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CHARACTERIZATION OF PERSONS SERVED IN THE FAMILY HEALTH STRATEGY: A CONTRIBUTION TO OBSTETRIC NURSING

Caracterização de gestantes atendidas na estrategia de saúde da família: uma contribuição para enfermagem obstétrica

Caracterización de gestantes atendidas en la estrategia de salud de la familia: una contribución para enfermate obstétrica

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ABSTRACT

Objective: To characterize the epidemiological profile of pregnant women assisted in the prenatal nursing consultation at a Family Health Unit in *Rio de Janeiro*. **Method:** descriptive, exploratory, quantitative study of the documentary type, using the technique of indirect observation and statistical analysis. **Results:** a total of 160 electronic records of pregnant women attended in 2014 were investigated. Most of the women were aged between 20-34 years (73.8%), brown (44.3%), and high school (26.9%). They were primigravidae (41.3%), without history of abortion (54.4%), did not plan for pregnancy (66.9%) and had first consultation in the first trimester of pregnancy (61.2%). **Conclusion:** although the majority of the pregnant women investigated have a low obstetric risk, the follow-up of women in the prenatal clinic becomes essential for a healthy pregnancy.

Descriptors: Family health strategy, Obstetric nursing, Prenatal care.

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RESUMO

Objetivo: Caracterizar o perfil epidemiológico das gestantes assistidas na consulta de enfermagem do pré-natal em uma Unidade de Saúde da Família do Rio de Janeiro. **Método:** estudo descritivo, exploratório, quantitativo do tipo documental, com emprego da técnica de observação indireta e análise estatística. **Resultados:** foram investigados 160 prontuários eletrônicos de gestantes atendidas em 2014. A maioria das mulheres tinha idades entre 20-34 anos (73,8%), cor parda (44,3%), mora com companheiro (46,3%), e ensino médio completo (26,9%). São primigestas (41,3%), sem história de aborto (54,4%), não planejaram a gravidez (66,9%) e tiveram primeira consulta no primeiro trimestre gestacional (61,2%). **Conclusão:** embora a maioria das gestantes investigadas tenha baixo risco obstétrico, o seguimento das mulheres na consulta de pré-natal torna-se primordial para uma gestação saudável.

Descritores: Estratégia saúde da família, Enfermagem obstétrica, Cuidado pré-natal.

RESUMEN

Objetivo: Caracterizar el perfil epidemiológico de las gestantes asistidas en la consulta de enfermería del prenatal en una Unidad de Salud de la Familia de Río de Janeiro. **Método:** estudio descriptivo, exploratorio, cuantitativo del tipo documental, con empleo de la técnica de observación indirecta y análisis estadístico. **Resultados:** se investigaron 160 prontuarios electrónicos de gestantes atendidas en 2014. La mayoría de las mujeres tenían edades entre 20-34 años (73,8%), color pardo (44,3%), vive con el compañero (46,3%), y la enseñanza media completa (26,9%). (41,3%), sin antecedentes de aborto (54,4%), no planificaron el embarazo (66,9%) y tuvieron primera consulta en el primer trimestre gestacional (61,2%). **Conclusión:** aunque la mayoría de las gestantes investigadas tienen bajo riesgo obstétrico, el seguimiento de las mujeres en la consulta de prenatal es primordial para una gestación sana.

Descriptores: Estrategia de salud familiar, Enfermería obstétrica, Atención prenatal.

INTRODUCTION

Maternal mortality is a serious global health problem. Approximately 90% of deaths occur in developing countries and the main causes are hypertensive diseases, hemorrhages, puerperal infections and abortion complications that could be prevented with proven interventions.[1-2]

In prenatal care, pregnant women need qualified monitoring to avoid unfavorable complications. Comprehensive care is necessary, considering socioeconomic, emotional and family aspects. This care enables the preservation of the woman's health and the fetus, favors adherence to periodic consultations, and contributes to the reduction of maternal and neonatal morbidity and mortality.[3]

For a humanized prenatal, health professionals, especially nurses from the Family Health Strategy (FHS), must know the epidemiological profile of pregnant women and understand their social context to plan necessary actions and care, incorporating educational activities on various topics . Quality prenatal care involves promoting health and comprehensiveness.[2]

The study is justified considering the existence of high rates of maternal and neonatal mortality in the State of *Rio de Janeiro* and in *Brazil*. Avoidable maternal deaths occur every day due to complications related to pregnancy or childbirth. Infant mortality rates have decreased in developing countries, but these reductions in mortality were largely due to the decrease in deaths from pneumonia and diarrheal diseases after the neonatal period, however early deaths related to prematurity, asphyxia at birth and infections had a smaller reduction.[4] Because of this, it was defined as a research problem: What is the epidemiological profile of pregnant women assisted in the prenatal nursing consultation at a Family Health Unit?

This investigation aims to characterize the epidemiological profile of pregnant women assisted in the prenatal nursing consultation at a Family Health Unit in *Rio de Janeiro*.

METHODS

Descriptive, exploratory, quantitative study, using documentary analysis. The study field was a Family Health Unit in the city of *Rio de Janeiro*, which has six health teams. 160 electronic medical records of pregnant women undergoing prenatal care at the unit in 2014 were used. This number corresponds to all pregnant women being monitored during the collection period.

As a data collection instrument, a form was used, structured with 25 items, about sociodemographic variables (age group, race / color, family situation and education), related to the woman's sexual and reproductive life (sexarc, number of pregnancies, births , abortions, live births, reproductive planning, early prenatal care, routine prenatal examinations), in addition to complaints and obstetric complications.

The data were organized with the aid of the Excel software and analyzed using descriptive statistics. The research was previously assessed and approved by the CEP of the City of *Rio de Janeiro* with number 558104, on March 7, 2014.

RESULTS AND DISCUSSION

From the analysis of the 160 electronic medical records of the pregnant women, the sociodemographic characteristics shown in table 1 emerged, it can be seen that 76 (47.50%) were aged between 28 and 34 years, of mixed race (71 / 44.38), 74 live with the partner (46.25%) and had completed high school (43 / 26.88%).

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Table 1- Distribution of pregnant women attended at the FHS according to their sociodemographic characteristics. *Rio de Janeiro*, RJ, Brazil, 2014

Variables	n	%
AGE GROUP (ANOS)		
14 - 19	21	13,13
20 - 27	42	26,25
28 - 34	76	47,50
35 - 39	14	8,75
Older than 40	07	4,38
RACE/COLOR		
White	35	21,88
Black	54	33,75
Brown	71	44,38
FAMILY ARRANGEMENT		
Lives alone	05	3,13
Lives with family	52	32,50
Lives with spouse	74	46,25
Non registered	29	18,13
SCHOOLING		
Incomplete primary school	37	23,13
Complete primary education	10	6,25
Incomplete high school	34	21,25
Complete high school	43	26,88
Incomplete higher education	12	7,50
Complete Higher Education	16	10,00
Not registered	08	5,00
Total	160	100,0

Table 2 shows the reproductive profile of the population studied, such as: sexarc, number of pregnancies, parity and abortions. It was noticed that of the participants that it was possible to analyze the sexarc, the beginning was early, 54 participants started in the range of 16 to 18 years old (33.45%); they were in their first pregnancy (66 / 41.25) and had no birth (72 / 45.00%); the majority had no abortion (87 / 54.38%); and 69 had two children (43.13%).

Table 2 - Characterization of the gynecological and obstetric antecedents of pregnant women attended at the FHS. *Rio de janeiro*, RJ, Brazil, 2014

Variables	n	%
SEXARC AGE		
13 - 15	8	5,00
16 - 18	54	33,75
Older than 18	35	21,88
Non registered	63	39,38
NUMBER OF PREGNANCIES		
1 pregnancy	66	41,25
2 pregnancies	49	30,63
3 pregnancies	35	21,88
Non registered	10	6,25
NUMBER OF CHILD-BIRTHS		
1 child-birth	36	22,50
2 child-births	22	13,75
3 child-births	18	11,25
Over 3 child-births	12	7,50
No child-birth	72	45,00
NUMBER OF ABORTIONS		
1 abortion	52	32,50
2 or 3 abortions	21	13,13
No abortion	87	54,38
NUMBER OF CHILDREN BORN ALIVE		
None	25	15,63
1 child	16	10,00
2 children	69	43,13
3 children	12	7,50
4 or more children	38	23,75
Total	160	100,0

The medical records contained information about the current pregnancy of women attended at the FHS, showing their health profile, shown in **table 3**. Most participants did not plan the pregnancy (107 / 66.88%); started prenatal care in the first trimester of pregnancy (98 / 61.25%); 62 participants were at ideal weight (38.75%); all participants had anti-HIV, toxoplasmosis and non-reactive hepatitis B and 158 did not react to the VDRL (98.75%).

Tabela 3 - Caracterização da gestação atual das mulheres atendidas na ESF. *Rio de Janeiro*, RJ, Brasil, 2014

Variáveis	n	%
PLANNED PREGNANCY		
Yes	53	33,13
No	107	66,88
PRE-NATAL START		
1st quarter	98	61,25
2nd quarter	62	38,75
3rd quarter	0	0,00
ETHILISM		
Yes	13	8,13
No	66	41,25
Uninformed	81	50,63
IMC AT THE 1ST PRE-NATAL CONSULTATION		
Low weight	15	9,38
Ideal	62	38,75
Overweight	48	30,00
Obesity	45	28,13
ANTI-HIV		
Non-Reagent	160	100,00
Reagent	0	0,00
SOROLOGY FOR VDRL		
Non-reagent	158	98,75
Reagent	2	1,28
SOROLOGY FOR TOXOPLASMOSIS		
Non-reagent	160	100,00
Reagent	0	0,00
HEPATITIS B SEROLOGY		
Non-reagent	160	100,00
Reagent	0	0,00
Total	160	100,0

Among the previous pathologies associated with pregnancy, five (05) women had Systemic Arterial Hypertension (SAH) and two (02) Diabetes Mellitus.

Most of the women investigated are in the ideal age range for reproduction (20 to 34 years old). However, there are pregnant women in the age group of 14 to 19 years old and above 35 years old, whose ages represent a risk for the evolution of pregnancy.[2]

Pregnancy in children under 19 years of age causes a series of problems to maternal health and perinatal complications, such as: premature labor, cesarean section, forceps delivery, pre-eclampsia, children with low birth weight and low vitality assessment. These risks tend to increase when associated with unfavorable socioeconomic and demographic conditions, making access to adequate assistance more difficult.[5]

As for the family situation, he realizes that most of them live with a partner (46.3%) and others live with family members (32.5%). In this context, it should be added that the participation of the partner since the beginning of pregnancy, in prenatal consultations, favors pregnancy, childbirth, the puerperium and success in breastfeeding, in addition to providing the construction of the paternal identity and bonds between father and baby.[6]

Most pregnant women have high school (26.9%) and some elementary school (23.2%). Studies indicate that the lower the education, the greater the difficulty in understanding the need for special care during pregnancy, leading to late onset and absence of prenatal care, inadequate nutrition, habits and addictions incompatible with pregnancy, often leading to the neonatal death.[7]

Regarding to the sexarc, 8 (5%) had their first sexual intercourse between 13-15 years old, however there was no record in 63 (39.4%) of the medical records. Young women

have started their sexual life early, often in an unplanned way, without necessary care, with the risk of contracting a sexually transmitted infection (STI) and / or an unplanned pregnancy. The beginning of the sexual life of Brazilians occurs, in general, during adolescence, with women starting later than men.[8-9]

Most women were primiparous (41.3%) and one was in the 10th pregnancy. As for the number of deliveries, 72% were nulliparous. A study[10] indicates that multiparous mothers with no previous obstetric complications feel more experienced and do not value prenatal care, primiparous women tend to seek prenatal care more often due to lack of experience.

As for the records of women who had had an abortion, it was identified that 52 (32.5%) had had it at least once. However, it was not possible to confirm whether the episodes were spontaneous or induced. A bibliometric study evaluated the causes of maternal death and the association with abortion, thus it was realized that deaths from abortion occurred in women of all ages and the cause of death was associated with infections caused by inadequate and unsafe procedures, highlighting the issue of illegal abortion, thus maternal death due to abortion, also associated with complications generated by it.[11]

Regarding the current pregnancy (**Table 3**), the majority (66.9%) was not planned. The decision to have a child is the result of several conscious and unconscious reasons, however, non-programming is associated, in most situations, with the incorrect use of contraceptive method.[12]

Unplanned pregnancies are frequent among women of different age groups and education levels, no matter how much it draws attention when it occurs in adolescence. However, the fact that the pregnancy was not scheduled does not mean that the child is not wanted. The behavior of women who do not program and do not want pregnancy, reinforces the idea that the social condition in which the woman lives, number of children, age, financial situation and marital status are determinants for accepting pregnancy.[13]

The gestational age at the beginning of prenatal care for the majority (61.2%) of women was in the first trimester of pregnancy (up to the 12th week), however, 38.8% started in the second trimester (between 12 - 24 weeks).

Considering the recommendation of the Ministry of Health of at least 06 (six) consultations initiated in the first trimester[2], it is worth noting that this guidance was not followed by all pregnant women. Some start prenatal care at an advanced date, and this may be due to some factors, such as difficulties with the health plan, mentioned by many women who seek assistance in the Unified Health System (SUS). Other recurring factors mentioned by some women are the difficulty in scheduling prenatal consultations at public health services, or even the difficulty in accepting pregnancy.

The care of women in early pregnancy has the purpose of carrying out preventive or therapeutic interventions during the gestational period. However, one must recognize the possibility of failures in the early capture of pregnant women. As for smoking and drinking, it is observed that few pregnant women reported these habits. These may not be revealed by the woman, due to possible disapproval from health professionals.[2]

Alcoholism can compromise maternal and fetal health, the most serious of which is fetal alcohol syndrome, where growth restriction, developmental delay and distinct facial characteristics occur; in addition it can cause miscarriage, placental abruption and premature labor. There is no amount of consumption considered safe and its use should be discouraged throughout the gestational period.[14]

When analyzing the pre-gestational Body Mass Index (BMI) of women = 30% it was found that they were overweight. Maternal obesity contributes to the occurrence of intrauterine growth retardation, gestational diabetes mellitus, fetal macrosomia, pre-eclampsia, respiratory complications such as sleep apnea and asthma, thromboembolic diseases and preterm delivery.[2]

In relation to the prenatal exams recommended, all medical records had records of non-reactive serology for toxoplasmosis, HIV and hepatitis B. As for the diagnosis of syphilis (VDRL), most (98.8%) had the non-reactive result. This data is relevant, since syphilis can cause fetal malformations, risk of miscarriage, low birth weight, prematurity or neonatal death[2]. From the perspective of prenatal care, it is recommended to request tests at an appropriate time to prevent and treat diseases in a timely manner.[15]

Among the previous pathologies associated with pregnancy, five had Systemic Arterial Hypertension and two Diabetes Mellitus. Pregnancy can stimulate SAH in previously normotensive women or worsen a picture of previous chronic hypertension. It is known that hypertensive syndromes in pregnancy are important causes of maternal morbidity and mortality in Brazil. Increased blood glucose can also increase the incidence of pre-eclampsia in pregnancy, the chance of developing diabetes, and decreased tolerance to carbohydrates after pregnancy.[2]

Monitoring women during prenatal care is important for detecting and preventing possible obstetric complications through timely intervention. Knowing the personal, reproductive and social history of the pregnant woman, as well as her past experiences allows individual and integral care, paying attention to her peculiarities, fears and doubts, taking on importance in this context the obstetric guidelines and the involvement that contribute to increase the woman's self-esteem and control of the gestation process.[2]

SUS should ensure care for women throughout the pregnancy-puerperal period through actions that integrate promotion, prevention and monitoring of pregnant women and newborns. Comprehensive care for women's needs

requires organization and use of appropriate means and resources for each situation, emphasizing the importance of seeking strategies that facilitate access to health services.[3] Quality prenatal care is considered may contribute to the reduction of maternal and child mortality rates.

A study carried out in *Minas Gerais* to demonstrate the relevance of prenatal care by the Family Health Strategy, shows a differentiated line of care for pregnant women starting with the identification, by Community Health Agents (CHA), of women with menstrual delay, the which already indicates the probable pregnancy diagnosis. Upon detection, an appointment is immediately scheduled or sent to the Family Health Unit in order to start the consultation with the team's doctor or nurse. Given the importance of the quality of prenatal care in reducing maternal and perinatal morbidity and mortality, several studies were carried out to evaluate the quality of care provided to pregnant women and it was evidenced that the Family Health Strategy provides quality prenatal care, and that the link established between professionals at the unit and the CHA with the pregnant women is essential for their adherence to the Prenatal Care Program.[16]

According to the Ministry of Health, frank dialogue, sensitivity and the perception capacity of those who follow prenatal care are basic conditions for health knowledge to be made available to women and their families - the main actors of pregnancy and childbirth. An open listening, without judgments or prejudices, that allows the woman to talk about her intimacy with security, strengthens the pregnant woman on her way to delivery and helps to build knowledge about herself, contributing to a peaceful and healthy birth of the baby and maintenance mother's health.[16]

In addition to the individual consultation with the nurse and the medical team, there are group activities that are one of the methodologies used by the FHS, in order to encourage the insertion of pregnant women in prenatal care. This space for discussion allows the consultation to continue. The most common issues are the importance of prenatal care, sexuality, hygiene and diet guidance, pregnancy development, bodily and emotional changes, signs and symptoms of childbirth, labor rights, newborn care, breastfeeding, puerperium and planning familiar. Pregnant women are the main focus of the learning process, however, being seen in their family and social context.[16]

With regard to the daily practice of the Family Health Strategy (FHS), access has welcoming as one of its foundations, being materialized through attitudes evidenced, in this case, in the intersubjective relationships established daily between professionals and service users. Far from representing an abstraction or utopia of difficult materialization, welcoming is translated into simple gestures with a cordial form of care, in which professionals call pregnant women by name, inform about conducts and procedures to be performed through an appropriate language, they listen and value the users' narratives, guarantee their privacy, among other humanized attitudes that can be operated, if respected the ethics of otherness.[3, 15,17]

CONCLUSIONS

The research allows the discussion of issues that permeate prenatal care and women's health in primary care, observing the variables that can interfere with the course and outcome of the pregnancy, such as social, demographic, gynecological and obstetric factors.

It allowed us to reinforce that maternal and perinatal health care in primary care should take place in a way that allows detecting and treating complications in a timely manner, making it possible to minimize unwanted consequences and favor the reduction of morbidity and mortality in the female population.

The study had as a limitation the sample size, however it is believed that the findings allowed to outline the epidemiological profile of pregnant women attended in a basic unit, emphasizing the importance of nursing care in prenatal care.

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