DOI: 10.4025/cienccuidsaude.v14i4.1524

OBSTETRIC PROFILE OF PUBLIC HEALTH SYSTEM USERS AFTER IMPLANTATION OF THE NETWORK MOTHER FROM THE STATE OF PARANÁ-BRAZIL[1]

Elisiane Soares Novaes*
Rosana Rosseto de Oliveira**
Emiliana Cristina Melo***
Patrícia Louise Rodrigues Varela****
Thais Aidar de Freitas Mathias*****

ABSTRACT
This study aimed to describe the sociodemographic and obstetric profile of resident mothers in the municipality of Maringa, attended by Network Mother from the State of Paraná. This is a descriptive study conducted with 592 postpartum women through interviews, the pregnant woman's card to the consultation and hospital records, between 2013 and 2014. There have been found mostly brown women (44.8%), had completed high school (46.1%), in stable union (86.3%), and exercising gainful occupation (52.0%). Of those interviewed, 67.8% started early prenatal care, 74.0% had seven or more visits, only 35.3% planned their pregnancy, 38,3% participated in groups of pregnant women and 67.7% were classified according to gestational risk. Of complications in pregnancy, urinary tract infection (37.3%), anemia (27.2 %) and hypertension (19.3%) were the most frequent. Given the high prevalence of adolescents (17.2%), cesarean delivery (57.3%), preterm birth (13.7%), and drug abuse during pregnancy (20.6%), showed the need the direction of attention, with a view to promoting the health of both mother and child.

Keywords: Health Profile. Epidemiology. Postpartum Period. Women's Health.

INTRODUCTION

The care to women during pregnancy and childbirth has been a priority of health policies in order to reduce maternal and infant morbidity and mortality, since this reflects significantly in the quality of life of a society[1]. To achieve a quality care, it is necessary to know the demographic, socioeconomic, obstetric and reproductive women met in a particular locality, region or area of coverage of the Family Health Strategy (FHS).

Knowledge of these features enables early identification of gestational risk, which is the discriminating tool in the process of recommending, generating and providing care to health in a different way, to achieve equity[2]. In addition, the construction of epidemiological and obstetric indicators precedes assessing the adequacy of prenatal and postpartum services, allowing to identify the effectiveness of these services to monitor the reduction in cesarean births, the early identification of pregnant women, the prenatal coverage, etc[2,3].

In 2011 the maternal mortality rate in Brazil was of 55.3 deaths per 100.000 live births, and in Paraná the rate was of 51.64. Because of this high rate and the fact that 85.0% of maternal deaths are considered preventable, the state of Paraná in 2012, launched the Network Mother from Paraná to significantly reduce maternal and child mortality indicators, aiming to achieve the goals set by Objectives Millennium development actions with classification of risk pregnancy and child, prenatal care and linking the pregnant woman to the referral hospital for the birth[5].

Strategies and policies for improving the health conditions such as Network Mother Paranaense are research findings that address women's needs and characteristics at local and regional level[5]. Therefore, it is necessary to carry out continuous design of the customer profile in order to contribute to the construction

[1]Search funded by the National Council for Scientific and Technological Development - CNPq, Universal Call (14/2012).
*Nurse. Master in Nursing by Universidade Estadual de Maringá (UEM), Maringá - PR, Brazil. E- mail: elisianenovaes@hotmail.com;
**Nurse. PhD in Nursing by UEM, Maringá - PR, Brazil. E- mail: rosanarosseto@gmail.com;
***Nurse. PhD in Nursing by UEM. Adjunct professor at the Universidade Estadual do Norte Paraná (UENP). E- mail: ecmelo@uenp.edu.br;
****Nurse. Doctoral Student by UEM. Professor at the Universidade Estadual do Paraná (UNESPAR). E-mail: patricialouisev@gmail.com;
*****Nurse. PhD in Public Health. Professor at the Department of Nursing and Graduate Program in Nursing at UEM, Maringá - PR, Brazil. E-mail: tafmathias@gmail.com.br

and evaluation of new health programs for women and children, as this started in 2012 in Paraná, in order to allow professionals and managers realize the targeting of assistance to the specific needs of the population served. Given this, and the need for pregnant women to know the users of public services in the city of Maringá, this study aimed to describing the socio-demographic and obstetric profile of resident mothers in Maringá, attended by Network Mother from Paraná.

METHODOLOGY

This is a descriptive, cross-sectional study of a quantitative approach, using data of mothers residents in the city of Maringá, who received birth care by the Unified Health System (SUS), between October 2013 and February 2014.

The city of Maringá is the third largest in the State of Paraná, with a population estimated at 385.753 inhabitants in 2013. It is the headquarters of the 15th Regional State Health, with urbanization rate of 98.6% and the Human Development Index (HDI) considered high (0.80), occupying the 23rd position in the HDI ranking of Brazilian cities[6]. The HDI of Paraná for the same year was 0.82 and the national 0.74[7].

The municipality has 33 Basic Health Units (BHU), 71 health teams of the family that cover about 70% of the population, two Emergency Care Units (APU) and nine hospitals, and six of these perform obstetric care, two public and four private[8]. Since 2012, the public network of maternal and child care is structured and organized according to the state program Network Mother from Parana[5].

It was calculated and a random representative sample from the number of living residents born in Maringá in 2012, proportionally stratified according to two hospitals serving the delivery by SUS in the city[4], with a confidence interval of 95,0% and error sample of 4,0% which, with a 12.0% increase for possible losses, totaled 592 births, 107 (18.1%) in teaching hospital and 485 (81.9%) in philanthropic hospital.

The analysis of the profile of mothers was performed according to the following variables: socioeconomic characteristics and maternal reproductive (age, race/color, marital status, education, occupation, family income, number of pregnancies, previous cesarean section and reproductive risk history (Premature previous child or low birth weight or miscarriage or stillbirth or dead child before reaching one year of age), obstetric characteristics and prenatal care (prenatal consultations, early prenatal care, pregnancy risk, duration pregnancy, desired birth held childbirth, participation in a pregnant women group), and individual conditions, behavioral, and pregnancy complications (use of alcohol, tobacco, illicit drug use, physical activity, adequate weight gain, unplanned pregnancy, pregnancy acceptance, urinary tract infection, hospitalization, anemia, hypertension, premature amniorexe, oligohydramnios, bleeding, diabetes, placenta previa, depression and others (HIV, syphilis, sexually transmitted disease, placenta previa, polyhydramnios, Rh incompatibility and malformation fetal).

Gestational weight gain was categorized into appropriate and inappropriate according to the Ministry of Health (MH) guidelines[2]. We calculated the gestational age based on ultrasound examination performed up to 20 weeks' gestation and in his absence, it was considered that recorded in the chart by obstetrician and in its absence, gestational age was calculated from the date of the last period reported by the mother, and in the absence of last menstrual period was used gestational age calculated by the pediatrician. This variable was stratified according to the World Health Organization (WHO), which classifies preterm birth according to gestational age: extremely preterm (<28 weeks), very preterm (28 - <32 weeks) and moderate preterm (32 - <37 completed weeks of gestation). Moderate preterm are further subdivided into neighboring premature or late (34 - <37 weeks)[9].

Data were collected from three sources: interviews, the pregnant woman's card and hospital records of the mothers. The variables of the blocks "socioeconomic and maternal reproductive characteristics" and "individual conditions, behavioral and complications during pregnancy" were obtained in the interview with the puerperal woman. The variables of the health conditions of women as "HIV infection", "syphilis", "STD", "placenta previa", "polyhydramnios", "Rh incompatibility", "fetal

malformation" and "type of birth". They were collected from medical records and the other variables have as a source the pregnant card.

The interviews were applied with electronic questionnaire (Google Docs application) in order to store the data in real time (online) and avoid the mistakes inherent in subsequent transcription. The same application was used to collect data from medical records. Data collection occurred by daily active search in the two hospitals where mothers were addressed in the rooming of hospitals and invited to participate in the study after approval and signing of the Term of Consent. We used the Statistical Package for Social Sciences (SPSS) version 20.1 for analysis of simple and relative frequency. The study was approved by the Ethics Committee for Research Involving Human Beings of the Universidade Estadual de Maringá-PR (No. 412.422/2013), having regard to Resolution 466/2012 of the National Research Council of the Ministry of Health.

RESULTS AND DISCUSSION

Women predominated in favorable reproductive age and relatively young (72.5%) because the average age was of 25 years old, with a minimum of 13 and maximum age 46 years old. The prevalence of adolescent mothers was 17.2% and only 10.3% were aged 35 (Table 1).

Percentage observed in the age group of mothers were close to those found in studies conducted in Salvador and Porto Alegre, pointing, respectively, 20.0% and 19.0% of adolescent mothers and approximately (73.0%) of pregnant women between 20 and 35 years old[3,10]. In 2006, the percentage of teenage mothers in the city of Maringá, using data from the Live Birth Information System (SINASC) was 13.5%, being below the state level (20.7%) and national (21.5%) for the same year[11]. In Brazil, the high pregnancy rates in adolescence occur in groups with low socioeconomic and family conditions and associated with low education and the consumption of drug abuse by teenagers[12]. Due to the physical and psychosocial specifics of this step evolutionary, the pregnant adolescent experiences emotional overload, demanding an effective monitoring and qualified to meet their needs. In this sample, 11 girls gave birth aged 13 to 15 years old[13].

Although most women are in the most appropriate age for breeding, the percentage of teenage mothers in this study (17.2%) indicates the need for greater emphasis on family planning for this group since there is a higher incidence of perinatal mortality and diseases between children of adolescent mothers[5,12,13]. Research shows that both pregnancies in teenagers and women over age of 35 are at increased risk of intrauterine growth restriction, fetal distress, intrauterine death and prematurity[12-16].

There was a predominance of mothers who declared themselves brown (44.8%), followed by that self-declared white (42.4%), black (11.5%) and yellow (1.3%) (Table 1). According to the risk criteria Network Paranaense Mother Program, the risk of infant mortality also doubles for black and indigenous mothers when compared to the risk of white mothers[5]. However, the self-declaration of racial identity is subjective, linked the identity of the individual and can change the percentages in different surveys[10,17].

Also in Table 1, it is found that 86.3% of women had a partner, a percentage close to 84% found by a survey of the socio-economic and obstetric profile of mothers attended in philanthropic hospital, held in Espírito Santo[16]. The importance of investigating the marital status is guided on possible economic and psychosocial support to pregnant women with stable situation. The insecure marital status is one of the reproductive risk factors identified by the Ministry of Health[2].

The degree of maternal education is also considered a risk factor, since it has a direct relationship with adherence to prenatal consultations and the infant mortality rate, as well as being an indicator of social status[2,17]. The income of the women in this study showed unfavorable social landscape, as more than half of the mothers (53.4%) had *per capita* incomes below the minimum wage. In relation to education, the findings showed that nearly half of the surveyed mothers had completed high school (46.1%). The prevalence of literacy was of 0.2%. An investigation of mothers hospitalized in Santa Cruz-RN in 2009 found that 52,0% had not

completed elementary school, 18,9% completed elementary and only 14,9% completed high school[18].

Table 1. Socio-demographic profile and reproductive of recent mothers serviced by SUS. Maringá-PR, 2014.

Variables	N	(%)
Age		
10 – 19	102	17.2
20 - 35	429	72.5
36 – 49	61	10.3
Race/Color		
White	251	42.4
Black	68	11.5
Dark skin	265	44.8
Yellow	8	1.3
Maritl status		
Witha partner	511	86.3
Without a patner	81	13.7
Schooling		
Illiterate	1	0.2
Elementary incomplete	79	13.3
Elementary complete	215	36.3
Complete high school	273	46.1
Complete higher education	24	4.1
Occupation		
Remunerated	308	52.0
Non remunerated	284	48.0
***Per capita* Family income(*)**		
< 1	316	53.4
1 – 2	225	38.0
> 2	51	8.6
Number of pregnancies		
First pregnancy	244	41.2
2-3	284	48.0
4 or more	64	10.8
Cesarean section**		
Yes	175	50.3
No	173	49.7
History of reproductive risk(**)		
Yes	135	38.8
No	213	61.2

*In minimum wages (R$ 720,00), in force in 2013. **Deleted the primiparous.

With regard to reproductive characteristics, 48.0% were in the second or third pregnancy, 41.2% were first pregnancy and only 10.8% were multiparous with four or more pregnancies (Table 1). Similar results were found in Maceió-AL and Rio Grande-RS, where it was found that most of the surveyed women had their first gestation, 46.8% and 41.6% respectively[19,20]. The Brazilian Institute of Geography and Statistics (IBGE) shows downward trend in the national birth rate. This social change is a result, to some extent, the increase in education and female participation in the job market as well as the increase in life expectancy of the population[21].

In this study, there is considerable percentage of women with reproductive risk history (38.8%), that is, said history of miscarriage, stillbirth, premature child born or low weight and/or child who died before reaching one year life. These features can be considered as gestational risk factors, indicating the possibility of a differentiated care, or possible referral to specialized services for high-risk pregnancy.

The gestational risk factors can be identified in the course of prenatal care, since health professionals are attentive to every stage of history, general physical examination and gynecological-obstetric examination. They can also be identified during the home visit, which is why the cohesion of the team is important.

Regarding obstetric characteristics and care, it appears that the context of the socio-economic status of the Maringa's population, coupled with the new model of maternal and child care, reflected in prenatal care rate (99.0%), in the early onset of consultations (67.%) and the number of women who had seven or more visits (74.0%). On average, women held eight pre-natal consultations (SD ± 3.1) (Table 2).

Age, race/color, social and educational level and unemployment influence access to health services and quality of care received[6,10,17]. However, the adequacy and quality of prenatal care are determined by the minimum performance of all recommended procedures, including the classification of gestational risk[16]. This basic action, to classify each pregnant woman in relation to risk, was not performed in 32.3% of pregnant women, an indication that many women are not being monitored in

accordance with their individual characteristics, as recommended by the rules of Network Mother Paranaense Program. Prenatal should be made on each woman as an individual, for failures in care may impact the rates of adverse events, such as premature birth (13.7%) and natural history of life-threatening diseases that, if not followed as priorities, lead to death[2,5].

Table 2. Obstetric characteristics and pre-natal care of mothers attended by SUS. Maringá-PR, 2014.

Variables	N	(%)
Pre-natal consultations		
None	4	0.7
1-3	29	4.9
4-6	121	20.4
7-10	302	51.0
≥11	136	23.0
Beginning of pre-natal(*)		
≤12 semanas	399	67.8
13 – 24 semanas	169	28.7
>24 semanas	20	3.4
Gestational risk		
High	60	10.1
Intermediate	21	3.5
Habitual	320	54.1
Non filled	191	32.3
Duration of the pregnncy		
<28	4	0.7
28- 31	2	0.3
32- 33	8	1.4
34- 36	67	11.3
≥ 37	511	86.3
Wished birth(*)		
Cesarean	161	28.0
Vaginal	413	72.0
Conducted birth		
Cesarean	339	57.3
Vaginal	253	42.7
Pregnants group		
Participated	227	38.3
Non participated	365	61.7

*Excluded 18 cases no reply.

Still in relation to obstetric characteristics it was evident the high prevalence of cesarean sections (57.3%), the paradoxical fact that 72.0% of mothers wanted vaginal delivery in early pregnancy. One of the indicators that assess the quality of obstetric care is the cesarean delivery rate because due to anesthetic complications, accidents and puerperal infections, the risk of morbidity and mortality is higher for women undergoing this procedure. Because of this, WHO sets the ideal maximum 15.0%; however, in Brazil are conducted four times more cesareans than recommended by WHO[22]. Several studies denounce the increase in national rates of caesarean sections and points marked differences between regions the country and even among the methods of financing health services[23].

The Mother Paranaense Network has set as a goal, reduction of 10.0% per annum in the number of cesarean section[24]. However, SINASC data show that the cesarean rate in Maringá, which in 2012 was 78.6%, decreased by only 3.7% compared to 2010 and 2.5% compared to 2011[4].

Analyzing the individual and behavioral characteristics, we can see significant prevalence of the use of legal drugs such as tobacco and alcohol, 12.7% and 11.7% respectively (Table 3). These percentages exceeded 7.0% and 9.0%, respectively, found in 2012 by research that investigated the use of drug abuse by pregnant women in Maringá[25].

Alcohol use during pregnancy deserves concern and accurate investigation, since it is associated with a dose-dependent manner with fetal growth restriction, cognitive disability, increased morbidity and mortality and fetal alcohol syndrome. Smoking is responsible for 20.0% of cases of newborns with low birth weight, 8.0% of premature births and 5.0% of all perinatal deaths and may also contribute to the syndrome of sudden infant death and cause major changes in system development fetal nervous[25,26].

The prevalence of illicit drug use (1.2%) remained constant compared to research conducted in the same county in 2012, founding 1.5%[24]. This same study found that pregnant women who receive illicit drugs are less assisted by prenatal services and have a higher incidence of complications in pregnancy[25]. While the use of drugs of abuse is considered little influenced by the intervention of health services, as it relates to multiple social factors, it is necessary to upgrade the skills of primary care for early

detection of the use of these substances in order to support the cessation of addiction and not only perform trial or isolated guidance on implications of using for the woman and the fetus[25]. In spite of the greatest benefits to fetal development occur by the termination of use of drugs of abuse even in early pregnancy, disruption at any point in pregnancy, or even postnatally, has a significant impact on health.

Table 3. Individual and behavioral characteristics and complications during pregnancy of recent mothers served by SUS. Maringá-PR, 2014.

Variables	Yes		No	
	N	(%)	N	(%)
Use of alcohol	69	11.7	523	88.3
Use of tobacco	75	12.7	517	87.3
Use of illicit drugs	7	1.2	585	98.9
Physical activity practice	34	5.8	558	94.2
Appropriate weight gain	298	50.3	294	49.7
Planned pregnancy	209	35.3	383	64.7
When not planned, did you accept?	186	48.6	197	51.4
Infection of the urinary tract	221	37.3	371	62.7
Hospitalization	195	32.9	397	67.1
Anemia	161	27.2	431	72.8
Hypertension	114	19.3	478	80.7
Premature Amniorexe	79	13.3	513	86.7
Oligohydramnios	62	10.5	530	89.5
Bleeding	59	10.0	533	90.0
Diabetes mellitus	36	6.1	556	93.9
Placental abruption	35	5.9	557	94.1
Depression	27	4.6	565	95.4
Other(*)	40	6.8	552	93.2

*HIV infection, syphilis, sexually transmitted disease, placenta previa, polyhydramnios, Rh incompatibility and fetal malformation.

It was observed that in 49.7% of mothers gestational weight gain was poor (Table 3), because, according to the WHO, women with low pre-pregnancy BMI should gain 12.5 to 18 kg and with adequate BMI between 11.5 to 16 kg overweight BMI between 7 and 11.5 kg and obese BMI of up to 7 kg[2]. Among the 294 women who had inadequate weight gain, 158 (54.0%) were classified by overweight and 136 (46.0%) due to lower gain recommended by the WHO.

The prevalence of inappropriate weight gain (50.3%) and physical inactivity (94.2%) may be associated with lack of health education throughout life and during prenatal care. In all, 62.0% of mothers did not participate in any meeting of group of pregnant women. The participation of pregnant women in educational activities of 27.5% found in a survey conducted in Iguatu-EC council it was also considered low[27].

The Ministry of Health points out that educational activities, linked to prenatal care, are fundamental to the pregnant woman acquires a better understanding of the gestational process and emphasizes that during group meetings should be addressed, among several issues, family planning, the importance of specific exercise for pregnant women and adequate nutrition for prevention of diseases[2]. Educational activities contribute to raise the family planning rate making it possible to increase the interval, reducing the number of unwanted pregnancies, and the postponement of pregnancy in adolescents or with chronic conditions (Table 3)[2,27].

The number of women who claim to have unplanned pregnancy (64.7%), and among these, the high percentage of those who did not accept the pregnancy (51.4%) indicates the urgent need for health services to identify factors associated with these events in order to rethink the actions to prevent unintended pregnancy and its complications. The unwanted pregnancy is related to unsafe abortion, anxiety and depression, especially in the puerperal period also has an important impact on the demand for prenatal care, adherence and duration of breastfeeding in children's nutritional status and the rates morbidity and mortality maternal and child[1,2].

Between the mothers of this study 74% reported having gone at least one complication during pregnancy. Among the major complications, urinary tract infection was the most prevalent (37.3%), followed by hospitalization (32.9%), anemia (27.2%) and hypertension (19.3%). Hospitalizations were mainly caused by urinary tract infection/kidney problems, hypertension, placenta previa, accidents and falls, among other causes. Similar findings were described by an assessment of

obstetric hospitalizations funded by SUS in the state of Paraná, which indicated obstetric hospitalization rate of 38.0% in 2011 and urinary tract infection as one of the most prevalent causes[28]. There are other less frequent complications which need to be investigated, such as HIV, syphilis, sexually transmitted disease, placenta previa, polyhydramnios, Rh incompatibility and fetal malformation which affected 6.8% of women investigated.

Given these results and the high percentage of postpartum women with reproductive risk history (39.0%), is possible to realize the need to act in the prevention of complications, is the demographic context (family planning), socioeconomic, behavioral (deletion of smoking, alcohol, nutrition counseling), biomedical (early diagnosis and treatment of diseases) and antenatal care (exams, consultations, health education and other recommended actions in number and frequency appropriate).

CONCLUSION

This research allows us to raise important epidemiological and obstetric characteristics of mothers attended by Network Mother Paranaense, residents in a medium-sized municipality in Paraná, which can support the actions of health professionals working in prenatal and postpartum care, in planning actions educational and construction and evaluation of this new maternal and child health program in line with the profile of the user population.

The epidemiological profile of this group is made up of mostly brown women, 20-34 years old, completed high school, in a stable relationship, with per capita income of up to one minimum wage, who performed paid work during pregnancy. Regarding the obstetric profile, the mothers had an average of two pregnancies; most began prenatal care early, made seven or more visits; however, did not participate in groups of pregnant women, nor made family planning. Generally these women did not practice physical activity during pregnancy and presented inadequate weight gain. The data confirm the high prevalence of cesarean and premature birth, showing that objective actions should be taken to adjust these fees to the goals of the Network Mother Paranaense.

The limitation of this research is in forgetting the bias inherent in the maternal recall. However, this study has important results, which can serve as strategic tools to the government to make changes and reorganize in order to fully assist the binomial mother and child services.

ACKNOWLEDGMENT

The authors thank the approved funding by the universal call – Notice MCTI/CNPq 14/2012 – Process 473708/2012-4.

PERFIL OBSTÉTRICO DE USUÁRIAS DO SISTEMA ÚNICO DE SAÚDE APÓS IMPLANTAÇÃO DA REDE MÃE PARANAENSE

RESUMO

Este estudo teve por objetivo descrever o perfil sociodemográfico e obstétrico das puérperas residentes em Maringá, atendidas pela Rede Mãe Paranaense. Estudo descritivo realizado com 592 puérperas por meio de entrevista, consulta ao cartão da gestante e prontuário hospitalar, entre 2013 e 2014. Encontraram-se, em sua maior parte, mulheres pardas (44,8%), com ensino médio completo (46,1%), a maioria em união estável (86,3%), e ocupação remunerada (52,0%). Das entrevistadas, 67,8% iniciaram precocemente o pré-natal e 74,0% realizaram sete ou mais consultas. Entretanto, apenas 35,3% planejaram a gravidez, 38,3% participaram de grupos de gestantes e 67,7% foram classificadas quanto ao risco gestacional. Das intercorrências na gestação, a infecção do trato urinário (37,3%), anemia (27,2%) e hipertensão arterial (19,3%) foram as mais frequentes. Devido à alta prevalência de gravidez na adolescência (17,2%), parto cesáreo (57,3%), nascimento prematuro (13,7%), e uso de drogas de abuso durante a gestação (20,6%), evidenciou-se a necessidade de direcionamento da atenção, com vistas à promoção da saúde do binômio mãe-filho.

Palavras-chave: Perfil de saúde. Epidemiologia. Puerpério. Saúde da mulher.

PERFIL OBSTÉTRICO DEL SISTEMA ÚNICO DE SALUD DESPUÉS DE LA IMPLANTACIÓN DE LA RED *MÃE PARANAENSE*

RESUMEN

Este estudio tuvo como objetivo describir el perfil socio-demográfico y obstétrico de madres residentes en Maringá-Paraná-Brasil, atendidas por la Red *Mãe Paranaense*. Este es un estudio descriptivo realizado con 592 puérperas a

través de entrevista, y consulta a la tarjeta de la mujer embarazada y a los registros médicos, entre 2013 y 2014. Se encontraron, en su mayoría, mujeres pardas (44,8%), con educación secundaria completa (46, 1%), la mayor parte en relaciones estables (86,3%), y con empleo remunerado (52,0%). De las entrevistadas, el 67,8% inició la atención prenatal precozmente y el 74,0% realizó siete o más consultas. Sin embargo, solo el 35,3% planeó el embarazo, el 38,3% participó de grupos de mujeres embarazadas y el 67,7% fue clasificado en cuanto al riesgo gestacional. De las complicaciones en el embarazo, la infección del tracto urinario (37,3%), anemia (27,2%) e hipertensión (19,3%) fueron las más frecuentes. Debido al alto número de embarazos en adolescentes (17,2%), la cesárea (57,3%), el nacimiento prematuro (13,7%), y el uso de drogas de abuso durante el embarazo (20,6%), se evidenció la necesitad de direccionar la atención, con el fin de promover la salud del binomio madre-hijo.

Palabras clave: Perfil de Salud. Epidemiología. Posparto. Salud de la Mujer.

REFERENCES

1. Ministério da Saúde(BR). Secretaria de Atenção à Saúde. Política Nacional de Atenção Integral à Saúde da Mulher: Princípios e Diretrizes. Brasília (DF): MS; 2011.

Ministério da Saúde(BR). Secretaria de Atenção à Saúde. Atenção ao pré-natal de baixo risco. Brasília(DF): MS; 2012.

2. Gomes RMT, César JÁ. Perfil epidemiológico de gestantes e qualidade do pré-natal em unidade básica de saúde em Porto Alegre, Rio Grande do Sul, Brasil. Rev Bras Med Fam Comunidade. 2013; 8(27):80-9. Disponível em: http://dx.doi.org/10.5712/rbmfc8(27)241

3. Ministério da Saúde(BR). Datasus: informações de saúde. [online]. Estatísticas vitais. Nascidos vivos. 2012. [citado em 2014 abr 3]. Disponível em: http://w3.datasus.gov.br/datasus/datasus.php

4. Brasil. Secretaria Estadual de Saúde do Paraná- Sesa. Linha Guia: Mãe Paranaense. Curitiba; 2012.

5. Instituto Paranaense de Desenvolvimento Econômico e Social (IPARDES). Paraná em números. 2014. [citado em 2014 abr 01]. Disponível em: <http://www.ipardes.gov.br/index.php?pg_conteudo=1&cod_conteudo=1>

6. Programa das Nações Unidas para o Desenvolvimento (PNUD). Relatório do Desenvolvimento Humano. 2014. [citado em 2014 set 01] Disponível em:< http://www.pnud.org.br>

7. Cadastro Nacional de Estabelecimentos de Saúde (CNES). Estabelecimentos de saúde do município de Maringá. [online]. 2012. [citado em 2014 jun 10]. Disponível em: <http://cnes.datasus.gov.br/Lista_Es_Municipio.asp?VEstado=41&VCodMunicipio=411520&NomeEstado=PARANA>

8. WHO. Born too soon: the global action report on preterm birth; 2012.

9. Rodrigues QP, Domingues PML, Nascimento ER. Perfil sociodemográfico de puérperas usuárias do Sistema Único de Saúde. Rev. enferm. UERJ, 2011 abr/jun; 19(2):242-8.

10. Melo EC, Mathias TAF. Características das mães e dos recém-nascidos em municípios-sede de regional de saúde no Paraná a partir dos dados do SINASC. Cogitare Enfermagem (UFPR). 2010; 15(2):293-301.

11. Faler CS, Câmara SG, Aerts DRGC, Alves GG, Béria JU. Family psychosocial characteristics, tobacco, alcohol, and other drug use, and teenage pregnancy. Cad Saúde Pública. 2008; 29(8):1654-63.

12. Vieira APR, Laudade LGR, Monteiro JCS, Nakano AMS. Maternidade na adolescência e apoio familiar: implicações no cuidado materno à criança e autocuidado no puerpério. Cienc Cuid Saude. 2013; 12(4):679-687.

13. Tavares KO, Paganotto KM, Frare JC, Carvalho MDB, Pelloso SM. Perfil de puérperas adolescentes atendidas em um hospital ensino do sul do país. Acta Scientiarum Health Sciences. 2012; 34(1):9-15.

14. Merino MFGL, Zani AV, EF Teston, Marques FRB, Marcon SS. As dificuldades da maternidade e o apoio familiar sob o olhar da mãe adolescente. Cienc Cuid Saude. 2013; 12(4):670-8.

15. Beeckman K, Louckx F, Downe S, Putman K. The relationship between antenatal care and preterm birth: the importance of content of care. Eur J Public Health. 2013; 23(3):366-71.

16. Leite FMC, Barbosa TKO, Mota JS, Nascimento LCN, Amorim MHC, Primo CC. Perfil socioeconômico e obstétrico de puérperas assistidas em uma maternidade filantrópica**.** Cogitare Enferm. 2013 abr/jun; 18(2):344-50.

17. Galvão MCB, Davim RNB. Profile of puerperal women hospitalized in a hospital. Rev enferm UFPE [online]. 2011; 5(7):1591-595.

18. Santos DTA, Campos CSM, Duarte ML. Perfil das patologias prevalentes na gestação de alto risco em uma maternidade escola de Maceió, Alagoas, Brasil. Rev Bras Med Fam Comunidade. 2014; 9(30):13-22.

19. Minasi JM, Barros AM, Souza CS, Pinheiro TM, Francioni FF, Kerber NPC. Perfil obstétrico e intercorrências de puérperas atendidas em visita domiciliária. Rev Rene. 2013; 14(4):757-64.

20. IBGE. Diretoria de pesquisas, coordenação de população e indicadores sociais. [online]. Projeções da população por sexo e idade para o Brasil, grandes regiões e unidades de federação. 2013 [citado em 2014 ago 24]. Disponível em: http://ibge.gov.br/home/estatistica/populacao/projecao_da_populacao/2013/default.shtm

21. Patah LEM, Malik AM. Modelos de assistência ao parto e taxa de cesárea em diferentes países. Rev Saúde Pública. 2011; 45(1):185-94.

22. Victora CG, et al. Saúde de mães e crianças no Brasil: progressos e desafios. Séries Saúde no Brasil. 2011; 2:32-46. Disponível em: http://thelancet.com

23. Paraná. Secretaria de Estado da Saúde do Paraná - SESA. Plano Estadual de Saúde Paraná 2012-2015. Curitiba; 2013.

24. Kassada DS, Marcon SS, Pagliarini MA, Rossi RM. Prevalência do uso de drogas de abuso por gestantes. Acta Paul Enferm. 2013; 26(5):467-71.

25. Marangoni SR, Oliveira MLF. Fatores desencadeantes do uso de drogas de abuso em mulheres. Texto Contexto Enferm. 2013; 22(3):662-70.

26. Gonçalves MLC, Silva HO, Oliveira TA, Rodrigues LV, Campos ALA. Perfil sociodemográfico e obstétrico de puérperas assistidas no município de Iguatu – CE. Rev Bras Promoç Saúde. 2012; 25(2):33-9.

27. Veras TCS, Mathias TAF. Principais causas de internações hospitalares por transtornos maternos. Rev Esc Enferm USP. 2014; 48(3):401-8. Disponível em: www.ee.usp.br/reeusp.

Corresponding author: Elisiane Soares Novaes. Programa de Pós-graduação em Enfermagem. Bloco 002, sala 001 Campus Universitário. Avenida Colombo, 5.790. CEP: 87020-900 – Maringá. Paraná. Brasil E-mail: elisianenovaes@hotmail.com

Submitted: 09/05/2015
Accepted: 12/12/2015