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Percepção de gestantes sobre a organização do serviço/ assistência em um pré-natal de baixo risco de Recife

Perceptions of pregnant women about the organization of the service/ assistance in prenatal low risk in Recife

Las percepciones de las mujeres embarazadas sobre la organización del servicio/asistencia en bajo riesgo prenatal de Recife

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ABSTRACT

Objective: To describe the epidemiological profile and the perception of low risk pregnant women care met in a maternity hospital in Recife. **Method**: Descriptive study with 94 pregnant women attending prenatal low risk, from April to May 2014. Data were collected from subjects and the Maternity Card, using a questionnaire. **Results:** 71% were brown/black, 17% low education, 26% single/divorced, 49% unemployed and 48% had family incomes below the minimum wage. 28% multigesta and 17% said at least one abortion. However, of the 69 (73.4%) who had undergone tests, 46% were little satisfied/dissatisfied with the delivery time of the exams. **Conclusion:** Knowing the profile and the satisfaction of pregnant women brings contributions to nursing, since it is for nurses to make prenatal visits of pregnant women considered low risk, being your responsibility to ensure a qualified prenatal care in an integrated manner.

Descriptors: Pregnant Women, Prenatal Care, Perception, Nursing Care.

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RESUMO

Objetivo: Descrever o perfil epidemiológico e a percepção da assistência de gestantes de baixo risco atendidas em uma maternidade do Recife/PE. **Método**: Estudo descritivo com 94 gestantes atendidas no pré-natal de baixo risco, de abril a maio de 2014. Os dados foram coletados dos sujeitos e do Cartão da Gestante, utilizando questionário. **Resultados**: 71% eram pardas/negras, 17% baixa escolaridade, 26% solteira/divorciada, 49% desempregada e 48% tinha renda familiar menor que um salário mínimo. 28% multigesta e 17% referiu no mínimo um aborto. Entretanto, das 69 (73,4%) que haviam realizado exames, 46% estavam pouco satisfeitas/ insatisfeitas com o tempo de entrega dos exames. **Conclusão:** Conhecer o perfil e a satisfação das gestantes traz contribuições para enfermagem, uma vez que compete ao enfermeiro realizar as consultas de pré-natal das gestantes consideradas de baixo risco, sendo de sua responsabilidade assegurar uma assistência pré-natal qualificada de maneira integral.
Descritores: Gestantes, Cuidado Pré-natal, Percepção, Cuidados de Enfermagem.

RESUMEN:

Objetivo: Describir el perfil epidemiológico y la percepción de las mujeres embarazadas de bajo riesgo asistencial se reunió en un hospital de maternidad en Recife. **Metodo**: Estudio descriptivo con 94 mujeres embarazadas que acuden a bajo riesgo prenatal, de abril a mayo de 2014. Los datos se obtuvieron de los sujetos y la tarjeta de la maternidad, mediante un cuestionario. **Resultados**: El 71% eran de color marrón/ negro, 17% bajo nivel de educación, 26% solteras/divorciada, 49% de desempleadas y el 48% tienen ingresos familiares por debajo del salario mínimo. 28% multigesta y 17% dicho al menos un aborto. Sin embargo, de las pruebas de 69 (73,4%) que habían sido sometidos, el 46% eran poco satisfechos/insatisfechos con el tiempo de entrega de los exámenes. **Conclusión:** Conocer el perfil y la satisfacción de las mujeres embarazadas aporta contribuciones a la enfermería, ya que es para que las enfermeras realizan visitas prenatales de las mujeres embarazadas consideradas de bajo riesgo, siendo su responsabilidad garantizar una atención prenatal calificada de una manera integrada.
Descriptores: Mujeres Embarazadas, Atención Prenatal, Percepción, Atención de Enfermería.

INTRODUCTION

Prenatal care comprises a set of actions aimed at women's health during pregnancy, in order to identify risks, act early before the situations encountered, ensure better health condition, prevent death and physical impairment for the mother and the fetus, in order to contribute to the reduction of maternal and fetal morbidity and mortality.[1]

A prenatal care and qualified and humanized puerperal occurs through the incorporation of warm pipelines and without unnecessary interventions and easy access to quality health services, which integrates all levels of care: promotion, prevention and health care for pregnant woman and the newborn, from basic outpatient care to hospital care for high risk.[2]

To understand the needs and perspective of the users of the Unified Health System is interesting that managers and care providers can assess their performance through quality indicators having as a base the satisfaction of users.[3] User satisfaction can be the best way to assess the quality of health care, it includes indicators of these three dimensions, going beyond the clinical problem. It is noted that an assessment has multiple and varied dimensions; however, what actually is being done is a judgment on the policy, programs and health services.[4] Thus, it serves as an evaluation indicator of both the structure and the process.[5]

The assessment of care quality should be done under three aspects: structure, process and health care results.

The latter being the referent changes related knowledge and behaviors, as well as user satisfaction due to the care provided. The stage of the process is related to the direct care, non-direct and the professionals' behavior.[6]

It is interesting to know what the population most need. After the diagnosis and revealed the main dissatisfactions as a service, they should lead for improvement in quality of care, which brings more benefits for community in order to strengthen planning processes and provide a better link and reception between professionals and users.[7]

The Ministry of Health, with the concern and purpose of standardizing the assessment of prenatal care, launched in 2002 the Program for Humanization of Prenatal and Birth (PHPN), which makes reference to the rights of pregnant women and children during prenatal, childbirth and the postpartum period, humanization of care to pregnant women, to the of the integrity process of health support network and improvement in ensuring acess.[8]

Although it is a very relevant content, it is remarkable the deficit of research that help the study on the characterization of women who perform prenatal visit, especially in the state of Pernambuco, whereas prenatal quality is one of the measures to be sought primarily by health managers when trying to combat the rates of maternal and perinatal morbidity and mortality.

This study aims to describe the epidemiological profile and the perception of low risk pregnant women care met in a maternity of Recife/PE.

METHOD

We conducted a descriptive study in the maternity clinic of a Recife city which holds, among other services, antenatal care for low-risk pregnant women.

The population consisted in convenience sample of 94 pregnant women aged over 18 years-old who attended the clinic for prenatal consultations during the period from April 1st to May 31st, 2014. Pregnant women who were not carrying the card for pregnant data collection were not included.

Data were collected through interviews of the subjects, using a structured questionnaire designed to search, with the term of free clarification, in which participants authorize their participation in research. Other supplementary information was collected from the Maternity Card.

The variables selected for the study were classified as: a) Sociodemographic (age group, race/color, schooling, marital status, occupation, family income, resident count in the household, number of rooms, home occupation type); b) Personal History (diseases, habits); c) Background Obstetric (number of pregnancies, number of births, number of abortions); d) Procedures performed and tests; e) Current Prenatal (to begin prenatal until the 4th month ≥ 6 consultations, Women/Quarter Gestational, Number of consultations/semester) and f) variables on the service and assistance (home organization/structure service, assistance provided by professionals, examinations realization). The variable "≥ 6 consultations" was analyzed only for pregnant women in the 3rd trimester.

To assess the adequacy of prenatal care we used the recommendations of the Humanization Program Guidelines of Childbirth (PHPN) considering for this study "appropriate" prenatal assistance if: a) the mother joined the prenatal to the 4th month of pregnancy; b) held at least once during pregnancy routine laboratory tests. It was considered "inadequate" prenatal care if at least one of these criteria is not met.

The questionnaires were entered into Excel spreadsheet and after processing consistency and analyzed in SPSS 18.0.

The project was approved by the Ethics Committee in Research of the University of Pernambuco, under CAAE: 26392214.0.0000.5207.

RESULTS

The population consisted of 94 pregnant women, 71.5% are brown or black, 56% were aged between 25 and 34 years-old; however, 8.5% were 35 years-old or older. As for education, about 50% completed high school and 17% had incomplete primary education or had not completed elementary school. Regarding marital status, 25.5% were single or divorced, while on the economic characteristics, 48.9% replied that they were unemployed, 48% lived on less than one minimum wage and 25.5% live in rented accommodation (Twable 1).

Table 1 - socioeconomic and demographic characteristics of pregnant women attending prenatal care from a public maternity of Recife-PE, 2014

Race/color	N	%
White/Oriental	23	24,5
Indigenous	3	3,2
Brown/Black	67	71,3
Age group		
18 to 24	33	35,1
25 to 34	53	56,4
35 and More	8	8,5

(To be continued)

(Continuation)

Education		
1st to 4th grade of elementary school	3	3,2
5th to 8th grade of elementary school	13	13,8
Incomplete high school	20	21,3
Complete high school	48	51,1
Incomplete/complete Higher Education	10	10,6
Marital status		
Married/stable Union	70	74,5
Single/divorced	24	25,5
Occupation		
Unemployed	46	48,9
Employed	37	39,4
Housewife	11	11,7
Family income		
Until 1 MW	45	47,9
2 to 3 MW	46	48,9
> 3 MW	3	3,2
The home occupation type		
Rent	24	25,5
Homeownership/courtesy	71	74,4

Source: Pregnant and Pregnant Card/MS.

Among the personal background, 34% were or have had urinary tract infection and the life habits, 8.5% were smokers. As for obstetrical history, most were pregnant for the second time (40.4%). As for parity, 43.6% and secundiparous. On abortion, 17% had at least one abortion event (Table 2).

Table 2 - Clinical characteristics and personal and obstetric history of pregnant women attending prenatal from a public maternity of Recife- PE, 2014

Personal antecedents	N	%
Diseases/Injuries *		
Urinary tract infection	32	34,0
Hypertension	7	7,4
Gynecological surgeries	8	8,5
Anemia	2	2,1
Others	4	4,3
None	48	51,1
Habits		
Alcohol consumption	1	11,1
Smoking	8	88,9
Obstetric Background	**N**	**%**
Number of pregnancy		
1	30	31,9
2	38	40,4
≥ 3	26	27,7

(To be continued)

(Continuation)

Obstetric Background	N	%
Number of delivery		
0	32	34,0
1	41	43,6
≥ 2	21	22,3
Number of abortion		
0	78	83,0
1	13	13,8
≥ 2	3	3,2

Source: Pregnant and Pregnant Card/MS

With regard to immunization, approximately 80% received tetanus immunization prenatally, or before, and 69.5% hepatitis B. In relation to routine test ordering, were observed the following percentages: Blood typing (90,1%), complete blood count (89%), fasting glucose (90.1%), VDRL (85.7%), urine type I (89%), Anti-HIV (85.7%), serology for hepatitis B (80.2%), toxoplasmosis (78%), and ultrasonography (85.7%). Other tests such as Cytology, Electrophoresis Hemoglobin, Anti-HCV and HTLV when combined accounted for 36.2%. The less performed laboratory tests were feces Parasitological (1%) and Indirect Coombs (6.5%). As regards the repetition of Anti-HIV and syphilis tests for pregnant women from the 30th week of gestation, met the request in 29.5% and 22.9% respectively (Table 3).

Table 3 - Frequency distribution of procedures and tests performed during prenatal care, Recife-PE, 2014

PROCEDURES/EXAMS	YES N (%)	NO N (%)
She received tetanus vaccine/immunized	74 (80,4)	18 (19,5)
She received hepatitis B vaccine/immunized	64 (69,5)	28 (30,4)
ABO-RH system	82 (90,1)	9 (9,8)
Hb/Ht	81 (89,0)	10 (10,9)
Fasting glycemia	82 (90,1)	9 (9,8)
VDRL	78 (85,7)	13 (14,2)
Urine I	81 (89,0)	10 (10,9)
Parasitological of Feces	1 (1,0)	91 (98,9)
Anti-HIV	78 (85,7)	13 (14,2)
HBsAG	73 (80,2)	18 (19,7)
Toxoplasmosis	71 (78,0)	20 (21,9)
Indirect Coombs	6 (6,5)	85 (93,4)
USG	78 (85,7)	13 (14,2)
Others	33 (36,2)	58 (63,7)
She repeated Anti-HIV (Expectant mothers from the 30th week)	14 (22,9)	47 (77,0)
She repeated VDRL (Expectant mothers from the 30th week)	18 (29,5)	43 (70,4)

Source: Pregnant and Pregnant Card/MS

The beginning of prenatal care was given until the end of the 1st trimester of pregnancy in 54.2%. Among pregnant women in the 3rd trimester (56), only 12.5% had 6 or more visits. As for prenatal care we observed suitability criteria recommended by PHPN in only 47.8% of pregnant women seen at the start of prenatal care until the 4th month of pregnancy and the request of the tests: ABO Rh, VDRL, urinalysis, blood glucose, Hb/Ht and Anti-HIV (Table 4).

Table 4 – Characterization of pregnant women according to early prenatal care, the trimester and the number of consultations per quarter, Recife-PE, 2014

Variable	Yes N(%)	No N(%)
Early prenatal care in the first trimester	51 (54,2)	43 (45,7)
≥ 6 consultations	7 (12,5)	49 (87,5)
Adequacy of prenatal care	27 (47,8)	29 (51,7)
Women/ Gestational quarter	**N (%)**	
1º Trimester	7 (7,4)	
2º Trimester	31 (32,9)	
3º Trimester	56 (59,5)	
Number of consultations/ Semester	**N (%)**	
Number of queries in the 1st quarter		
None	41 (43,6)	
≥1	53 (56,3)	
Number of queries in the 2nd quarter		
<2	18 (20,6)	
≥2	69 (79,3)	
Number of queries in the 3rd quarter		
<3	33 (58,9)	
≥3	23 (41,7)	

Source: Pregnant and Pregnant Card/MS

In item satisfaction, 59.6% of women were satisfied with the care of professionals and 22.3% were somewhat satisfied. On the organization/structure of services offered, 58.5% said they were very satisfied and 36.2% do not consider themselves satisfied and referred to assistance provided by professionals, 74.5% were satisfied, and the delivery time of tests ordered, the 69 (73.4%) who had performed tests, 46.4% were somewhat satisfied or dissatisfied (Table 5).

Table 5 - Characterization of pregnant women's satisfaction about the prenatal care offered in a maternity Recife-PE, 2014

Care variables	Satisfaction degree			
	Very satisfied	Satisfied	Little satisfied	Dissatisfied
	N(%)	N(%)	N(%)	N(%)
Reception	14(14,9)	56(59,6)	21(22,3)	3(3,2)
Organization/ Service Structure	55(58,5)	1(1,1)	34(36,2)	4(4,3)
Assistance provided by Professional	9(9,6)	70(74,5)	13(13,8)	2(2,1)
Exams	12(17,4)	25(36,2)	28(40,6)	4(5,8)

Source: Pregnant women.

DISCUSSION

This study showed a significant proportion of women who are 35 years-old and older, who are brown/black, with low education, single or divorced, unemployed, with income lower than 1 minimum wage, living in rented housing. The study also showed a significant proportion of pregnant women with a history of urinary infection, smoking, and history of miscarriage. With regard to immunization and exams, most had been vaccinated against tetanus and hepatitis B and had performed routine examinations; however, it emphasizes the low percentage of realization of Cytology, Electrophoresis Hemoglobin, Anti-HCV, and HTLV. It was also observed that just over a third of the women had not started prenatal care up to the 4th month of pregnancy and among pregnant women in the 3rd trimester less than one-sixth had performed 6 or more queries, more than half of pregnant women were satisfied with the reception of professionals, structure/organization of the service and support of health professionals.

The high proportion of late pregnant women in this study corroborates other national studies.[9,10] Age is a factor, since it is known the influence in the health of the Newborn (RN) and the pregnant woman. Advanced maternal age favors the increase in maternal mortality, regarding obstetric emergencies, hypertensive disorders, gestational diabetes, preeclampsia, among other complications and adverse perinatal conditions, such as stillbirth and low birth weight.[8]

Regarding race/color, a study[11] shows that black women are more likely to die from direct obstetric causes, and it is more frequent pilgrimage in search of care in labor. According to the Ministry of Health[12], the maternal mortality rate in brown/black women is almost six times higher compared to white women, these being more likely to get high blood pressure and diabetes due to their biological predisposition.

The low educational level is associated with high rates of maternal and perinatal mortality, since maternal education may be one of the fundamental parts during the pregnancy period for demonstrating great influence on the behavior of pregnant women. In this study, about half of pregnant women have completed high school; this result is similar to findings in national research.[13,9]

Education is a factor of utmost importance in prenatal care, since according to surveys,[9,14] pregnant women with low level of education and low socioeconomic status usually start prenatal care late and have a higher rate of absenteeism, besides presenting inadequate habits during pregnancy.

Some studies show that most pregnant women is married or in a relationship.[9] About marital status, it is emphasized that the presence of a partner is very important throughout the pregnancy process, especially when it accompanies his wife during prenatal consultations, which allows a better preparation of the couple for the birth, with a view that pregnancy is a stage full of changes[12,15]. Also, single women without social support are at increased risk of morbidity, high psychological stress, anxiety regarding maternity motivated both by the absence of a companion as by family fragmentation and even the gravidic changes, increasing the chance of presenting premature births.[12]

Regarding the occupation and family income, it is necessary to pay attention in this study that the condition of unemployment and low income may be being aggravated by the fact that most of the women dwell in rented homes, thereby increasing household expenditure. This condition is similar to a study in Fortaleza[16], which considers the low family income as a risk factor for birth of infants of low birth weight and premature births, and other perinatal complications. In this perspective, the low income makes it impossible to achieve good standards of education, food, health and general resources, negatively interfering with your life and health[15]. Given that some studies indicate that health professionals need to be aware of the socioeconomic conditions of its customers and the possible health risks from these factors.[9]

Among the diseases/relevant diseases of pregnant women, the urinary tract infections (UTI) are prevalent in pregnant women and are the most responsible for hospital admissions during this period. They are associated with conditions of multi-parity, low socioeconomic status, ITU past history and high age, and may result in maternal complications such as pyelonephritis and septic shock; and fetal such as premature birth, low birthweight infants, premature rupture of membranes and perinatal deaths[17].

Smoking and alcohol are predisposing lifestyle habits for risk pregnancy. A smoker pregnant inhaled nicotine encourages the increased fetal heart rate, low growth and development and neurological disorders, also increases the risk of miscarriage, while alcohol consumption in early pregnancy is associated with increased risk of congenital birth defects.[12]

The immunization through vaccination during pregnancy aims to preserve the pregnant woman's health and fetus.[12] Neonatal tetanus is an acute nature of the disease, which has a high gravity, it is not transferable and has as a preventive

measure, specific nature, immunization by tetanus shot "dT". A study in Rio Grande do Norte has identified about 90% of pregnant women were vaccinated against tetanus[13], while, this study found about 80% of pregnant women were vaccinated with "dT", this vaccine is part of the calendar of pregnant women and can be considered a marker in the quality of care, these findings show a weakness in the immunization program.

The second main route of transmission of hepatitis B is the vertical, i.e., from mother to baby during pregnancy. In Brazil, vaccination against hepatitis B is available for the population is aged less than 20 years-old and for vulnerable groups such as pregnant women after the first trimester of pregancy.[18]

In these pregnant women were found who have not been immunized against hepatitis B, about 30%. Meanwhile, a study in Pelotas found that 23% of women have not been vaccinated against hepatitis B. The main reason for them was no request by health professional.[19] Precisely to weigh the pregnant woman's risk of acquiring unvaccinated disease and transmit during pregnancy, the National Immunization Program (NIP) emphasizes the importance of receiving the vaccine by those against hepatitis B[12].

The proportion of pregnant women who did not undergo serology for hepatitis B, together with those who did not undergo vaccination, shows a greater exposure of infants to hepatitis B, although is higher the coverage of the vaccine against such morbity.[18] With regard to immunization of hepatitis B the number of studies is very limited, indicating a greater need for studies that address this issue.

It has been as obstacles to the fulfillment of prenatal care protocol, as regards the part of the immunization, poor compliance of professional and/or pregnant women to the vaccination protocol and problems with registration of vaccination in the pregnant card, setting these as factors that should be further investigated to guide strategies of actions.[20]

The request of tests during prenatal care enables early and timely identification of morbidities, prevents complications related to the transmission of infectious agents to the embryo and/or fetus during pregnancy, allows the treatment of abnormalities found with a view to cure or control of maternal disease, preventing vertical transmission, possible maternal, fetal and infant deaths, thus contributing to the reduction of maternal mortality as well as infant mortality. The results make up a monitoring for classification of prenatal risk by targeting assistance to achieve the comprehensive care of pregnant women in all its needs.[19,21-2]

In this study it could be observed the non-request of routine tests to all pregnant women, configured as an unsuitability to PHPN, which recommends their request at the first prenatal visit, as this is an appropriate strategy to prevent, to identify and to correct the abnormalities that can affect the mother and fetus, and institute treatment of existing diseases or that may occur during pregnancy, equating to other studies.[23]

In a study on prenatal screening, held in medium-sized municipality in the metropolitan region of São Paulo, some hypotheses were raised to explain the low test coverage in the third trimester: the professionals are used to request the exams only in the first consultation and many fail to ask them again near the thirtieth week of pregnancy and some women fail to take the exams for the second time, although they were requested. These assumptions may also explain what happened in this study.[24]

Early initiation of prenatal care allows access to diagnostic and therapeutic methods for various diseases with serious repercussions for the health of the woman and the baby, such as hypertension, diabetes, anemia, infection with syphilis and HIV, among others. It also provides the measurement of gestational age more precise, favors better monitoring of fetal growth and development, basing this way decision-making during the pregnancy period.[20] The results resemble other researches.[21-5] Such results serve as indicators for the reformulation of strategies with regard to the immediate capture of those pregnant women to prenatal care service, in order to promote a comprehensive care from the beginning of her pregnancy, in a timely manner, better understanding their behavior and acting by their timely needs and resolutivity.[25]

The service profile in which the survey was conducted does not favor the active search of pregnant women because its operation is based on spontaneous demand, i.e., a woman who wants to be answered in this clinic just realize their schedule and will be further monitored. Thus, women from different localities have been met in this unit, thus hindering an appropriate funding strategy because the coverage area becomes extensive and territorial point of view, unattainable. From this finding and in view of the risk classification of these women, in which all have a low risk, it is suggested a study of why this public has not been served in their communities by the Family Health Strategy (FHS).

The low number of women who had six or more consultations is convergent with the national study[26]; however it presents significant discrepancies with other studies in which the values are superiors.[1,9,19] This variable has an important limitation due to the type of study as well as the time of data collection, where pregnant women had different gestational ages and were under follow-up, showing the study an underestimation of the number of consultations, making this discussion without great value to this study.

Regarding the number of queries per trimester, the analysis could only be performed substantially in pregnant women who were in the second and third trimesters, before a retrospective logic, thus the compliance of the quarter for query number denotes the difficulty that the service is in adjusting the rules established by PHPN.[8]

Reconnecting the timely initiation of prenatal care according to PHPN[8], i.e. until the 4th month of pregnancy, the request of the routine tests are ABO Rh, VDRL, urinalysis, blood glucose, Hb/Ht and Anti-HIV, the

adequacy of prenatal care was found to be in accordance with the findings in Rio Grande do Sul and higher than in Porto Alegre[27-8]; however, it is noteworthy that both studies analyze other associated indicators. In this regard, it is noted that achieving the goals set by PHPN is a challenge and that some actions, which directly interfere in prenatal care, depend solely on the ESF, according to PHPN as early identification of pregnant women, to optimize the start of prenatal care, the active search of pregnant women presenting missed visits or inadequate number of these, the development of educational activities for pregnant women in order to improve prenatal care.

According to the Ministry of Health recommendations, the pregnant woman should have at least 6 consultations throughout pregnancy[8]. It is very important that the pregnant woman reaches the large number of queries, but does not guarantee excellence in quality of care, as this and other studies have found women in late pregnancy, whose routine tests had not been requested yet.[29]

As for the degree of satisfaction, pregnant women with higher levels of education in the consultations may have a more comprehensive view of the circumstances that are happening to them[14-6], as well as feel more secure at the delivery.[29]

When asked about the degree of satisfaction of pregnant women as regards the reception, organization/structure of the service, the assistance provided by professionals and the time for exams, it was identified that most of them had high satisfaction. Based on this variable, the service is classified as effective in relation to the assistance offered to users. Similarly, it seems that they accomplish what the Ministry of Health recommends, since a humanized and qualified prenatal care takes place from a quality of service, speed of access to appropriate health services, associated to integrated actions in levels of attention to promotion, prevention and health care of pregnant women and newborn.[14]

Cozy practices provide the identification of the main vulnerability of pregnant women taking into account their social context, as well as creating a bond of trust between the professional and the pregnant woman, allowing for greater acceptance and continuance of these women in division.[8]

Despite the limitations, this study brings great contributions to nursing, since it is for nurses to perform prenatal consultations of pregnant women considered low risk, being their responsibility to ensure a qualified prenatal care in a comprehensive manner through targeted actions to the scope of the promotion, prevention and treatment of possible disorders, in addition to providing educational guidance that shows the importance of pre-natal monitoring.[30]

Limitations of this study include quality ratings, the period of data collection and the type of study. It may have been underestimated as some tests and vaccination against influenza, because some tests may have been conducted and not recorded on the card of the pregnant woman and the period of data collection may have underestimated the influenza vaccination coverage, which occurs in seasonal period. In this study, the data indicate a single moment, showing the changes in the quality of prenatal care over time.

CONCLUSIONS

To establish the particularities of a given population is the initial measure to draw up action plans based on the needs met. Thus it is important to characterize the population attended in health services so that there is a direction of these actions, making the most resolute assistance and effective, adapting them to the profile found. Thus, the results of this study may help to direct the development of strategies to improve the quality of prenatal care, translating into a powerful tool for the management assess the quality of prenatal care offered to the population.

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