Profile of Pregnant Women Served in a family Health Strategy in Belém-Pa, Brazil

Paula Sousa da Silva Rocha[1], Aldebaram Mariana Abreu da Silva[2], Carlene Leandro Tavares[2], Emilly Emily Manuelli Mendonça Sena[3], Ewellyn Natália Assunção Ferreira[5], Thalyta Mariany Rêgo Lopes Ueno[4], Francinéa de Nazaré Ferreira de Castilho[3], Francisco Rodrigues Martins[6], Eliane Moura da Silva[1], Juliana Custódio Lopes[6], Camilla Castilho Maia[3], Andrea da Silva Pereira Amaral[5], Priscila Rodrigues Tavares[3], Joacy Pedro Franco David[1], Rafael Everton Assunção Ribeiro da Costa[7], Susi dos Santos Barreto de Souza[1], Dayara de Nazaré Rosa de Carvalho[3]

[1,2]University Center of Pará (CESUPA). Belém, Pará - Brazil.
[3]State University of Pará (UEPA). Belém, Pará – Brazil.
[4]Amazonas State University (UEA). Manaus, Amazonas - Brazil.
[5]University of the Amazon (UNAMA). Belém, Pará, Brazil.
[6]University Hospital of the Federal University of Grande Dourados (HU-UFGD). Dourados, Mato Grosso do Sul – Brazil
[7]State University of Piauí (UESPI). Teresina, Piauí - Brazil.

Abstract— *Objective: This research aims to monitor the profile of pregnant women attended by a Family Health Strategy (ESF) team. Method: Exploratory, retrospective study of document analysis, with a quantitative approach. Results / discussion: the medical records of 74 pregnant women registered at the FHS in Belém-Pará were evaluated, where it was possible to analyze the general profile of the pregnant women. Conclusion: based on the knowledge of the profile of these pregnant women, health professionals should rethink actions aimed at this target audience, especially in carrying out educational activities that help or develop a healthy pregnancy.*

Keywords— ***Pregnant. Prenatal. Epidemiological profile.***

I. INTRODUCTION

One of the most important stages in the life of any woman is the pregnancy that corresponds to the period before birth, that is, the development of the embryo. The gestational period is a moment characterized by physical changes accompanied by physiological and emotional changes.

In view of the above, the Ministry of Health (MS) instituted the Prenatal and Birth Humanization Program (PHPN), through Ordinance / GM No. 569 of 2000, which administers the duty and the right to prenatal care (PN) dignified and qualified throughout the period of childbirth, birth and puerperium[1].

Prenatal care stands out as a key factor for both protection and prevention against adverse events during pregnancy, as it allows the identification and clinical management of timely interventions on potential risk factors for complications of the mother-fetus binomial. The failure or inadequate performance of this assistance is related to high rates of maternal and child morbidity and mortality[2].

To meet the principles of integrality and improve prenatal care in our country, the Ministry of Health implemented in 2000 the Humanization Program for Prenatal and Birth, which determines that Brazilian municipalities must overcome this challenge and meet the minimum recommendations to offer quality care, through actions such as: establish universal coverage, favor and promote early the initiation of prenatal treatment, implement preventive and curative actions through an integrated health network, hold at least six consultations and guarantee their frequency, perform clinical and laboratory procedures and promote educational activities[3].

The Family Health Strategy (FHS) was created in Brazil, in 2006, as an assistance system with the use of restructuring primary health care. For the FHS to act in line with the fundamentals of the Unified Health System (SUS), it must have a multidisciplinary team. Each ESF team will be responsible for welcoming and accompanying the pregnant woman from her micro-area and the capture of this pregnant woman must occur until the fourth month of pregnancy, by the Community Health Agent (CHA) or by the direct search of the woman with suspected pregnancy, directly accessing the health team[4].

The importance of knowing the population served by the FHS, such as pregnant women, allows the planning of actions, the definition of priorities and interventions, directing the pregnant woman in the way that best suits the identified profile[5]. Thus, the object of study of the present research is the identification of the profile of the managers attended by a team of the Family Health Strategy in the city of Belém, Pará.

Given the above, this study aims to outline the profile of pregnant women attended by a Family Health Strategy team, in the neighborhood of Guamá, in the city of Belém do Pará.

II. METHOD

This research is an exploratory, retrospective document analysis research with a quantitative approach, which will have the purpose of identifying the profile of pregnant women, carried out in a family health strategy in the city of Belém-Pará, which serves 2,170 inhabitants and has 80 pregnant women enrolled in the prenatal program, the study was carried out in 2018. The research subjects consisted of 74 pregnant women with medical records registered at the FHS of Riacho Doce, who started prenatal care in 2018 and were attended by the teams of this health establishment. Pregnant women with mental illness were excluded from the study and those characterized as high-risk pregnancies.

Qualitative data from the ready-to-use tests were analyzed in the chi-square adherence test[6]. The alpha level = 0.5 (alpha error 5%) was adjusted to reject a null hypothesis. The biostatistical project was carried out in the software dEasygner and the program BioEstat version 5.3 was used for the application of hypothesis tests.

The research was sent to the Ethics Committee of the University Center of the State of Pará, according to the ethical-legal precepts, the research met the norms of Resolution No. 466/2012 of the National Health Council, where it obtained approval from the Ethics and Research Committee from Centro Universitário do Pará. Under opinion nº: 3,189,267 CAAE: 08052318.6.0000.5169. In order to maintain the anonymity of the information collected, the identities of the participants were kept anonymous by using codes such as: A1, A2, A3, A4…, following the order of data collection from the medical records.

Table 1 - General profile of pregnant women attended by a family health strategy team, in the neighborhood of Guamá, in the city of Belém-Pa, year 2018.

Feature	N	%	p-value
Marital status			**0.0058 ***
Married	17	23.0	
Single	36	48.6	
Stable	17	23.0	
SIC	4	5.4	
Family income			**<0.0001 ***
Without income	4	5.4	
Up to 1 salary	38	51.4	
2 to 4 salaries	17	23.0	
> 5 salaries	0	0.0	
SIC	15	20.3	
Age of menarche			**0.0330 ***

9	2	2.7	
10	1	1.4	
11	7	9.5	
12	8	10.8	
SIC	56	75.7	
Number of deliveries			**0.7133**
No delivery	28	37.8	
A delivery	23	31.1	
Two deliveries	23	31.1	
Family background			**0.2332**
SAH	17	23.0	
DM	9	12.2	
SAH + DM	17	23.0	
Twinning	19	25.7	
Others	12	16.2	
Gestational trimester			**<0.0001 ***
1st quarter	41	55.4	
2nd quarter	29	39.2	
3rd quarter	4	5.4	

Source: Prepared by the authors.

Table 1 shows the general characteristics of the pregnant women with an emphasis on marital status, family income, age at menarche, number of births, family history and gestational trimester. The predominant characteristics are related to the marital status, family income and gestational quarter of these women, it was evidenced, respectively, that more than half are single (48.6%), the family income of these women up to 1 salary (51.4%) and started prenatal care in the 1st gestational trimester (55.4%). As for the number of parturitions, (37.8%) they did not have any birth, and those who had one or two parturitions had the same results (31.1%). Regarding the result of menarche age, it was observed that the vast majority of medical records did not have collected information (75.7%).

Regarding marital status, the highest percentage corresponds to single pregnant women (48.6%), this is an important aspect to be considered, since the absence of the father, in general, brings less economic stability to the family and single women who have a three times greater risk of not having prenatal care when compared to those who have a stable relationship. The lack of contact with the baby's father, together with low maternal education, contributed both to not seeking care and to carrying out fewer consultations during pregnancy7.

Regarding family income, it can be said that pregnant women have low economic power, since the majority (51.4%) reported having an income of up to 1 minimum wage and some reported not having any type of income (5.4 %). Analyzing this data is important, since it represents a health indicator, since lower economic conditions lead to greater restriction of access to health services and is considered a risk factor for complications during pregnancy. Thus, income is a factor that may influence the planning of pregnancy, as well as the performance of prenatal care8.

With regard to women in the group in relation to the age of menarche, the result was that 75.7% did not have information in the medical record. However, from the results collected, the age of menarche at 11 years old corresponds to 9.5% and at 12 years old to 10.8% of the total.

The lack of information in the data referring to the age of menarche in the medical records analyzed is detrimental to the studies, since the age of menarche is closely related to the beginning of early sexual life. Currently, adolescents are starting their sex life earlier and this results in a significant increase in the risk of acquiring a sexually transmitted infection (STI) and/or an unplanned pregnancy[9].

Regarding the family history of the pregnant women analyzed, the most routine results were: twin pregnancy, Systemic Artistic Hypertension (SAH) combined with Diabetes Mellitus (DM) and only Systemic Arterial Hypertension (SAH), it was shown that, respectively, 25.7% of the pregnant women had twinning cases in the family. It is essential that family history is observed and recorded, since this information indicates a possible risk factor for a predisposition for the development of some harmful diseases in the pregnancy period, such as gestational diabetes and the Specific Hypertensive Syndrome of Pregnancy (SHEG), increased as chances of a high-risk pregnancy[10].

With regard to the beginning of prenatal care, the data show that 55.4% of pregnant women started prenatal care in the first trimester of pregnancy, 39.2% started in the second trimester and 5.4% started in the third trimester. It is noted that 44.6% of pregnant women attended started prenatal care late, which is extremely harmful to the health of the mother-fetus binomial, since prenatal care stands out as an essential factor to promote health maternal and fetal, to track possible adverse events and clinical handling of complications as early as possible. Thus, it has the consequence of decreasing maternal and child morbidity and mortality 11.

III. CONCLUSION

We conclude that it is important to adopt educational measures on the importance of prenatal care, so that improvements in the health of pregnant women can be achieved in the long term, in order to reduce the rates of maternal and child morbidity and mortality.

Therefore, health professionals need to approach pregnant women and the community as a whole in a welcoming and humanized manner, developing activities focused on primary care and health education strategies, with a focus on health promotion and prevention. Consequently, through this study, the aim is to contribute for health professionals to reflect on the importance of the profile of pregnant women in the sphere of public health.

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