

Sociodemographic profile and access to prenatal care of puerperae of a public hospital

Perfil sociodemográfico e acesso à assistência pré-natal das puérperas de um hospital público

Perfil sociodemográfico y acceso a la asistencia prenatal de las puérperas de un hospital público

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This study aims to assess the association between the socio-demographic profile and access to prenatal of puerperae who gave birth in a public hospital in the countryside of São Paulo, SP, Brazil. This is a descriptive, cross-sectional and quantitative study, conducted with 261 puerperae, in the second half of 2016, of which 99,6% had access to prenatal, 87,3% initiated care during the first trimester of pregnancy and 91,9% underwent six or more medical consultations. Women without work had less access to prenatal checkups. The participation in health education activities appeared only on 18% of the participants. Access to prenatal is heading to universalization, in the aspects related with early identification and the number of consultations. Inequalities in the access of specific groups can still be observed, requiring effective strategies for their inclusion.

Descriptors: Woman's health; Prenatal care; Socioeconomics factors; Maternal and child health; Health education.

Este estudo tem como objetivo verificar a associação entre perfil sociodemográfico e acesso ao pré-natal de puérperas que tiveram seus partos em um hospital público do interior de São Paulo. Trata-se de estudo descritivo, transversal, quantitativo, realizado com 261 puérperas, no segundo semestre de 2016, das quais: 99,6% tiveram acesso ao pré-natal, 87,3% iniciaram o acompanhamento durante o primeiro trimestre da gestação e 91,9% realizaram seis ou mais consultas. As puérperas sem ocupação no mercado de trabalho tiveram menor acesso às consultas pré-natal. A participação de ações de educação em saúde se deu apenas com 18% das pesquisadas. O acesso ao pré-natal caminha para a universalização nos aspectos da captação precoce e número de consultas. Persistem desigualdades no acesso em grupos específicos, exigindo ações estratégias efetivas para inclusão desses contingentes.

Descritores: Saúde da mulher; Cuidado pré-natal; Fatores socioeconômicos; Saúde materno-infantil; Educação em saúde.

Este estudio tiene como objetivo verificar la asociación entre perfil sociodemográfico y acceso al prenatal de puérperas que hicieron sus partos en un hospital público del interior de São Paulo. Se trata de un estudio descriptivo, transversal, cuantitativo, realizado con 261 puérperas en el segundo semestre de 2016, de las cuales: 99,6% tuvieron acceso al prenatal, 87,3% iniciaron el acompañamiento durante el primer trimestre de la gestación y 91,9% realizaron seis o más consultas. Las puérperas sin ocupación en el mercado de trabajo tuvieron menor acceso a las consultas del prenatal. La participación de acciones de educación en salud se dio apenas con 18% de las investigadas. El acceso al prenatal camina para la universalización en los aspectos de la captación precoz y número de consultas. Persisten desigualdades en el acceso en grupos específicos, exigiendo acciones estratégicas efectivas para inclusión de estos contingentes.

Descriptores: Salud de la mujer; Atención prenatal; Factores socioeconómicos; Salud materno-infantil; Educación en salud.

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INTRODUCTION

Prenatal care aims to embrace women since the beginning of their pregnancy to ensure a safe evolution; to identify as early as possible risky situations, prevent pregnancy and puerperal cycle complications, as well as prepare the mother for a safe childbirth, puerperium and lactation^{1,2}.

During pregnancy numerous transformations take place, which can generate fears, doubts, anxieties, fantasies, or simply the curiosity to know what happens inside the body of a pregnant woman. A good prenatal has as an implicit characteristic the appreciation of these aspects, since to have quality, because to be of quality, the prenatal care should be organized based on the needs and the socio-environmental context of the mother, and not restrict itself to biological factors. For this reason, it is important for health professionals to be prepared to hear the demands of pregnant women and clarify their doubts, enriching the pedagogical process of education in health with the active participation of the pregnant woman in the prenatal^{1,2}.

Each year there are approximately 120 million pregnancies in the world, as well as more than half a million deaths of pregnant women and puerperae, related to complications in the pregnancy-puerperal process. There are also 50 million illnesses or severe disabilities related to pregnancy on record. Almost 95% of these complications occur in underdeveloped or developing countries³.

With the aim of improving the assistance offered to pregnant women, the Ministry of Health implemented, in 2000, the Prenatal and Birth Humanization Program (PHPN), because until that year, there was not a model that guided the assistance to pregnant women in Brazil. The humanization of the care is one of the goals of the Program, which seeks to, among others, increase the adherence of women to prenatal care and childbirth, through an effective admission. The program also focuses on educational actions directed to pregnant women, since the lack of information can lead to insecurity, negatively influencing the prenatal as a whole^{4,5}.

The PHPN establishes a minimum of six prenatal consultations, preferably one in the first quarter, two in the second quarter and three in the last quarter of gestation, and beginning the follow-up until the fourth month of gestation. The program also provides a routine of laboratory exams like the dosage of hemoglobin and hematocrit (Hb/Hct), blood group and Rh factor, serology for syphilis (VDRL), Fasting Blood Sugar, Urine Test and anti-HIV serology. Other tests can be added to this minimum routine, such as tests for hepatitis B, rubella, and toxoplasmosis, protoparasitological exam, oncotic colpocytology, gram stain of vaginal secretion, Urine Analysis, Hemoglobin Electrophoresis and obstetric ultrasonography. The importance of the maternal-fetal monitoring in all consultations also stands out, as well as the vaccination status of the women^{4,5}.

Another strategy for maternal and child health was the implementation, in 2011, by the Ministry of Health, of the *Rede Cegonha* ("Stork Network"), aiming to implement a network of care that ensures women the right to reproductive planning and to a humanized pregnancy, childbirth and puerperium assistance, and assures the children the right to a safe birth and a healthy development and growth. This strategy aims to structure and organize the health assistance to women and children in the country^{6,7}.

After the creation of these public policies, there has been a considerable increase in access to prenatal care, as well as in its quality. Data from the National Survey of Health from 2013, showed that 97.4% of women had prenatal assistance, 83.7% started it with less than 13 weeks of gestation, 75.2% declared to have received guidance about signs of pregnancy danger and 82.4% received guidance on breastfeeding⁸.

Regarding the exams performed in prenatal care, 97.3% of pregnant women said they had undergone blood tests; 64.8% had undergone serology for syphilis and 88.8% for HIV; and 98.1% underwent urine tests. It could be observed that 97.7% of women performed at least an ultrasonography during the prenatal⁸.

Although there has been an improvement in the indexes of access and quality of prenatal care, there is no equality, and there are many factors that contribute to these differences, social aspects standing out in this regard⁹⁻¹¹. Thus, this study aims to investigate the association between the socio-demographic profile and access to prenatal of women who had given birth in a public hospital in the countryside of São Paulo.

METHOD

This is a descriptive, cross-sectional and quantitative study, carried out with the mother in the puerperal period, in a maternal and child reference hospital in the countryside of São Paulo, from August to October 2016.

The sample size calculation was based on the number of deliveries performed by the health care institution (approximately 4,000 births a year), on the greater variability possible based on the prevalence (50.0%), on a significance level of 5% and on a sample size error of 10%. Thus, it was stipulated a sample of 253 women, plus a 3% margin of safety, resulting in 261 participants. Puerperal women that did not wish to participate in the research and those whose clinical conditions made impossible to participate were excluded from the study.

A questionnaire was applied to the women hospitalized due to the birth process, containing questions addressing socio-demographic characteristics, such as: age, city of origin, educational level, marital status, occupation, and family income; and aspects of reproduction, like: number of pregnancies, births, abortions, and live births; and aspects related to the access to prenatal, measured through: number of consultations, the quarter of the beginning of the prenatal assistance and participation in health educational activities. The instrument made it possible to know the information most often obtained by the pregnant women in educational activities, as

well as the nature of the health service where they were accompanied.

For statistical analyses, the package SAS 9.2 was used. Initially, the description of the sample's profile was carried out, using absolute and relative frequencies and quantitative variables, measures of central tendency and dispersion. To assess the degree of dependency of the variables of interest, the chi-square test was used, with a level of significance of 5%.

The study was submitted and approved by the Ethics Committee in Research with Humans, with opinion n. 1.624.548, which followed strictly the recommendations of the Resolution MS/CNS 466/12 and the Declaration of Helsinki.

RESULTS

261 women in the puerperal period participated. Their profile showed that they lived in the municipality where the research was conducted (81.2%), their average age was 26.2 ± 6.9 , they lived with their companions (82.4%), completed high school (42.1%), had a family income of up to two minimum wages (39.8%), and no formal work (54.0%) (Table 1).

About the obstetric background, the average number of gestations was 2.19 ± 1.37 , the average of births was 0.96 ± 1.15 , and that of abortions was of 0.25 ± 0.61 . The median of live births was 2. Among the participants, 44.4% were primiparae, and 55.6% multiparous.

The majority (99.6%) had access to prenatal care, and 90.8% used the public health system, since the hospital where the research was conducted attended, predominantly, users of the Unified Health System (SUS). 87.3% began prenatal care in the 1st trimester of pregnancy. The average of consultations per pregnant woman was 8.76 ± 2.25 , and 91.6% had six or more consultations during the prenatal (Table 2).

Table 1. Puerperae sociodemographic characteristics, São Paulo, 2016.

Variable	N	%
Age Group		
≤ 19 years	48	18.4
20 - 35 years	188	72.0
> 35 years	25	9.6
Educational level		
Illiterate	2	0.7
Incomplete elementary school	32	12.3
Elementary school	25	9.6
Incomplete high school	37	14.2
High school	110	42.1
Incomplete college degree	14	5.4
College degree	41	15.7
Marital status		
With a companion	215	82.4
Without a companion	46	17.6
Occupation		
Home care	141	54.0
Paid work	120	46.0
Income		
No income	5	1.9
Up to 1 minimum wage	32	12.3
1 to 2 minimum wages	104	39.8
3 to 4 minimum wages	99	37.9
More than 4 minimum wages	21	8.0

Participation in educational activities was low (18.5%), and from the 48 who reported receiving orientations from health professionals in the prenatal, 56.3% indicated the following themes: physical and psychological modifications due to the pregnancy process; the management of the most frequent problems in pregnancy; warning signs in pregnancy that require healthcare assistance; types of deliveries, and their respective benefits and risks; the reference hospital for childbirth or emergencies; and breastfeeding.

In the associations between access to prenatal care (measured by the number of consultations) and puerperal variables,

there was a higher percentage of six consultations or more among older women, with higher educational levels, with companions and paid occupations. However, only the latter was significant for most prenatal consultations (Table 3).

In the association analysis between access to prenatal care (measured by the quarter of the beginning of the prenatal) and maternal variables, although no statistical significance, was observed a higher prevalence of early prenatal care on women with the same profile: women in the higher age group, higher educational levels, with companions, and who had paid and formal work (Table 4).

Table 2. Puerperae according to aspects related to prenatal care, São Paulo, 2016.

Variable	N	%
Prenatal		
Yes	260	99.6
No	1	0.4
Institution		
Public	236	90.8
Private health care plan	19	7.3
Private	5	1.9
Number of consultations		
< 6 consultations	22	8.4
≥6 consultations	239	91.6
Starting quarter		
1st quarter	227	87.3
2nd quarter	30	11.5
3rd quarter	3	1.2
Participation in educational groups		
Yes	48	18.5
No	212	81.5

Table 3. Puerperae according to sociodemographic characteristics and the number of prenatal consultations, São Paulo, 2016.

Variables	Number of consultations				P-value*
	< 6		≥ 6		
	N	%	N	%	
Age					0.9424
≤ 19 years	6	12.5	42	87.5	
20 – 35 years	15	8.0	173	92.0	
> 35 years	1	4.0	24	96.0	
Educational level					0.7373
0 – 8 years	11	11.5	85	88.5	
9 – 11 years	10	8.1	114	91.9	
≥ 12 years	1	2.4	40	97.6	
Marital status					0.3427
With a companion	16	7.4	199	92.6	
Without a companion	6	13.0	40	87.0	
Occupation					0.0120
Home care	18	12.8	123	87.2	
Paid work	4	3.3	116	96.7	
With paid work (n=120)					0.5793
Formal work	3	3.3	88	96.7	
Informal work	1	3.4	28	96.6	
Income					0.9877
0 to 1 minimum wage	2	5.4	35	94.6	
1 to 4 minimum wages	19	9.4	184	90.6	
More than 4 minimum wages	1	4.8	20	95.2	

*Chi-square test.

Table 4. Puerperae according to sociodemographic characteristics and quarter of the beginning of the prenatal care, São Paulo, 2016.

Variables	Quarter of beginning				P-value
	1st		2nd and 3rd		
	N	%	N	%	
Age					0.3123
≤ 19 years	38	79.2	10	20.8	
20 – 35 years	164	87.7	23	12.3	
> 35 years	25	100.0	0	-	
Educational level					0.5129
0 – 8 years	82	85.4	14	14.6	
9 – 11 years	106	85.5	18	14.5	
≥ 12 years	39	97.5	1	2.5	
Marital status					0.0738
With a companion	191	89.3	23	10.7	
Without a companion	36	78.3	10	21.7	
Occupation					0.1632
Home care	118	84.3	22	15.7	
Paid work	109	90.8	11	9.2	
With paid work (n=120)					0.1735
Formal work	85	93.4	6	6.6	
Informal work	24	82.8	5	17.2	
Income					0.9083
0 to 1 minimum wage	30	81.1	7	18.9	
1 to 4 minimum wages	179	88.6	23	11.4	
More than 4 minimum wages	18	85.7	3	14.3	

*Chi-square test

In relation to the creation of bonds with the health care system, a statistical significance was observed between educational level and access to public service, according to which the lower the education level the greater the use of the SUS; women with higher education levels mostly go to private health institutions (Table 5).

Table 5. Puerperae according to sociodemographic characteristics and prenatal institution, São Paulo, 2016.

Variables	Prenatal institution				P-value
	Public		Private		
	N	%	N	%	
Age					0.5684
≤ 19 years	46	95.8	2	4.2	
20 – 35 years	167	89.3	20	10.7	
> 35 years	25	100.0	0	-	
Educational level					0.0045
0 – 8 years	94	97.9	2	2.1	
9 – 11 years	112	90.3	12	9.7	
≥ 12 years	30	75.0	10	25.0	
Marital status					0.3269
With companion	192	89.7	22	10.3	
Without a companion	44	95.7	2	4.3	
Occupation					0.057
Home care	132	94.3	8	5.7	
Paid work	104	86.7	16	13.3	
With paid work					0.8181
Formal work	79	86.8	12	13.2	
Informal work	25	86.2	4	13.8	
Income					0.7979
0 to 1 minimum wage	33	89.2	4	10.8	
1 to 4 minimum wages	186	92.1	16	7.9	
More than 4 minimum wages	17	81.0	4	19.0	

Chi-square test

DISCUSSION

The sociodemographic profile of the participants of this study showed an average age similar to the population-based study "Born in Brazil"¹² where the average was 25.7 years. It was also similar in the distribution between the two age groups most at risk, teenagers (18.4%) and higher than 35-year-olds (9.6%), regarding which the national survey found the following results: 18.2% and 10.5%, respectively¹².

The educational level was higher than the national average and suggests a better condition of social development in the Southeast region of the country. More than half of the participants studied more than eight years, while the same indicator for the country shows that half the pregnant women studied only until elementary School¹².

In the state of São Paulo, the educational level of mothers has been increasing in recent decades; in 2004, 35.4% of mothers had less than 8 years of study and 64.6%, more than 8 years; ten years later, in 2014, the percentage of mothers with less than 8 years of study fell to 13.8% and those with more than 8 years rose up to 86.2%¹³.

About the marital status it was found that 82.4% of the population lived with a companion. The partner presence can be an important factor of support in this period, when the couple shares the moments of pregnancy and childbirth¹⁴.

The results found in this research resembles those from a survey conducted in the same health institution in 2011, with 886 puerperae, whose percentage of women with a companion was of 81.2%¹⁵. Largest differences in percentages were observed in the comparison with other studies, such as those held in Porto Alegre, with 238 pregnant women (75.2% with partner)¹⁶; in Fortaleza, with 310 pregnant women (75.8% with partner)¹⁷; and in Piauí, with 376 puerperae (66.2%)¹⁸.

Although the insertion of women in the labor market is relevant, in this study, the majority (54,0%) referred to be houseworkers, this was also observed in the studies cited above, in Porto Alegre (60.0%)¹⁶

and Fortaleza (58,4%)¹⁷, as well as in Recife, in a study with 1,021 mothers (63.7%)¹⁹.

About the family income, a little more than half of the participants (54.0%) had an income of up to two minimum wages, where 22.7% were up to one minimum wage. The income results are similar to the mothers of Recife, where 22.2% had a monthly family income of up to one minimum wage¹⁹, but differ from the participants of a study conducted in another capital of the northeast, Fortaleza, where 90.9% had a family income of up to one minimum wage¹⁷.

Several studies have pointed out that the maternal characteristics interfere in the access to prenatal care, where inadequacies were related to a younger age, black skin, multiparous women, without a companion, with no paid work, lower educational levels, low economic classes, and residence in the north and northeast regions of Brazil²²; low educational level, younger age²⁵, low income⁹, greater number of children¹⁰, low maternal education, low family income, no companion, use of public health services, multiparous women, and maternal age of 35 years or more¹¹. In this study, however, only the occupation "Housework" was significant for access ($p=0.0120$).

In this study it was also found that the access to public institutions was related to women with low educational levels (p -value=0.0045). In the population-based study "Born in Brazil", most of the consultations were held in the public services, and prenatal care was offered by these services mainly the regions north and northeast, to women with lower age and educational level, black or indigenous, without a partner, with a greater number of pregnancies and with previous negative outcomes¹².

As to the profile of obstetric care, the results revealed that the majority of the participants (99.6%) had access to prenatal care, underwent six or more consultations (87.3%) and started follow-up in the 1st trimester of gestation.

The prenatal care was carried out for 99.6% of the sample, following the national indicator of coverage for prenatal of 98.7%¹², with a small variation compared to other

studies conducted in different regions of the country: 96.6% in Criciúma-SC⁹, 95.4% in Caxias do Sul-RS¹⁰, 89.5% in São Luís-MA¹¹, 97.8% in Iguatu-CE², 98.8% in the north of Espírito Santo²¹, and in a previous study held in the same municipality (99.7%)²⁰.

Access to prenatal, measured through an early reception (in the 1st quarter of gestation) and by six or more consultations, showed a better result than that obtained in the population-based national survey "Born in Brazil", where the indicators were 75.8% and 73.1%, respectively¹². It was also higher than in Porto Alegre, which showed results of 75.2% and 87.0%, respectively¹⁶, and in the hospital of Caxias do Sul, with 702 puerperae, (34.7% and 90.3%, respectively)¹⁰. This study corroborates another finding that indicates the significant national coverage of prenatal care, although there are still regional and social inequalities to an appropriate access²².

From the perspective of reduction of inequalities in the access, it is necessary for health services, especially in primary care, to deal with the challenge of including in prenatal care this persistent number of pregnant women, who still have no follow-up during pregnancy. Although it may seem modest (about 0.4% in this study), this group depends on effective strategies that can improve the number of women who come for prenatal care, because they probably belong to social risk groups, a population more prone not to adhere to programs of health in function of the situation of vulnerability.

Female users of drugs constitute one of these groups and were portrayed in a study as having an average age of 29 years, being predominantly non-white (78.56%), unmarried (54.04%), frequently exchanging sex for money or drugs (55.36%) and homeless (45.66%). This vulnerable group has a reproductive profile that stands out regarding the average of Brazilian women, there being respectively 3.82 pregnancies and 2.56 live births per users of crack and/or the like, in contrast with the national projection of fertility, where the average is of 1.9 children per women²⁶.

Another aspect of this study that deserves attention due to a much lower result

than other studies published in the country is related to educational activities, whether individual or in groups. Only 18.5% of the respondents reported that they remember having taken part in some educational activity during prenatal care. The low adherence to educational groups was also observed in other studies, albeit with better indicators of adherence: 34%²⁴, 41.2%¹⁶, and 28.2%².

Focusing only on protocol procedures aimed at physiological problems, relegating to a second plan the activities of health education, is an attitude mentioned in studies in the area of nursing, as is the need to adopt more effective methodological strategies, capable of providing results that cannot be forgotten immediately by pregnant women after the activities²⁷⁻²⁸.

The educational actions are the main difference in the assistance and have the purpose of encouraging a change of attitude and cause a women to react by reflecting on the promotion of more healthier practices regarding their own health, the health of the baby and the family — who, even in the prenatal, should be involved together with the pregnant woman and her companion²⁷.

Being from the population group of women with non-white skin color is among the sociodemographic characteristics associated with a low access to health²⁹. This is a limitation of this study, since this variable was not addressed in the profile of the women interviewed. However, the lack of this information does not compromise the analysis of the results or the initial proposal of the study.

CONCLUSION

The study showed that among the participants, the access to prenatal care started up to the 1st trimester of gestation and involved six or more consultations, a result that moves forward the universality and is prevalent among pregnant women with higher educational levels, who live with their companions, do not have a paid work and have family income of up to two minimum wages, being the occupation a statistically significant factor.

The group of women without economic activity have less access to the adequate number of consultations, a situation that imposes to the health care team the challenge of getting to know the territory under their responsibility, to identify those groups with greater needs and vulnerabilities and provide the means to admit early these pregnant women, as well as to ensure the execution of at least six consultations throughout the pregnancy.

The study also showed that educational activities, although highlighted in public health care policies, are not, as of yet, a focus of prenatal care, and this is another challenge to the health care teams.

The nurse, who is the closest professional to the activity of health education, is expected, among other aspects, to seek out educational methods that can contribute for the teaching-learning process to become interesting to the pregnant women and their families and that assist effectively in a healthy development of pregnancy, childbirth and puerperium.

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CONTRIBUTIONS

Márcia Regina Campos Costa da Fonseca has contributed in the design of the research project, the analysis and discussion of results, and in the writing. **Paula Visnardi** acted in the collection and analysis of data. **Maria Cristina Traldi** participated in the discussion and in the critical review.

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