality did not occur in the hospital was associated to the multidisciplinary work, [... *because I think we have a multidisciplinary team today*...] this means that this kind of work does not occur with visibility in the reality of the other interviewees, since their responses did not internalize this aspect. In the view of Rêgo *et al.* (2018), the multiprofessional team is a significant aspect to allow greater interaction between the scientific body and the patient, in order to reduce perinatal mortality. In this case, the use of the team as a factor that leads to little visibility of mortality in the hospital is also emphasized in theory.

Technical training

Technical training is important to ascertain the care provided in its particularities. In other words, the quality of training is as important as its existence. Thus, the focus was on whether nurses' training was periodic, whether it was for everyone and whether the protocols were known. These aspects are explored in the units of context presented below.

Training in the logic of the Public Policy of the state: The Mãe Paranaense Network Program is a statewide network that seeks to establish goals, norms and attitudes of change so as to improve the care for mothers and newborns, avoiding infant and maternal mortality. The sub-items below demonstrate aspects of the Program, as well as some of its limitations.

The meeting is annual: Regarding the meeting, its importance was emphasized, particularly the fact that the periodicity is annual. This is shown by the interviewee, as follows.

> N.02 - Yes, aham, we go there! We participate in the annual meeting of the Mãe Paranaense Network, and I was, by the way, the one who went there. And then this information is passed on to the nurses first and every nurse goes to her nursing technician team. The doctors also participate in this meeting to be able to pass on the information to the other doctors.

The interviewee stated that the training existed, it was given in annual basis, and the information obtained at the meeting was passed on to the team in order to make everyone involved aware of the changes and perspectives of the program. Thus, not everyone participated and the information was passed on indirectly. For Neto *et al.* (2017), the Mãe Paranaense Network Program did not become a situational divisor of the state, as it was the original objective. This is because its creation did not reduce neonatal and maternal mortality nor did it increase the quality of care at significant levels. In the author's words, nurses must "direct a look at care actions aimed at health promotion and early detection of diseases with a view to reducing infant mortality indicators and consequently for RMP (Mãe Paranaense Network) to achieve better results" (NETO *et al.,* 2017).

Gaps in the training: The interviewees' statements pointed to a public policy whose participation was not extended to the majority, either because of lack of interest or lack of access. While it is possible to make a critique, it is also important to understand the position of the interviewees about this lack of participation.

> N.12 - I believe that not everyone has training.
>
> N.16 - The whole team should have that specialization, have that knowledge, that graduation. But it is actually not like that.
>
> N.15 - Not all, but we, as people say, we are trained in what we work; for example, I do not even remember what the protocol says, I will be very honest, we are the ones who say the things in which the technician has to be trained according to what he does, in his place of work.

The responses point to a recognition of the importance of qualification, but stress that they do not have it. One of the responses highlights the qualification of some, in the present moment. But the number of responses mentioning non-participation in the program is greater than those doing so. For Frank *et al.* (2016), the Mãe Paranaense Network Program is evaluated in terms of meeting the objectives, but little is studied about other types of research: training for professionals to use measures that provide what is necessary to meet these stipulated goals. In the view of Neto *et al.* (2017), once nurses are aware of the real need to improve knowledge through established prerogatives, their practices may change. If this internalization does not appear, the Program will be partially followed and its results will not be positive. Neto *et al.* (2017) also considers that multiprofessional work should be improved from programs encouraged by public policies. It is essential that nurses be sensitized to the training, in order to adhere to the regulations and to improve their work practice. Thus, it is important to pay attention to the nurses and the ways in which they grasp new information, streamlining their work results.

Knowing the protocols: Knowledge of protocols is another intrinsic factor, since it determines the actions to be performed to improve the quality of care that directly impact the reduction of perinatal mortality. In this sense, the discourse of nurses demonstrates whether or not there is standardization in the care or training to know the protocols, as exemplified below:

> N.11- Here they give it, those that are offered by Mãe Paranaense Network. Not from SUS. Because the last ones were not from SUS... we even tried to participate but, no, it was not open to the Private Network. Only for the public network.
>
> N.07 – There should have, right? To unify, to standardize the service, but it is not like that, we even looked for it, but it was not available to us.
>
> N.14 – There is. Not so frequently. From now on, our director has demanded that there must be a monthly protocol, protocols must be done. Leave written information, because there is actually a conduct to be performed according to the protocol of the Mãe Paranaense network. But we have nothing documented the care protocol. From now on, with this obligation of the shifts being involved in the elaboration of protocols, I believe that they will start to work better.

The first aspect raised regarding the protocols refers to the restrictiveness of the MP Network Program for the Private Network, keeping in mind that the offer is exclusive to the public sector. Another verified fact is that the standardization could generate improvements for the service provided. The first two interviewees still showed that they would like, or that they sought, to participate for standardization of care, but that they have not been successful in this search. As for the following reports, the presence of routines for protocol internalization is emphasized. This is because if some norms of the MP Network leaves the traditional context of work of nurses, it is possible that they do not follow them, opting for their habitual trajectory of work. Regarding the mothers, the case is the same, since the nurses affirmed the fact that not all mothers follow what is proposed by the program. Finally, the last interview demonstrated in the section showed that the protocol was inserted gradually, based on the obligation imposed by the director, and the sanctioning of some obligations. [*...From now on, our director has demanded that there must be a monthly protocol, protocols must be done*]. For Nicolini (2012), practices consist of routines defined historically or by means of regulations. According to the author, practices can be altered when they are internalized by the subjects from a re-educative process, reinforced by repetition, and evaluated. It is necessary that there be a joint construction of protocols with the other members of the multiprofessional team, since the use of protocols presupposes an evidence-based nursing, promotes constant learning of the subjects, and causes the latter to execute updated practices. Moreover, the protocols protect nurses from legal proceedings, minimize communication noise, and, ultimately, tend to improve care quality and reduce perinatal deaths. For David (2014), "the implantation of protocols, by nurses and doctors, is necessary in the care in the Health Care Units because they guarantee the quality of assistance provided by the service". It is therefore fundamental that there is respect for the guidelines, as well as training so that its operation becomes effective, either in the Health Units or other hospital institutions.

Assistance that works

It is important to question the actions that are working. The question made is important because it presupposes that it is necessary to think and act in order to modify the current situation, thus avoiding perinatal mortality. Acting, training and rethinking individual attitudes are necessary actions to make the changes palpable.

Actions carried out: Actions are important ways to understand what is being done to reduce perinatal mortality. The nurses' statements highlighted some of these attitudes, as follows:

> N.15 - And we give that little lecture there, so they have a little information. Because we cannot do much now at the end of the gestation, right?
>
> N.07 - Qualifying the professionals. Yes, I think everyone is seeking technical training so as to guide them, when to look for the hospital, what should be done before that, the tests to be done.
>
> N.09- So we are under constant training in the hospital, the hospital itself offers a lot of training for us, including a course that we are going to do for obstetric emergencies, so we are involved to really improve and empower our teams, right?

One of the interviewees understands the educational action through continuing education as a "little lecture" for the nurses. The use of this words may indicate that there is no understanding or appreciation of this formation, which is seen only as a lecture. And there are probably no other educational methods. The Ministry of Health's policy of continuing and permanent education recommends that there must be constant training to obtain information and facilitate communication between different sectors. "Strategies should contain adequate languages, including accessibility for people with disabilities, content of interest to local society and the use of conventional, regional and popular media, and the internet" (BRASIL, 2009, p. 18). Based on the knowledge acquired, the same interviewee emphasized the need to pass on to patients what has been learned [*... so as to guide them, when to look for the hospital, what should be done before that, the tests to be done]*. Ideas from other states, such as Santa Catarina, were also cited. Furthermore, one of the nurses emphasized the existence of the Adequate Childbirth, a program that encourages humanized childbirth and promotes collaboration with the MP Network Program in the private health network. Another action mentioned by one of the subjects was the meeting with the pregnant women to provide instructions about the realization of examinations and consultations. Monthly meetings and training complete the list of actions taken that were mentioned. For Gomes *et al.* (2018), lectures are needed to bring current themes or recent changes into the work environment, be it in the health area or in another field of knowledge. In the case of the first interviewee's speech, the lecture was not perceived in her intentions, which devalued the activity in her speech. The assistance provided through capacity building is seen by the authors as a necessary process to reinforce immediate prerogatives. Another mentioned action was adequate childbirth. And what is adequate childbirth? In what adequate childbirth collaborate with the reduction of perinatal death?

In the view of Carvalho, Leal and Lima (2018), this program can be defined from three different models focused on reducing cesarean sections. "In the first, the hospital has a team to receive the pregnant women and to assist the birth; in the second, the doctor who assists the prenatal care is the same one who assists the delivery; in the third, the prenatal doctor may or may not be the same who will assesst the delivery" (CARVALHO, LEAL and LIMA, 2018, p.7). Regarding the Adequate Childbirth mentioned by the interviewee, the intention to make this moment more humanized and to reduce Cesarean sections is evident. The attention given is integrated

and does not burden health professionals. Follow-up is done consistently at the time of delivery. Another aspect focused by the authors Carvalho, Leal and Lima (2018) is the guidance to pregnant women during examinations and consultations. This factor also provides greater contact and possibility of performing humanized delivery. For Baggio *et al.* (2016), monthly meetings and training are concrete actions that help in the internalization of routines and establishment of labor standards. In this way, it is noticed that the actions raised by the interviewees are important, although there is no full awareness of their validity within the context of improving perinatal mortality.

There are no changes: The changes are not always perceptible in the professional reality of nurses. Some see a different scenario. They see no changes tand believe that they do not affect them in their demands. The interviewees cited some justifications such as the below ones:

> N.05 - I think that nothing is being done to change reality in the future.
> N.08 - I do not see improvements now, but yes, they can change that, right?

Just as some interviewees acknowledged the existence of changes in delivery care, there were also those who did not recognize changes in the reality they work. For Alves *et al.* (2018), the lack of perception of changes is associated with work overload and lack of professional motivation. In order for changes to be perceived, it is important that the employees feel valued, or that truly impacting actions be established in their work routine. However, the lack of perception of changes can also be associated with the continuity of the problems, lack of structure, and lack of resources. The denial is as important as the acceptance of the existence of the problem. The information revealed by these research subjects shows a heterogeneous field, and showed that the problem is perceived in a differentiated way by the nurses.

Final considerations: The research showed that the discourses of nurses are not homogeneous, in view of the particularities of the speeches of the participants. However, there was a recognition of fragilities, points of care, structural and technological deficiencies, and lack of training of some professionals. The identification of the nurses' attitudes regarding perinatal death showed concern in improving work practices, as well as with receiving qualification and specialization. The multi professional team was also mentioned, but the speeches present in the interviews indicated that this work still walks gradually, far from the ideal. Although some professionals still recognized specialization or praised structure, they were a minority in the picture analyzed in the whole. In addition, there was a significant emphasis on the need for change, indicating concern for more promising results. It is still perceived that the speeches of nurses extenuated more problems related to the specialization for the standardization of the Mãe Paranaense Network Program, which is also implicit in the place of speech, because there was a greater blame attributed to this aspect in the scenario of perinatal mortality. The research also showed other relevant information, such as lack of multiprofessional work, shortage of offerings of specializations focused on the Mãe Paranaense Network Program and the intention of professional improvement in daily practice. Furthermore, the objectives were reached insofar as they identify the attitudes of hospital nurses regarding perinatal death, mainly the perception of each professional in knowing the difficulties and what they can do with the help of a multiprofessional team so that the cases of perinatal death do not occur and be directly linked to assistance and to quality of care. The concern is, therefore, already an indication that improvement of the picture is possible. It is now up to the intervention and awareness of the role of nurses, so that there is effective permanent education to reduce perinatal mortality.

REFERENCES

ALVES, S. R. *et al.* 2018. Serviços de saúde mental: percepção da enfermagem em relação à sobrecarga e condições de trabalho. Rev. pesqui. cuid. fundam.(Online), p. 25-29.

BAGGIO, M. A. *et al.* 2016. Programa Rede Mãe Paranaense: análise da atenção pré-natal em uma regional de saúde. CogitareEnferm [Internet], v. 21, n. 3, p. 1-10.

BARDIN, L. 2004. Análise de conteúdo. 3. ed. Lisboa: Edições 70.

BORBOLATO, B. M., CARDOSO, M. P. 2015. O impacto do pré-natal na prevenção do parto prematuro. RevistaThêma et Scientia, v. 5, n. 1, p. 147-159.

BRASIL, 2011. Programa Rede Cegonha. Ministério da Saúde. Brasília. pp. 6-75.

CAREGNATO, R.T.A., MUTTI, R. 2006. Pesquisa qualitativa: Análise de discurso versus análise de conteúdo. Texto Contexto Enferm, Florianópolis, Out-Dez; 15(4): 679-8.

CARVALHO, M. S., LEAL, M. C., LIMA, L. D. 2018. Nascendo no Brasil, uma entrevista com Maria do Carmo Leal.

DAVID, E. R. H. *et al.* 2014. Influência do protocolo no atendimento em unidades de saúde na área materna infantil na província do Cunene-Angola. Dissertação de Mestrado. 145f.

DE PAULA JÚNIOR, J. D. *et al.* 2017. Perfil da mortalidade neonatal no município de Ubá/MG, Brasil (2008-2010. Revista Brasileira de Pesquisa em Saúde/Brazilian Journal of Health Research, v. 18, n. 3, p. 24-31.

FONSECA, S. C., COUTINHO, E. S. F. 2014. Pesquisa sobre mortalidade perinatal no Brasil: revisão da metodologia e dos resultados. Cadernos de Saúde Pública, v. 21, p. S7-S19.

FRANÇA, E. *et al.* 2016. Mudança do perfil de causas de mortalidade infantil no Brasil entre 1996 e 2010: porque avaliar listas de classificação das causas perinatais. Anais, p. 1-18.

FRANÇA, E., LANSKY, S. 2016. Mortalidade infantil neonatal no Brasil: situação, tendências e perspectivas. Anais, p.1-29.

FRANK, B. R. B. *et al.* 2016. Avaliação da implementação do programa rede mãe paranaense em três regionais de saúde. pp.215-229.

GOMES, R. M. G. M. *et al.* 2018. Sistematização da assistência de enfermagem: revisitando a literatura brasileira. Id on Line REVISTA DE PSICOLOGIA, v. 12, n. 40, p. 995-1012.

LOPES, B. G. 2018. Perspectivas maternas sobre mortalidade perinatal. Dissertação de Mestrado em Ciências da Saúde. – Universidade Estadual de Ponta Grossa, Ponta Grossa. 182f.

NICOLINI, D. 2012. Practice theory, work, and organization: An introduction. 1. ed. Oxford: University Press.

OLIVEIRA, G. de A. *et al.* 2017. A importância do trabalho da enfermagem no atendimento a gestante na ESF. Cadernos de enfermagem, v.1, n.35, São Paulo, USP, pp.23-35

PARANÁ. 2017. Linha Guia Rede Mãe Paranaense. Secretaria de Estado da Saúde. 6ª ed. v.1, Brasil.

PARANÁ. 2018. Taxa de Mortalidade Infantil/1.000 Nascidos Vivos Paraná, 2010 a 2018. Secretaria de Estado da Saúde do Paraná. SESA - Superintendência de Vigilância em Saúde. SVS - Centro de Epidemiologia. CEPI - Divisão de Informações Epidemiológicas. DVIEP. Curitiba, 16 de Julho de 2018, Brasil.

RÊGO, M. G. da S. *et al.* 2018. Perinatal deaths preventable by intervention of the Unified Health System of Brazil. Revista gaucha de enfermagem, n.2, v. 39, pp.49-62.

SCABELO GALAVOTE, H. *et al.* 2016. O trabalho do enfermeiro na atenção primária à saúde. Escola Anna Nery Revista de Enfermagem, v. 20, n. 1, pp. 85-98.

****