Original Article

Prenatal care: preparation for childbirth in primary healthcare in the south of Brazil

Pré-natal: preparo para o parto na atenção primária à saúde no sul do Brasil

Atención prenatal: preparo para el parto en la atención primaria de la salud en el sur de Brasil

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ABSTRACT

Objective: To evaluate the relationship between prenatal care and delivery guidelines in Primary Health Care.

Methods: This is a cross-sectional study, with 358 puerperal women of a public maternity from the south of Brazil. The data collection was performed from July to October of 2013, with prenatal card data transcription and a structured interview. The data has been analyzed through the use of the Chi-square test ($p \leq 0.05$).

Results: The prenatal care had a high coverage (85,5%) and early start by 71,8% of the women, however, 52% of them did not receive orientation for the childbirth. There was a statistical association between receiving orientation for the childbirth and fewer visits ($p=0.028$), longer interval between the last prenatal visit and the childbirth ($p=0.002$), and the classification of the prenatal care as intermediate and inadequate ($p=0.024$).

Conclusions: Despite of the ideal number of visits, the quality of care has been classified as intermediate or inadequate, besides that, precarious access to the orientation for the childbirth during the prenatal care has been evidenced.

Keywords: Prenatal care. Childbirth. Health education. Obstetric nursing.

RESUMO

Objetivo: Avaliar a relação entre assistência pré-natal e orientações para o parto na Atenção Primária à Saúde.

Métodos: Estudo transversal com 358 puérperas de maternidade pública do sul do Brasil. Coleta de dados realizada de julho a outubro de 2013, com transcrição de dados do cartão de pré-natal e entrevista estruturada. Dados analizados pelo Teste Qui-quadrado ($p \leq 0,05$).

Resultados: O pré-natal teve alta cobertura (85,5%) e início precoce em 71,8% das mulheres, porém 52% destas não receberam orientação para o parto. Houve associação estatística entre o recebimento de orientação para o parto e menor número de consultas ($p=0,028$), maior intervalo entre a última consulta pré-natal e o parto ($p=0,002$) e classificação do cuidado pré-natal como intermediário e inadequado ($p=0,024$).

Conclusões: Apesar da oferta ideal do número de consultas, a qualidade do cuidado foi classificada como intermediária ou inadequada e evidenciou-se acesso precário a orientações para o parto durante o pré-natal.

Palavras-chave: Cuidado pré-natal. Parto. Educação em saúde. Enfermagem obstétrica.

RESUMEN

Objetivo: Evaluar la relación entre asistencia prenatal y orientaciones para el parto en la Atención Primaria a la Salud.

Métodos: Estudio transversal con 358 puérperas de maternidad pública del sur de Brasil. Recolección de datos realizada de julio a octubre de 2013, con transcripción de datos de la tarjeta de prenatal y entrevista estructurada. Datos analizados por el test Chi-cuadrado ($p \leq 0,05$).

Resultados: El prenatal tuvo alta cobertura (85,5%) e inicio precoz en 71,8% de las mujeres, pero el 52% de ellas no recibieron orientación para el parto. Se observó una asociación estadística entre la recepción de orientación para el parto y el menor número de consultas ($p = 0,028$), mayor intervalo entre la última consulta prenatal y el parto ($p=0,002$) y clasificación del cuidado prenatal como intermediario e inadecuado ($p=0,024$).

Conclusiones: A pesar de la oferta ideal del número de consultas, la calidad del cuidado fue clasificada como intermediaria o inadecuada y se evidenció acceso precario a orientaciones para el parto durante el prenatal.

Palabras clave: Atención prenatal. Parto. Educación en salud. Enfermería obstétrica.

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INTRODUCTION

The experience of becoming a mother is one of the most significant aspects of a woman's life, and pregnancy is a period of intense transformation[1]. Prenatal follow-up is a key component in assisting pregnant women to ensure better maternal and neonatal outcomes[2-3]. In addition to watching the evolution of the pregnancy, diagnosing and treating comorbidities, it is a unique opportunity for the nurse to develop health education actions[4].

According to data from the World Health Organization (WHO), deaths and diseases related to pregnancy are still unacceptably high. In 2015, about 303,000 women died from pregnancy-related causes, 2.7 million babies died during the first 28 days of life, and 2.6 million babies were born dead. Despite these indicators, the access to better quality healthcare during pregnancy and childbirth has prevented many of these deaths and illnesses in the last two decades, as well as improved the pregnancy experience. Overall, however, only 64% of women receive prenatal care four or more times throughout their pregnancy[5].

The arrival of a child should be a moment of celebration and pleasure, but the perinatal indicators and the experiences lived by the Brazilian women show a worrying reality, which has emphasized the investment in public policies[6].

In 2000, the Ministry of Health (MH) established the Prenatal and Birth Humanization Program (PBHP), a model that standardized the assistance to pregnant women and proposed the linkage between prenatal and delivery services. After a decade, within the scope of the Unified Health System (SUS), the "Rede Cegonha" (RC) and, soon afterwards, in the state of Paraná, the "Rede Mãe Paranaense" (RMP) were instituted. Both with the aim of improving women's health in the puerperal pregnancy cycle, and reducing maternal and neonatal mortality rates[3,7-8]. Among the recommendations proposed by these programs in the prenatal care and during the embracement, are the early intake of the pregnant women (up to the end of the first trimester); the active search for absences; a minimum of six visits; the guarantee to perform complementary exams; the practice of educational actions; the encouragement for natural childbirth and the reduction of unnecessary cesarean sections; the attachment to the place of birth; and adequate recording of information on the pregnant woman's card[1,9-10]. In addition, the Primary Healthcare (PHC) team became responsible for the risk stratification, which classifies the pregnant woman as habitual risk, intermediate risk or high risk. This evaluation is permanent, and should be done in every prenatal visit[10].

Nursing plays a fundamental role in the operationalization of all these actions, acting directly in the care or acting as a link between the other professionals of the health team.

However, even with advances in the PHC, some Brazilian studies point to failures in the prenatal care, such as difficulties in access, late onset, low number of visits, poor orientation, incomplete procedures and lack of links between the prenatal services and the childbirth, impairing the quality and effectiveness of the care[4,7-8,11].

In this sense, we experience today a challenging scenario, but an extremely fertile and promising period of transition regarding the revision of values, concepts and practices, in the prenatal care, childbirth and puerperium[6]. In addition to governmental initiatives, scientific events, national and international research and documentaries that show successes and challenges in the implementation of good practices of assistance, there is the women's movement, present on the streets and in the social networks, that fight for the humanization of the pre-birth, birth and birth, against any form of gender violence, including obstetric violence[12-13].

Therefore, in view of the unique importance of the prenatal care, this study aimed at evaluating the relationship between the characteristics of the prenatal care and the orientation for the childbirth received by pregnant women in the Primary Healthcare in a city in southern Brazil.

METHODS

This is an analytical cross-sectional study related to a prospective cohort study conducted in a public hospital in Londrina/PR. It should be highlighted that the primary healthcare of this city is organized by the Family Health Strategy (FHS) and has 93 professional teams distributed in 52 Basic Health Units (BHUs), 40 in the urban area. These teams are composed of 109 doctors, 105 nurses, 190 nursing technicians and 316 Community Health Agents (CHA). The BHUs of the urban area, in addition to the family health teams, have 10 teams from the Family Health Support Center (FHSC) composed of other health professionals (physiotherapy, physical education, nutrition, psychology and pharmacy) who work in partnership with the FHS in their respective territories. All the usual and intermediate risk pregnant women of the city are forwarded to the Lucilla Ballalai Municipal Maternity[14-15].

Puerperas of usual or intermediate obstetric risk hospitalized in this maternity hospital and who lived in the urban area of the city of Londrina have been included. Puerperas with high risk diagnosis and who did not reside in this city have been excluded due to the difficulty of visiting them for the follow-up study. For the sample calculation, the population of 3,415 births occurred in this maternity hospital in 2012, margin of error of 5%, and confidence level of 95%, obtaining a ***n*** of 358, has been considered.

Three obstetrical nurses, students of the Postgraduate Nursing Program of the Universidade Estadual of Londrina, previously trained, have participated in the data collection. This occurred in the period from July to October of 2013, during the hospitalization of puerperae in the joint accommodation, after childbirth. A semi-structured instrument has been used with socioeconomic, and also demographic and obstetric data, information about the prenatal follow-up contained in the pregnant woman's card and the report of the participants of the survey about the orientation for the childbirth and the attachment to the reference maternity. The data referring to the prenatal followed the adequacy proposal of this care based on Coutinho et al.[16], which analyzes the notes of the pregnant woman's card to classify the care as adequate, inadequate or intermediate. This evaluation includes the gestational age at the beginning of the prenatal care, the number of appointments performed, the interval between the last visit and delivery, the recording of laboratory test results, ultrasonography and clinical-obstetric procedures.

The data has been compiled in the Statistical Package for Social Sciences (SPSS) program, version 20.0, and analyzed through the Chi-square test for the search for possible associations ($p \leq 0.05$) between the independent variables and the dependent variable - Orientation for the childbirth during the prenatal care.

In compliance with the determinations of the Resolution 466/12 of the National Health Council[17], this research has been approved by the Research Ethics Committee Involving Human Beings of the Universidade Estadual of Londrina (CEP/UEL), CAAE: 19352513.9.0000.5231 of 16/07/2013. Participants have been properly informed about the research and about their anonymity, signing the Informed Consent Term (ICT).

RESULTS

The highest percentage of puerperae was young adults (53.9%), with average schooling (67.6%), unpaid occupation (58.9%), partner (84.1%), family income between two to three minimum wages (46.1%), and multiparous (60.6%). More than half of the women (52%) did not receive any orientation during the prenatal care, 38.2% of whom were pregnant with the first child (Table 1).

There was no statistically significant difference between receiving orientation for the childbirth during the prenatal care and socioeconomic, demographic and obstetric characteristics. However, it is worth pointing out that women who had a previous cesarean section were less oriented (20.9%) for delivery during the prenatal period than women with a previous normal delivery (43%) (Table 1).

Most women (85.5%) had six or more prenatal appointments and started it early (71.8%), but the adequacy of this follow-up has been classified as intermediate in most cases (47.2%). A significant proportion (37.7%) was not oriented to the reference maternity and only 15.1% reported having visited the maternity during the pregnancy (Table 2).

There was statistical significance between receiving orientation for the childbirth and the number of prenatal visits performed ($p=0.028$). Among women who performed more than six visits, 81.7% reported not having received orientation for the childbirth during the prenatal care. Receiving orientation for the childbirth and the interval between the last prenatal visit and delivery also presented statistical significance ($p=0.002$). Women who had an interval of up to 15 days between the last prenatal visit and delivery received more guidance (80.8%). There was also statistical significance between prenatal adequacy and orientation for the childbirth ($p=0.024$). Among the women who did not receive orientation for the childbirth (52%), the inadequacy of the prenatal care reached 30.1% (Table 2).

Figure 1 shows that, in addition to infrequent, the orientation for the childbirth did not present continuity, since only 5.6% of the women reported having received them during all the prenatal care.

Among the puerperae (n=172) who received orientation, 18.7% were encouraged for normal labor by the PHC team and 17% received guidance on signs of labor onset (Table 3).

DISCUSSION

Studies show that failures in the prenatal care, difficulty in access, late onset, low number of visits and poor orientation during the gestational process impair the quality of care and favor the increase of maternal and neonatal morbidity and mortality[1,3-4,6,11]. However, few studies have analyzed the prenatal care based on data from the prenatal care plus the information from the puerperal women.

The present study pointed out that the failures in the orientation for the childbirth during the gestational follow-up were significant, in relation to the number of visits, the interval between the last prenatal visit, and the delivery and adequacy of this care.

The characteristics of the women in this study, in relation to age, schooling, marital status and parity were similar to those found in other Brazilian studies carried out in public institutions, with a predominance of young pregnant women with partners, multiparous women and low to average schooling[4,11,16].

Table 1 – Distribution of socioeconomic, demographic and obstetric characteristics of women according to the orientation for the childbirth received during the prenatal care. Londrina, Paraná, Brazil, 2013.

	Orientation for the childbirth				
	Yes		No		
	n	%	n	%	p value*
Age (in years)					
Up to 19	36	20.9	40	21.5	0.817
20 to 34	119	69.2	124	66.7	
35 and over	17	9.9	22	11.8	
Marital situation					
With partner	143	83.1	158	84.9	0.641
Without partner	29	16.9	28	15.1	
Schooling (years of study)					
Low (1 to 7 years)	36	20.9	53	28.5	0.087
Average (8 to 11 years)	121	70.3	121	65.1	
High (more than 11 years)	15	8.7	12	6.5	
Occupation situation					
Paid	74	43.0	73	39.2	0.469
Unpaid	98	57.0	113	60.8	
Family income**					
Up to 1 minimum wage	40	23.3	46	24.7	0.656
From 2 to 3 minimum wages	85	49.4	80	43.0	
More than 3 minimum wages	47	27.3	60	32.3	
Parity					
Primiparous	70	40.7	71	38.2	0.626
Multiparous	102	59.3	115	61.8	
Previous normal delivery					
No	98	57.0	102	54.8	0.684
Yes	74	43.0	84	45.2	
Previous Cesarean section					
No	136	79.1	146	78.5	0.894
Yes	36	20.9	40	21.5	

Source: Research data, 2013.
*Chi-square test ($p < 0.05$)
**Minimum wage in 2013 - R$ 678.00.

In addition to proving coverage effectiveness, the satisfactory presentation of the prenatal card at the admission for delivery showed that the primary care of the city adequately carried out the orientation regarding the importance of this document. This card serves as a communication link between the prenatal and delivery assistance team, recording the results of exams and problems identified during the pregnancy, thus guiding appropriate procedures for the time of delivery[7-8].

The MH recommends that the prenatal care should start before the end of the third month, that is, until the 13th week, and that the pregnant woman should make at least six visits[2,9-10]. The early onset of the prenatal follow-up enables the diagnosis and treatment of several pathologies that can seriously interfere with maternal and fetal health, as well as estimate gestational age more reliably, which provides better monitoring of fetal growth and maturity[9]. Personal problems regarding the acceptance of the pregnancy, especially in adolescence; difficulty related to work or school; access barriers; problems with appointment schedules and lack of early diagnosis of pregnancy may also be related to the late onset of the prenatal care[4].

Other authors point not only to the fragility in the work process for the early capture of the pregnant woman, but also to the lack of awareness of the population about the importance of this care. Adding to this, among other crucial aspects of effective prenatal care and encouragement of adherence to the service, are the formation of a bond, the welcoming and respectful posture of the team associated

Table 2 – Distribution of prenatal variables according to the orientation for the childbirth. Londrina, Paraná, Brazil, 2013.

	Orientation for the childbirth				
	Yes		No		
	n	%	n	%	p value*
No. of prenatal visits**					
6 and over	154	90.6	152	81.7	0.028
3 to 5	14	8.2	31	16.7	
0 to 2	2	1.2	3	1.6	
Gestational week at the start of the prenatal care**					
Until the 13th week	129	75.9	128	68.8	0.175
14th to 27th week	35	20.6	50	26.9	
28th week and over	6	3.5	8	4.3	
Interval between the last prenatal visit and the childbirth**					
Up to 15 days	137	80.6	123	66.1	0.002
16 days or more	33	19.4	63	33.9	
Adequacy of the prenatal care according to Coutinho**					
Adequate	53	31.2	38	20.4	0.024
Intermediate	77	45.3	92	49.5	
Inadequate	40	23.5	56	30.1	
Guidance on the attachment to the place of birth					
Yes	110	64.0	113	60.8	0.533
No	62	36.0	73	39.2	
Visited maternity during pregnancy					
Yes	30	17.4	24	12.9	0.231
No	142	82.6	162	87.1	

Source: Research data, 2013.
*Chi-square test ($p<0.05$)
**n=356 (Two pregnant women did not deliver the prenatal card at the admission to the maternity ward)

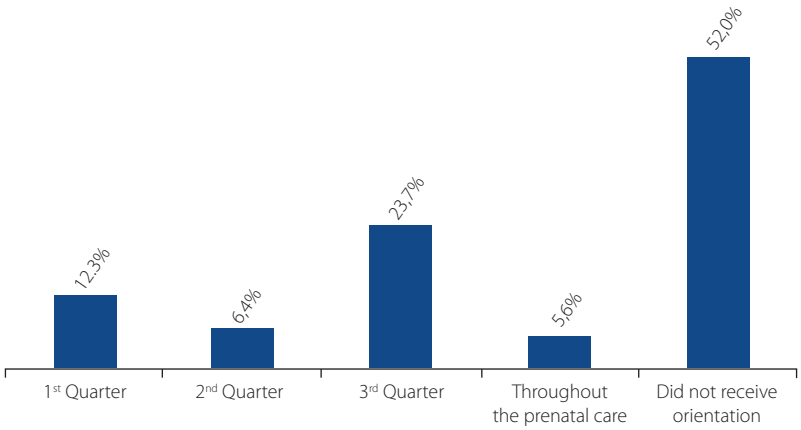

Figure 1 – Percentage of women who received guidelines for the childbirth during the prenatal care. Londrina, Paraná, Brazil, 2013

Source: Research data, 2013.

Table 3 – Distribution of the type of orientation for delivery during the prenatal care. Londrina, Paraná, Brazil, 2013.

Type of orientation for the childbirth	n	%
Incentive to normal delivery	67	18.7
Signs of onset of labor	61	17.0
Differences between the normal delivery and the cesarean delivery	15	4.2
Beneficial practices for the evolution of labor and pain relief	12	3.4
Inadequate orientation*	17	4.7
Total	**172**	**48.0**

Source: Research data, 2013.

*Look for another service, cesarean benefits, go to the maternity at the beginning of the latent phase of labor, do not make scandal to be well treated.

with qualified listening to the needs of the pregnant woman, and the co-responsibility of care between both[1,8,18].

This situation is evident when it is verified, according to the parameters recommended by the MH, that the prenatal coverage of the study population was satisfactory, being higher than the rate presented in other Brazilian studies[3,8,11,16]. On the other hand, the classification of adequacy proposed by Coutinho[16] has evidenced an intermediate prenatal care to the women of this study.

The women who received the least orientation were those who had the prenatal care classified as intermediate and inadequate. Other authors have also argued that care assessments based on the number of prenatal visits may hide serious quality problems, underestimating the effectiveness of the care provided[11]. The aforementioned research indicated that early onset and an adequate number of visits were associated with greater adequacy of the orientations regarding the delivery, but these guidelines were extremely limited[11]. Specifically in relation to nurses' performance, this fact may be due to general or specialized training in family health or public health, prioritized by the local managers, to the detriment of the obstetrician nurse, who would be the most prepared professional to act with the pregnant women and their families.

The WHO recommends the implementation of the continuity of the care models conducted by a specialist, in which an obstetrician nurse, through the established bond with the woman, supports her in the prenatal, intrapartum and postnatal periods, ensuring greater effectiveness in the quality of direct care offered to the mother-child binomial[5].

The humanization of the prenatal care is impaired when the work process is focused on productivity and care protocols, with quick and superficial appointments, which value the measurements more than the sharing of knowledge and experiences[18-19]. In the present study, the gap between the productivity and the quality of care has been evidenced by the fact that a large proportion of the women who did not receive orientation for the child birth had six or more prenatal visits.

This context shows a lack of commitment to the quality and the insufficient role of this monitoring in the preparation of the woman for the childbirth, despite a high prenatal coverage[2]. Authors also state that public policies emphasize the availability and access to prenatal care, and leave the content of the appointments and the quality of this service in the background[16].

The prenatal appointment itself involves very simple procedures and does not demand a sophisticated physical structure, and professionals - previously trained in the use of light technologies - must use this visit to detect the individual needs of each pregnant woman, aiming at a holistic and humanized care, that leads the woman to a gestation with more autonomy and knowledge[1,18-19].

It has also been observed that the longer the interval between the last prenatal visit and the delivery, the lower the number of pregnant women who have been oriented on delivery. This refers to the classic and erroneous idea that we can "discharge" the prenatal care if gestation follows a normal course. However, the end of the gestation is the period in which the highest probability of obstetric complications is concentrated, and it should, therefore, be followed more frequently in the prenatal service, ending only when the pregnant woman is admitted to the maternity ward for delivery[12].

It is worth highlighting that similar to other national studies[3-4,11], little more than half of the pregnant women have been oriented about the place of birth, although there is a municipal maternity that is a reference for usual and intermediate risk. Less than a third did not visit the maternity hospital, this being, also, an action of responsibility

of the PHC[10]. This disinformation can lead the woman to the pilgrimage to the delivery assistance, which can generate complications to the binomial[3,11].

The low proportion of women who were advised about labor and delivery during the prenatal care, and receiving inadequate orientation, has again evidenced the inadequacy of this care[1]. The professional's posture can change this scenario, facilitate the embracement and enhance the interpersonal relations between this and the pregnant woman.

It adds to the inadequacy of care, the neglect of the MH in its prenatal manual, since it highlights the benefits of a planned cesarean delivery, such as "convenience, greater safety for the baby and less trauma in the pelvic floor of the pregnant woman, besides not suffering the pain of the delivery"[11].

In a study also carried out in Paraná, there was a lack of orientation about the childbirth in the prenatal care and the lack of professionals trained in health education. The preparation for maternity was limited to the care of the newborn, showing a lack of the care regarding the process of birth[1]. This reality leads us to the discussion on human rights, which are central to the promotion of the health and well-being of the pregnant women, as well as to the provision of high-quality care. The British Institute of Human Rights asked the Royal College of Obstetrical Nurses of the United Kingdom for a guide on the care for the puerperal gravid cycle, highlighting that their experience and expertise ensured that it was practical and relevant[20]. It should be emphasized that the organization of care to women during the period of pregnancy, childbirth and the puerperium is fully implemented by the obstetrical nurses in these countries.

Regarding the guidelines on how to better experience labor and the teaching of exercises to deal better with pain in this process were extremely scarce. These guidelines are of great value to the empowerment of women, especially those who will experience this moment for the first time[12].

It is understood that 'what to do' and 'why to do' are aspects of assistance already widely discussed in a systematic way. However, 'how to' seems to be lost in the context of the work process in the prenatal care. The support group or the "pregnant women's wheel" is an example of action that complements the care of the prenatal visits, prepares the couple for the childbirth, teaching body exercises that will facilitate labor[1-2]. Other strategies like this should aim at changing the attitude of the woman and her partner so that, instead of facing the delivery with fear and pain, they can see this process with security, tranquility and active participation[2,10].

As a limit of this study, it is pointed out its transversal characteristic, which reflects a specific reality in a specific time. However, the information generated is representative of this reality and it may serve as a basis for further studies on the same theme.

CONCLUSION

The characteristics of the prenatal care associated with less delivery orientation were the lower number of visits, the longer interval between the last visit and the delivery, and the classification of the adequacy of the prenatal care as intermediate and inadequate. These findings indicate the paths that need to be explored by the managers, the health team and, especially, the nurse, so that these women can be better prepared for the time of delivery. They also highlight the need of development of other studies, which explore how to make the access to the essential orientation for the childbirth during the prenatal care effective, as well as to investigate the need for the incorporation of the obstetrician nurse in the teams that work in primary healthcare.

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