The lived experience of the obstetric emergency: a phenomenological study with Mexican women

La experiencia vivida de la emergencia obstétrica: un estudio fenomenológico con mujeres mexicanas[1]

Yesica Yolanda Rangel-Flores[a]
https://orcid.org/0000-0001-5673-6891
E-mail: yesica.rangel@uaslp.mx

Diana Topacio Rincón-Zúñiga[a]
https://orcid.org/0000-0002-7783-2687
E-mail: topacio.rincon@gmail.com

Luis Eduardo Hernández-Ibarra[a]
https://orcid.org/0000-0002-3889-7533
E-mail: eduardo.ibarra@uaslp.mx

[a]Universidad Autónoma de San Luis Potosí. Facultad de Enfermería y Nutrición. Programa de Maestría en Salud Pública. Universidad Autónoma de San Luis Potosí. San Luis Potosi, S.L.P., México.

Abstract

This article aims to explore the experience of Mexican women in the obstetric emergency. This qualitative-phenomenological study was conducted with data collected by means of in-depth interviews with 15 women survivors of this experience, performed from January to September 2017. Obtained data were processed through discourse analysis and interpreted based on the four dimensions of the phenomenology of perception, namely: body, time, space, and relationality. Despite perceiving the complications at early stages, interviewees waited for objective symptoms before seeking for healthcare. According to them, timely treatment seeking did not imply an adequate management. Moreover, these women also reported insufficient support from both formal and informal networks in the provision of specialized treatment. Society and government must articulate strategies that empower women for the attention to obstetric emergencies, besides implementing actions that promote their self-care while guaranteeing timely and specialized care.

Keywords: Emergency; Obstetrics; Experience; Phenomenology; Qualitative Research.

Correspondence
Yesica Yolanda Rangel-Flores.
Av. Niño Artillero, 130. Zona Universitaria. Ext. 5083. San Luis Potosí, S.L.P. México. CEP 78240.

1 Study carried out with resources from the Programa para el Desarrollo *Profesional Docente, para el Tipo Superior* (PRODEP), funded by scholarship UASLP-PTC-578 granted to the first author.

Resumen

Este estudio pretende profundizar en la experiencia vivida por mujeres mexicanas en la emergencia obstétrica. Para ello, se realizó un estudio cualitativo-fenomenológico por medio de entrevistas en profundidad a 15 mujeres sobrevivientes de esta experiencia que se realizaron en el periodo de enero a septiembre de 2017. La información se procesó mediante análisis fenomenológico del discurso, y para su interpretación se organizó en las cuatro dimensiones de la fenomenología de la percepción: cuerpo, tiempo, espacio y relacionabilidad. Las informantes percibieron la complicación de forma temprana, sin embargo, postergaron la atención institucional hasta que se hicieron presentes signos objetivos de complicación; la llegada puntual a los servicios de salud no implicó, desde su percepción, la certeza de manejo oportuno y adecuado, además se reportó un insuficiente apoyo de las redes formales e informales para el traslado y la atención especializada. Es necesario que sociedad y gobierno articulen estrategias que empoderen a las mujeres para la atención a las situaciones de emergencia obstétrica, acciones que promuevan su autocuidado pero garanticen también el apoyo pronto y expedito de sus redes y una atención profesional de calidad.

Palabras clave: Emergencia; Obstetricia; Experiencia; Fenomenología; Investigación Cualitativa.

Introduction

Maternal death (MD) continues to be a serious problem in most underdeveloped countries, contributing significantly to the estimated 830 deaths per day worldwide. Latin America is one of the regions that, together with Sub-Saharan Africa and Asia, represents a critical area for maternal death. Only in this continent, 60 maternal deaths per 100,000 births occurred in 2015, resulting in a reduction of only 52% for the period from 1990 to 2015 (CELADE, 2015).

In Mexico, the reduction in the MD for the period 1990-2013 was only 26.8%, almost half of the reduction in Latin America as a whole, placing it in tenth place among the countries of this continent and below the average achieved by it (Kassebaum *et al.*, 2014). In this country, as in most of the world, the majority of maternal deaths are associated with hypertensive disorders of pregnancy, hemorrhage (due to prolonged or obstructed delivery, uterine rupture and ectopic pregnancy), abortion and sepsis. The situations described above are classified as obstetrical emergencies, understood as *"nosological conditions that endanger the life of the woman during the pregnancy-puerperal stage and/or the product of gestation requiring immediate medical and/or surgical attention by qualified medical personnel"* (Centro Nacional de Equidad de Género y Salud Reproductiva, 2016).

The importance of timely identification by women, seeking transfer and timely treatment becomes relevant when it has been documented that the average time to death following the onset of an obstetric emergency is two hours for hemorrhage, two days on average for eclampsia and obstructed labor, and up to six days in the case of an infectious process (Ouédraogo, 2010).

In the review of documents related to the studies conducted on obstetric emergencies, the prevalence of studies that focus on the performance of health personnel at the time of the event was identified, leaving aside the documentation of the disjunctions faced by women to identify the problem and seek transportation. The few studies that explored

women's perspectives have focused on identifying their level of awareness of the warning signs (García; Montañez, 2012), their perception about the quality of medical care they received (Mohd *et al.*, 2017), and barriers to accessing professional care (Hussein *et al.*, 2016). Other studies, although based on working with women who have experienced an obstetric emergency, focus their interest on exploring the impact that this experience brought to their lives after the event and not on the awareness developed during the emergency (Madeline, 2016; Elmir, 2014).

However, only one study aimed to deepen the experience of obstetric emergency and reported that this experience is lived as a traumatic and conflictive event, whose scope impacts on the demand, trust and fears towards professionals and the health system in general (Szulik; Szwarc, 2015). It is important to mention that the research was not a phenomenological approach, but an ethnography.

Based on the review of the studies conducted on the subject, it is pertinent to explore the experience of obstetric emergencies from the phenomenological perspective, considering this approach allows revealing how women experience the phenomena from the meaning they give to the processes, in their consciousness and from a perspective that, although considered individual, is based on ways of seeing and inhabiting the world that make sense within the collectives in which these people have developed (Berger; Luckmann, 2005).

The objective of this research was to delve into the lived experience of Mexican women in obstetric emergencies, assuming that what they have to say about their own experience and from their subjectivity will contribute to the construction of public health policies sensitive to different realities.

Methods and procedures

This is a qualitative study based on the phenomenology of perception proposed by Merleau Ponty. He was interested in understanding the complexity of the lived experience, interpreting the meanings that underlie the way of reconstructing the event from one's own subjectivity.

We collected information from January to September 2017, with 15 women residing in the north-central region of Mexico. The decision to work with women from this region resulted from the existence of different conditions of human development and social welfare with the potential to determine diverse emotional experiences at the time of obstetric emergency, a factor that contributes to the external validity of the study.

Potential participants were identified from the records of obstetrics and gynecology services of public hospitals in the region. After a rigorous and systematic review of the clinical records, we selected those who had undergone an obstetric emergency in the last three years, without having experienced a perinatal death as result. The decision not to invite women whose children had died was mainly due to ethical considerations, since it was assumed that those who had experienced a perinatal loss would be more emotionally vulnerable, meaning a risk to their psychological safety.

Once identified, they were contacted by telephone to arrange a first meeting with the interviewers. In this first meeting, the nature and scope of the study were explained, and a conversation was held with them to confirm that what was documented in the clinical record coincided with their experience. Within the aforementioned framework, the purposive sampling strategy was implemented (Mendieta, 2015), since women who had experienced the phenomenon of obstetric emergency in depth were invited to participate so that they could remember the event and would like to talk about it.

In a second meeting, the informed consent was obtained and the initial interview was conducted. The information was collected by means of a phenomenological interview whose central question that started the story was: "Could you tell us about the day your child was born?" Both interviewers ensured that the women were free to construct their own stories and the only intervention they made consisted in taking care

of the chronological narrative of the stories, in order to avoid information gaps that could result in absences that would complicate the research team's clear understanding of the experience.

Two researchers from the research team conducted the interviews. The decision to have women interview the survivors was based in the consideration that, given that reproductive processes are also considered as sexual, being interviewed by a man could affect the richness of the women's narratives.

The number of interviews was determined based on the saturation criterion of the experience, and the interviews stopped once they began to construct redundant narratives about the experiences. The interviews lasted approximately 90 minutes, and a single interview was sufficient to delve into the experience of obstetric emergency.

The interviews were audio-recorded with prior informed consent and transcribed by the researchers who conducted them. Subsequently, we deleted the audios to guarantee the protection of the data provided by the informants. Phenomenological-interpretative analysis was applied to the transcribed interviews, following the steps: (1) Transcription, (2) Elaboration of general meaning units, (3) Elaboration of meaning Units relevant to the research topic, and (4) Verification of the relevant meaning units.

For the analysis of the narratives, the units of analysis were grouped into four dimensions considered by phenomenology: Corporeality (the lived body), temporality (the lived time), spatiality (the lived space), and relationality (the lived interaction relations). (Álvarez *et al.*, 2010).

The study complied with the ethical and legal criteria that govern research both internationally and nationally, particularly the Declaration of Helsinki and the Mexican General Health Law. The study was classified of minimal risk, since it was anticipated that the participants could trigger emotional crises by recalling a painful episode in their lives. Thus, it was proposed to suspend the interview in case of emotional crisis, to provide support and psychological accompaniment. However, there were no crisis situations. The Research Ethics Committee of the Health Services of San Luis Potosí approved and monitored the protocol, with registration SLP/002/2017.

Results

Sociodemographic characterization

We worked with 15 women, with an average age of 22.9 years old, a minimum of 16, a maximum of 39 and a mode of 18; 86.6% were engaged in housework, 6.6% were employed and 6.6% were studying. The majority had completed secondary school (46.6%) and primary school (33.3%); there were no professional women. Eighty percent were in a stable union and married when the obstetric emergency occurred, and 20% referred to themselves as a single mother.

Obstetric profiles and characterization of the emergency obstetric event

The emergency obstetric event occurred when the majority were in their first gestation (66.6%), followed by second gestation (26.6%) and there was one case of fourth gestation. In terms of gestational age, 40% of women had the experience between 38 and 39.6 weeks of gestation (WG), 26.6% between 32 and 34 WG, and 20% after 40 WG.

Regarding the situation that led to the obstetric emergency, 93.3% (N=14) had an admission diagnosis associated with hypertensive disorders of pregnancy, of which 21.4% (N=3) were admitted with developing eclampsia and 14.2% (N=2) with Hellp syndrome. The other participant was admitted with septicemia, following resolution of cesarean delivery and a history of diabetes mellitus.

Dimension I: emergence in corporeality

When the body that feels bad is not enough, validation of the discomfort from others is necessary

The participants agreed that they sensed early that something was wrong with their bodies

when they had the obstetric emergency. However, all of them considered it was premature and unnecessary to ask for help from their family or professional networks, since the data on obstetric complications remained at the subjective level (discomfort) and were not evident, so they could not be subject to verification by other people (family or professionals). Based on the above, most of the women preferred to continue with their daily activities, waiting for signs detected by their family members to justify the need for specialized care. Some of the signs that became evident were the impossibility to continue walking, severe edema, vomiting, incapacitating pain, among others.

Romina, for example, reported feeling relieved when finally in the early morning she started vomiting, had intense headache and difficulties to walk; after having spent a whole afternoon with epigastric pain and the intuition that this was not normal. She thought, with all these objective data of complication, her relatives would not hesitate to take her to the hospital and health center would not postpone her care, since she looked really bad:

> *I had been having severe pain since the afternoon, here* [points to the epigastrium]*. I thought it could be because of the baby, but I wasn't sure, I didn't know if, yes, it was bad, I didn't look so bad, at night I started with a lot of vomiting, the headache, the dizziness of not being able to walk. This happened in the early morning, I got scared, but we knew it was bad, and my husband and mother-in-law told me we had to go to the hospital, I had to go to the hospital, to be treated, but 'right now!'.* (Romina)

Unfortunately, not all the women reported having maintained consciousness when these serious symptoms were present; such was the case of Micaela, who did not consider herself sufficiently ill until she suffered convulsions:

> *I felt bad, had a headache, I felt I couldn't see well, I was dizzy, I thought about going to the hospital, but I said "maybe sleeping will help", I didn't look bad, bad, no. I could walk, I fell asleep until around three in the morning when I started to convulse, my sister was sleeping in the same room, when I woke up I was in the hospital.* (Micaela)

Dimension II: time in the emergency

Waiting patiently for the evolution of the complication

They also reported having experienced being returned to their homes on more than one occasion, under the argument that there was insufficient "data" to admit them in the hospital:

> *I knew I had high blood pressure, so I went on Friday; he checked me and told me to come back on Saturday and depending on what they saw, I would stay. And I went on Saturday and that's when my blood pressure was really high, and then they sent me to the emergency room for the operation.* (Ángela)

The time that marks the evolution in the experience and resolution of obstetric emergencies does not correspond to the physiological processes that occur in their bodies or in the decision-making that women do regarding when to seek specialized care, but depends on the institutional time and the judgment that medical personnel make about their cases.

> *During the last two months I have been going there many times, I felt bad, I had already been hospitalized once because of blood pressure, the second time it was the same, for high blood pressure, but they told me it was not so high, but I felt really bad, I could not hold my head, I could not see well, but they said no, that it was controlled and they sent me back to my home.* (Rubí)

Another situation was the underestimation by the women themselves of the limited time available to specialized personnel to guarantee the lives of the women and their children once an obstetric emergency occurs. Several delayed seeking care

because they put the fulfillment of a series of social functions associated with gender, mainly associated with motherhood and caring for others, as Catalina reports:

> *I started feeling bad from the time I woke up, I had a strong headache, but the pain came and went, it wasn't so strong, so I stayed like that. My sisters were working and I was taking care of the children and it was like nothing was happening because the pain came and went, they left the children and when they came back to get them I told my mother that I needed to go to the hospital.* (Catalina)

Sandra, for example, developed septicemia after the cesarean section and, although the signs of the complication became evident very early, she delayed going to the hospital as long as possible in order not to be absent from her son's care:

> *My temperature was high, I took baths but it didn't stay below 39 and it reached 40, they put wet towels on my forehead and stomach to lower my temperature, but I was thinking that I was going to leave the boy and I wouldn't give food for him... He* [the husband] *was here, and my daughters too, they are not children anymore, but I was the one taking care of the boy.* (Sandra)

This is even more complex when the woman is pregnant and the expected date of delivery is distant. The fear of the baby being born before being able to stay alive by himself was one of the reasons that delayed the decision to go to the health institutions, referring to the fear of being operated on and having premature children.

Dimension III: space and emergence

Hospitals as spaces that do not always provide solutions

The place where the obstetric emergency occurs does not seem to be a determining issue regarding the management of the adverse event. Alejandra, who began with convulsions watching a football match on a community field, had an assertive community response. She was quickly transferred to a second level care hospital, but Karla, whose emergency obstetric event was identified while attending a prenatal check-up, experienced a series of difficulties that delayed the referral and transfer between the first and second level of care.

Karla's case was particularly relevant, since it would be expected that the transfer would be much more agile between first and second level care due to the existence of referral and counter-referral protocols. This was not the case, at least in her experience:

> *That day I went to the doctor's office, not because I felt bad, just because it was my appointment. The doctor who attended me scolded me and told me why I didn't go before because my blood pressure was too high, he sent me to the hospital but he couldn't find my file, he had to do all the paperwork again, he asked a social worker to accompany me to the hospital, but it took a long time, because they didn't want to lend her the van because they were going to use it for something else at the same health center.* (Karla)

Dimension IV: Relationships in the emergency

Insufficient support in formal and informal networks

Insufficient support from both formal and informal networks was identified. Regarding the first ones, the experience of gender-based violence was documented as a condition with negative potential influencing obstetric emergency outcomes. This was the Bere's case, who sought strategies to leave her partner's house and move closer to her parents' house, where she had a more solid network to guarantee her and her son's wellbeing:

> *I was in the house with him, then I started to suffer with the first health problems, I had a headache, I couldn't see clearly, and I had a lot of fatigue in my back, but I knew he wasn't going to take me to the hospital. So I made a plan with my sister that I would fight with him to come here* [to his mother's house]*, because I knew that I would need someone*

to take me to the hospital if I had those symptoms again. (Berenice)

This experience of feeling fearful, insecure and surrounded by people with insufficient capacity to guarantee their safety was also experienced in first-level health care services:

They couldn't find my medical file, he [the doctor] *started* [to] *make a file because according to me I didn't have one, but he scolded me, as if it was my fault that they couldn't find the file, he took the card I had and made me another one, I told him to give me mine because they were going to ask for it at the hospital, he didn't give it to me...* (Karla)

Final considerations

This study documented that women do not have the necessary skills (knowledge, attitudinal and evaluative) to identify and act on the initial and subjective warning signs. Regarding knowledge competencies, it was identified that the informants perceived the discomfort; however, they did not problematize it associated with pathological states of gestation. Mengole and Lannacone (2009) have previously pointed out that at a younger age women present not only a lack of knowledge about the warning signs, but also a general lack of knowledge about sexuality and reproduction.

Regarding attitudinal competencies in relation to when and to whom to communicate the identification of these warning signs, even when something is identified as being out of the ordinary, women do not always have the networks in place to ensure prompt and expeditious transfer. In addition, they show resistance to approach health services at an early stage. Mengole and Lannacone (2009) have also documented the existence of a negative attitude towards approaching health services to seek care.

In terms of value competencies, women did not assume themselves derived from their experience of obstetric emergency as close to death, which definitely dictated the evolution tendency that they let advance in their extreme maternal morbidity states. In addition, there is a prevailing lack of trust and certainty about the effectiveness of the treatment they could receive in health services.

With regard to the **experience of the emergency lived from the corporeality**, there is a symbolic distance within the imaginary from which these women conceptualize the body during the event of the obstetric emergency, that is, the body "that feels sick" is not the same as the body "that looks sick". The reasons that compel women to wait patiently for the manifestation of objective and verifiable signs depends, as we have seen in the women's narratives, on the need to be certain of the support they will receive from their family and institutional support networks. As documented by Modh *et al.* (2017) in a study in Malaysia, coping by family support networks to make appropriate timely transfer is often ineffective when warning signs are not sufficiently evident.

The lack of previous experience against which to validate the subjective symptomatology associated with the initial moment of obstetric emergency may be the main obstacle to identifying the initial complication and even the confidence to approach the relevant health services for help. García and Montañez (2012) pointed out that one of the most important determinants in the identification of warning signs is the fact of having been pregnant previously, since the medical discourse received on physiological and pathological changes has been evaluated in the context of an experiential experience.

On the other hand, we consider it relevant to highlight that in our study the presence of informants whose ages are ascribed to the youth stage prevailed, which supports a finding that has been previously pointed out in epidemiological studies on extreme maternal morbidity (Oliveira *et al.*, 2014). In our study, as in those of the authors mentioned above, there were no women over 40 years of age, which we explain in line with Oliveira *et al.* (2014): *"women in older age ranges are up to 25% more likely to die"*, this makes it likely that

older women are not listed as survivors, but rather as cases of maternal death.

The reasons that discouraged women from reporting initial complaints were the fear that they would be questioned by family members or health personnel, because of these symptoms (not verifiable in that situation). Fear of communicating the existence of a complication of which they are not certain, as well as insecurity in the support of third parties (family members and healthcare personnel), has been referred to by Perón and Da Silva (2011) as a situation that discourages appropriate communication of obstetric warning signs.

Bedoya (2019) associated the lack of security of women about their ability to listen, interpret and relate to their own bodies to a consequence of the complex medicalization on women's bodies, more specifically on reproductive processes, that has been made and strengthened over the last century. With the technification of the approach to bodies from westernized medicine, attention use to be focused on the measurement of the objective, making the subjective invisible, particularly when it comes to the subjectivity of women, a gender that has been constructed in the collective imagination – as opposed to the masculine – with a tendency to magnify their moods through histrionic personalities. (APA, 2013).

The medicalization, technification and mechanization of care that characterizes the care of women's reproductive processes within postmodern institutions have demonstrated a direct relationship with the reduction of maternal and infant morbidity and mortality (Hernández; Echeverría; Gomariz, 2017). Moreover, it has compelled women to learn to distrust their own knowledge and intuitions to interpret and validate the signs of their bodies, convincing them that only other people can and should interpret them. These other people even prescribe how they should feel during pregnancy, trying of course to make their experience fit in with what is written in books that, from a positivist science, find it unnecessary to incorporate the subjective experience of the women who live these processes. Disempowering women of their subjectivity to understand their own bodies represents in fact one of the most important problems in the field of bioethics, since it places them in a state of subordination in relation to their own bodies, depriving them of the autonomy to decide and do with themselves (Urrea, 2012).

The westernized medical perspective has also contributed to the development of a social imaginary representing reproductive process as pathological and/or risky processes. Positioning pregnancy and childbirth from a perspective that pathologizes and justifies a protocolized interventionism has resulted in women undergoing these processes considering discomfort as "normal". Consequently, they normalize the incipient symptomatology of obstetric emergencies, which at first are not perceptible to others because they are not incapacitating. Godoy *et al.* (2009) have previously addressed how this westernized view of pregnancy and childbirth pathologizes these stages and contributes to making initial warning signs invisible, and consequently delays the search for specialized care.

Regarding the second dimension, which is the **lived experience from time**, contrary to what has been reported in other studies (Aguiar; Tanaka, 2016; Szúlik; Szwarc, 2015), none of the participants in this study reported having perceived themselves in a near-death situation. This can be explained in terms of what Godoy *et al.* (2009) have pointed out regarding the prevalence of a lack of knowledge among women that does not allow them to elucidate the potential and serious implications of the event of obstetric emergency.

Most of the informants –even those who knew they were diagnosed with a hypertensive disorder of pregnancy– reported waiting patiently for the worsening of incipient discomfort. In many cases, the reason for this wait was due to the fear that family members or health personnel would question these complaints, after they were reported. Seeing themselves as "sick enough", from their imagination, reduces the likelihood of being rejected for hospital admission, an aspect that was important to them, particularly

for those who had been rejected for admission on previous occasions.

The above finding is relevant, as it highlights the reason why women do not approach health services early. Only a personal resistance to approach health personnel, as Mengole and Lannacone (2009) pointed out, does not explain this. On the contrary, women have sought specialized care early, and given that their experience was negative, in obstetric emergency it becomes a complex decision to seek health services. The existence of referral and counter-referral systems has been a controversial issue in health policy research in Mexico. Collado and Sanchez (2012) documented how the referral and counter-referral system in the field of obstetric care is nonexistent and even a phenomenon of hospital multi-rejection, which violates the right to health in women and their children.

These institutional multi-rejection practices may result in maternal deaths, but even if they do not, it does not mean that this practice does not have a negative impact on maternal health. Collado and Sánchez (2015) realized, in line with this study, that the lack of adherence to referral and counter-referral guidelines results in a delay in the arrival of women with extreme maternal morbidity conditions to second level care institutions, mainly because in the context of these previous experiences, women lose confidence and credibility in the actions and institutional actors. We will add to the above that these multi-rejection practices teach them to doubt their action in order to identify alarm signals reliably.

Time is then established as a variable not determined by the decision-making or autonomy of the women whose lives are at risk, but is placed in the scenario of institutions, corporations with a bureaucratized dynamic and another sense of time. This is relevant in terms of Merleau-Ponty's statement that time does not exist in things, but in the relations with things (Hirose *et al.* 2015). The time between the identification and resolution of an obstetric emergency does not depend absolutely on the agency that women and their families have to go to a hospital institution. This time does not even depend on the infrastructure and equipment that the institution has, it includes them, but the complex intersection between the (inter)subjectivities of the women, their relatives and the health actors should not be ignored. Each of these actors, from their own subjectivity, will determine the urgency of the intervention is and the cost of not acting immediately.

However, the lack of certainty about the seriousness of their condition is not the only thing that delays women from leaving their homes for health facilities; there is also the fulfillment of a series of domestic tasks derived from their role as homemakers and mothers. In women who were not primigravidae, the care of other children was one of the reasons why they did not go quickly for an obstetric check-up, which is "natural" in a Mexican context where gender inequality is the result and, in turn, the origin of the absence of participatory fatherhood in child rearing (López, 2017).

The tendency of women to devalue the importance of their own well-being in order to safeguard that of their children becomes evident when they narrate that one of the reasons that delayed their arrival at the hospital was the desire not to have their pregnancies terminated, since they believed that prematurity was inexorably incompatible with survival. Reis *et al.* (2016) pointed out earlier how the fear of possible prematurity is associated with increased distress and suffering during the experience and, with it, hinders decision making to seek help.

The **third dimension embodies that phenomenology is the space.** It was documented how, through the experiences, the survivors position in their consciousness the health institutions within a plane of non-resolution.

The place where the obstetric emergency is does not represent -from the experience of these women- a variable that differentiates the emotions of anguish, fear and uncertainty in which the experience is framed. Women do not identify this space as a place of support response and resolution of the event. The narrative of a more pertinent and decisive community response than that presented in a basic health unit that

has referral and counter-referral protocols for these types of cases was particularly striking, corroborating the affirmations of Collado and Sánchez (2015) that this model is non-existent in the operation.

Finding the "meaning" of the places by means of experiential experience is essential for people to develop care trajectories that guarantee them certainty and credibility in the institutions. The results of this study show how the lived experience in the obstetric emergency contributes to a social phenomenon that Eyles (1989) named "delocalization", which refers to the removal of the socially prescribed meaning of a place, since in reality it does not function for what it should do.

Finally, **the fourth dimension of phenomenology refers to relationality or communicability**, understood as the interpersonal relationships that influence the significance of the experience, in this case the obstetric emergency. The most significant aspect of this dimension is that no functional support was identified in the possible support networks, which are made up of family and institutional actors.

This study documents that, as already pointed out by Hirose (2015), the presence of a partner is not always a protective factor for the successful resolution of an obstetric emergency. Mainly because our study, like that of mentioned author, documents the existence of domestic violence, which is instituted as a threat to the effective resolution of the obstetric emergency. Domestic violence is pointed out as a variable associated with a greater probability of spontaneous abortions (Biswas *et al.* 2015). This finding contradicts, or at least demands a less generalist position, the arguments that Haelterman (2003) constructs in relation to the presence of the partner playing a fundamental role in the trajectory of pregnancy and its resolution, attributing *"nine times more complications in women who do not have a partner during gestation, compared to those who have a partner"*.

This study identified, as Aguiar and Tanaka (2016) have also done, that the performance of the network of healthcare actors does not always generate certainty and confidence in women during this traumatic event, but can enhance the fear and uncertainty that accompanies the experience. Fear of discrimination and blaming health personnel for the situation that afflicts them may also be a factor that delays seeking institutional help (Rangel; Martinez, 2017).

In summary, this research identified three issues associated with the delay in seeking transfer and professional care: first, women lack the skills (knowledge, attitudinal and evaluative) to identify obstetric warning signs; second, those who sensed that something abnormal was happening doubted to be able to recognize that they were experiencing a pregnancy-related complication; and third, the prevalence of an imaginary of pregnancy as a situation framed by pain and discomfort, which "normalizes" the initial discomfort.

Most of them dismissed the risk of death associated with the complication, mainly because at the time of the event they did not have complete information about the extent of the complication for their lives and that of their children. In addition, most of them had their first gestational experience and had no previous experience to validate the (im)relevance of the incipient discomfort of the obstetric emergency. Finally, it was identified that women do not attribute a resolution capacity to health institutions and report non-existent referral and counter-referral processes, as well as insufficient support from formal (institutions) and informal (families) networks. The findings allow us to reflect on the need for society and government to articulate strategies to empower women to deal with obstetric emergencies, actions promoting their self-care and guaranteeing immediate support from their networks and quality professional care.

References

AGUIAR, C.; TANAKA, A. C. Memórias coletivas de mulheres que vivenciaram o near miss materno: necessidades de saúde e direitos humanos.

Cad. Saúde Pública, Rio de Janeiro, v. 32, n. 9, p. 1-13, 2016. DOI: 10.1590/0102-311X00161215

ÁLVAREZ, M. *et al.* Caracterización de la morbilidad materna extremadamente grave. *Rev Cubana Hig Epidemiol*, La Habana, v. 48, n. 3, p. 310-320, 2010. Disponível em: <http://scielo.sld.cu/pdf/hie/v48n3/hie10310.pdf>. Acesso em: 11 out. 2021

AMERICAN PSYCHIATRIC ASSOCIATION – APA. *Diagnostic and statistical manual of mental disorders*. 5. ed. Washington, DC: American Psychiatric Association, 2013.

BEDOYA, L.; AGUDELO, A. Relación de las mujeres en embarazo, parto y postparto (EPP) con los servicios de salid según la clase social. *Revista Gerencia y Políticas de Salud*, Bogotá, DC, v. 18, n. 36, p. 1-12, 2019. DOI: 10.11144/Javeriana.rgsp18-36.rmep

BERGER, P. L.; LUCKMANN, T. *La construcción social de la realidad.* Buenos Aires: Amorrortu editores, 2005.

BISWAS, A. *et al.* Intimate partner violence during pregnancy and victim's perception on miscarriage. *International Journal of Public Health Research*, New York, v. 3, n 2, p. 58-63, 2015. Disponível em: < http://www.openscienceonline.com/journal/archive2?journalId=718&paperId=1433>. Acesso em: 11 out. 2021.

CELADE – Centro Latinoamericano y Caribeño de Demografía. Hacia la armonización de las estimaciones de mortalidad materna en América Latina. *Serie Población y Desarrollo*, Santiago, n. 108, LC/L.3735, 2015. Disponível em: < https://repositorio.cepal.org/bitstream/handle/11362/7143/LCL3735_es.pdf?sequence=1&isAllowed=y>. Acesso em: 11 out. 2021.

CENTRO NACIONAL DE EQUIDAD DE GÉNERO Y SALUD REPRODUCTIVA. Triage obstétrico, código mater y equipo de respuesta inmediata obstétrica. Lineamiento técnico. *Secretaría de la salud*, Ciudad de México, 2016. Disponível em: <https://www.gob.mx/cms/uploads/attachment/file/131801/web_TriageObstetricoCM.pdf>. Acesso em: 11 out. 2021.

COLLADO-PEÑA, S. P.; SÁNCHEZ-BRINGAS, A. Referencia y contrarreferencia o multi-rechazo hospitalario? Un abordaje cualitativo. *Revista CONAMED*, Ciudad de México, v. 17, n. 1, p. 23-31, 2012. Disponível em: <https://www.medigraphic.com/pdfs/conamed/con-2012/cons121d.pdf>. Acesso em: 11 out. 2021.

COLLADO-PEÑA, S.; SÁNCHEZ-BRINGAS, A. Dificultades y obstáculos en la atención obstétrica: un estudio de caso. *Género y Salud en cifras*, Ciudad de México, v. 13, n. 3, p. 25-36, 2015. Disponível em: <https://www.gob.mx/cms/uploads/attachment/file/245089/13_3Art3.pdf>. Acesso em: 11 out. 2021.

ELMIR, R. Finding meaning in life following emergency postpartum hysterectomy: what doesn't kill us makes us stronger. *Journal of Midwifery Womens Health*, Silver Spring, v. 59, n. 5, p. 510-515, 2014. DOI: 10.1111/jmwh.12169

EYLES, J. The geography of everyday life. In: GREGORY, D.; WALFORD, R. (Ed.). *Horizons in human geography*. Totowa: Barnes & Noble, 1989. p.102-117.

GARCÍA, J. F.; MONTAÑEZ, M. I. Signos y síntomas de alarma obstétrica. Acerca del conocimiento que tienen las mujeres. *Revista médica del Instituto Mexicano del Seguro Social*, Ciudad de México, v. 50, n. 6, p. 651-657, 2012. Disponível em: <http://new.medigraphic.com/cgi-bin/resumen.cgi?IDARTICULO=41767>. Acesso em: 11 out. 2021.

GODOY, S. R. *et al.* Near miss: repercussões e percepção da assistência recebida por mulheres sobreviventes egressas de uma unidade de terapia intensiva. *Acta Paul Enferm*, São Paulo, v. 22, n. 2, p. 162-168, 2009. DOI: 10.1590/S0103-21002009000200008

HAELTERMAN, E. *et al.* Social deprivation and poor access to care as risk factors for severe pre-eclampsia. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, Bruselas, v. 111, n. 1, p. 25-32, 2003. DOI: 10.1016/S0301-2115(03)00161-1

HERNÁNDEZ, J. M.; ECHEVARRÍA, P.; GOMARIZ, M. J. ¿Némesis obstétrica o disminución del riesgo? A debate bioético el abordaje intervencionista en los partos de bajo riesgo.

Acta bioethica, Santiago, v. 23, n. 1, p. 161-170, 2017. DOI: 10.4067/S1726-569X2017000100161

HIROSE, A. *et al.* Determinants of delays in travelling to an emergency obstetric care facility in Herat, Afghanistan: an analysis of cross-sectional survey data and spatial modelling. BMC Pregnancy and Childbirth, Londres, v. 15, n. 14, p. s/n, 2015. DOI: 10.1186/s12884-015-0435-1

HUSSEIN, J. *et al.* Maternal death and obstetric care audits in Nigeria: a systematic review of barriers and enabling factors in the provision of emergency care. Reproductive health, Londres, v. 13, n. 47, p. 1, 2016. DOI: 10.1186/s12978-016-0158-4

KASSEBAUM, N. *et al.* Global, regional and national levels and causes of maternal mortality during 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. *The Lancet*, Londres, v. 384, n. 9947, p. 980-1004, 2014. DOI: 10.1016/S0140-6736(14)60696-6

LÓPEZ ESTRADA, S. Políticas de cuidado infantil en América Latina: análisis comparado de Chile, Costa Rica, Uruguay y México. *Frontera norte*, Tijuana, v. 29, n. 58, p. 25-46, 2017. DOI: 10.17428/rfn.v29i58.495

MADELEINE, C. Understanding psychological traumatic birth experiences: a literature review. *Journal woman and birth*, Camberra, v. 29, n. 3, p. 203-207, 2016. DOI: 10.1016/j.wombi.2015.10.009

MENDIETA, G. Informantes y muestreo en investigación cualitativa. *Investigaciones Andina*, Bogotá, DC, v. 17, n. 30, p. 1148-1150, 2015. Disponível em: <http://www.redalyc.org/pdf/2390/239035878001.pdf>. Acesso em: 11 out. 2021.

MENGOLE, T.; LANNACONE, J. Factores socioculturales, conocimiento yactitudes de las primigestas adolescentes y no adolescentes frente al embarazo en el Hospital José Agurto Tello Chosica, Lima, Perú, 2009. *The Biologist*, Lima, v. 8, n. 2, p. 164-178, 2009. Disponível em: <https://dialnet.unirioja.es/servlet/articulo?codigo=4004820>. Acceso em: 20 out. 2021.

MOHD, N.; NIK, N. H.; AB, A.; ZAHARAH, S. The experiences of women with maternal near miss and their perception of quality of care in Kelantan, Malaysia: a qualitative study. BMC *Pregnancy and Childbirth*, Londres, v. 17, n. 1, p. 1, 2017. DOI: 10.1186/s12884-017-1377-6

OLIVEIRA, F. C.; SURITA, F. G.; PINTO, E. S. J. L.; CECATTI, J. G.; PARPINELLI, M. A.; HADDAD, S. M.; COSTA, M. L.; PACAGNELLA, R. C.; SOUSA, M. H.; SOUZA, J. P. Brazilian Network for Surveillance of Severe Maternal Morbidity Study Group. Severe maternal morbidity and maternal near miss in the extremes of reproductive age: results from a national cross-sectional multicenter study. BMC *Pregnancy Childbirth*, Reino Unido, v. 14, n. 77, p. 1, 2014. DOI: 10.1186/1471-2393-14-77

OUÉDRAOGO, I. El tratamiento oportuno de las complicaciones obstétricas como estrategia de reducción de la mortalidad materna, 2010. *Kalu Institute*. Disponível em: <https://kaluinstitute.org/es/el-tratamiento-oportuno-de-las-complicaciones-obstetricas-como-estrategia-de-reduccion-de-la-mortalidad-materna-2/>. Acesso em: 11 out. 2021.

PERON GIAXA, T. E.; DA SILVA, M. L. Miedo e inseguridad de la gestante durante el trabajo de parto como motivos para la demanda de internación precoz. *Investigación y Educación en Enfermería*, Medellín, v. 29, n. 3, p. 363-369, 2011. Disponível em: <https://www.redalyc.org/pdf/1052/105222406004.pdf>. Acesso em: 11 out. 2021.

RANGEL, Y. Y.; MARTÍNEZ, A. G. (In) visibilizaciones de violencia obstétrica en las percepciones de indígenas del centro norte de México. *Investigação qualitativa em saúde*, Lisboa, v. 2, pp. 1145-1154, 2017. Disponível em: <https://proceedings.ciaiq.org/index.php/ciaiq2017/article/view/1451/1408>. Acesso em: 11 out. 2021.

REIS, L. G.; PEPE V. L.; CAETANO, R. Safe motherhood in Brazil: the long road to the realization of a right. *Physis Revista de Salud Colectiva*, Río de Janeiro, v. 21, n 3, p. 1139-1160, 2011. Disponível em: <http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-73312011000300020>. Acesso em: 11 out. 2021.

SZULIK, D.; SZWARC, L. Era una bomba de tiempo: el derrotero de la morbilidad materna severa en el Área Metropolitana de Buenos Aires. *Salud colectiva*, Buenos Aires, v. 11, n. 4, p. 553-564, 2015. DOI: 10.18294/sc.2015.795

URREA, F. El cuerpo de las mujeres gestantes: un diálogo entre la bioética y el género. *Revista Colombiana de Bioética*, Bogotá, DC, v. 7, n. 1, p. 97-110, 2012. Disponível em: <https://pesquisa.bvsalud.org/portal/resource/pt/lil-750288>. Acesso em: 11 out. 2021.

Authors' contribution

Rangel-Flores is responsible for obtaining funding for the research, constructing the protocol, collecting and analyzing data, and preparing the initial and final proposal for the article.
Rincón-Zúñiga collaborated in the construction of the protocol, collected and analyzed the data.
Hernández-Ibarra assisted in the methodological aspects of the research.

Received: 31/10/2019
Re-submitted: 31/10/2019
Approved: 27/09/2021