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ORIGINAL ARTICLE

# ANALYSIS OF ASPECTS OF PRENATAL CARE THROUGH INFORMATION OF THE PREGNANT WOMAN'S BOOKLET[1]

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## ABSTRACT

**Objective:** to analyze aspects of the prenatal care process through information from the pregnant woman's booklet. **Method:** this is a descriptive, quantitative research, with data collection carried out from September to December 2019, in Basic Health Units, maternity and emergency and obstetric emergency of a hospital linked to the Unified Health System, in a municipality in the Midwest region. Data were analyzed using descriptive statistics. **Results:** data were collected from 156 pregnant women's books. Most women started prenatal care early, had weight and height evaluated in all consultations. However, most of the complementary tests of the first trimester were not performed or recorded, as well as the measurement of uterine height and supplementation of folic acid and ferrous sulfate. **Conclusion:** there is a need to improve the care process during prenatal care. Essential data for prenatal care were not adequately completed.

**Keywords:** Prenatal Care. Pregnant Women. Maternal Mortality.

## INTRODUCTION

Pregnancy is the only time when women experience physical and emotional changes. It is a moment of great importance for the woman, bringing modifications, besides physical, psychological and social changes, which require adaptation and generate new meanings for her life[1,2].

During such modifications, it is essential to follow up with nursing professionals and physicians in order to maintain maternal-fetal health. For this, the health services that perform prenatal care need to be accessible, humanized and of quality[3].

Indicators of prenatal care include: prenatal coverage; average number of prenatal visits and percentage of pregnant women who started prenatal care in the first trimester of pregnancy; routine examinations performed; and the guidance provided on the reference maternity hospital[4,5]. Adequate prenatal coverage impacts maternal and child morbidity and mortality and quality of health care in the region, because the better the care for pregnant women, the lower the fragility in the services provided to that population.

In Brazil, prenatal coverage has followed a growing trend over the years, with coverage exceeding 95% since the early 2000s. However, prenatal care does not necessarily mean adequacy of care[6,7]. This is intensified in black women who occupy unfavorable social positions[7].

Prenatal care is an important link between Primary Health Care (PHC) services and hospital care, and its absence, by itself, can increase the risk for the pregnant woman and the newborn. Pregnant women who had unfavorable outcomes in pregnancy, such as postpartum hospitalization

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and maternal mortality, presented obstetric complications[8].

Prenatal care contributes to more favorable outcomes, allowing early detection and treatment of conditions, as well as controlling other risk factors and complications such as hypertension, gestational diabetes, sexually transmitted infections (STIs), anemia, eclampsia, threat of premature birth, among others[8]. Thus, it is questioned: what is the quality of prenatal care performed in pregnant women attending public health services?

This study has great relevance because it performs a situational assessment of aspects of assistance to pregnant women served by the Unified Health System (SUS). Data, such as the measurement of anthropometric measurements, uterine height, fetal heartbeat, guidelines, request for tests, among other procedures performed in prenatal consultations, are described in the booklet of the pregnant woman, made by the Brazilian Ministry of Health, available in the Health Care Network. These data allow qualifying the services, favoring the early diagnosis of possible complications that may be possible to interventions during prenatal care. From the analysis of these data, strategies for improving the assistance provided can be developed. Thus, this study aimed to analyze aspects of the prenatal care process through information present in the pregnant woman's booklet.

## METHOD

This work is a clipping of a larger research entitled "Evaluation of health services actions during prenatal care", carried out by the Tutorial Education Program (PET) of the Federal University of Mato Grosso do Sul. For a better understanding, we used the Checklist Strengthening the Reporting of Observational Studies in Epidemiology (STROBE), which aims at a more adequate report of this type of study.

This is a descriptive, cross-sectional and quantitative research, with data collection in four Basic Health Units, maternity and urgency and obstetric emergency of a hospital linked to SUS, in a municipality located in the Midwest region of Brazil. The collections in the Basic Health Units were performed through the selection and authorization of the Municipal Health Department.

Pregnant and/or parturient women with at least one prenatal visit and older than 18 years were included. Pregnant women without clinical conditions were excluded, that is, they had a risk of aggravation according to the risk classification in obstetrics during care in the hospital unit and/or who were in the delivery room.

Data collection took place from September to December 2019, by a group of properly trained researchers, at least once a week, in the Basic Health Units and in the hospital (maternity and/or emergency and obstetric emergency). The data collection instrument was prepared by the research team and was composed of data regarding the sociodemographic profile, obstetric clinical history, the vaccination calendar of the pregnant woman, nutritional monitoring, prenatal care, complementary examinations, current clinical-obstetric characteristics and gestational follow-up. Pregnant women were approached before and/or after prenatal consultations in PHC units or in the maternity ward during hospitalization or waiting for consultation in the emergency and obstetric emergency department. All pregnant women who met the inclusion/exclusion criteria were invited to provide the pregnant woman's booklet, so that the data completed by the health professionals were collected in it.

The instrument for data collection was made by the researchers and contained information that could be collected and/ or should be completed during prenatal care. For this study, the variables studied relate to sociodemographic information and the process of prenatal care, such as consultation of the beginning of prenatal care, weight and height measurement, nutritional monitoring chart, blood pressure measurement and uterine height, supplementation of iron and folic acid and request for complementary tests.

To evaluate the process during prenatal care, indicators of clinical-obstetric evaluation and complementary tests were constructed, based on the recommendations of the Brazilian Ministry of Health, addressed in other studies. The indicators were considered adequate when: beginning of prenatal care occurred within 12

weeks (early consultation); all tests of the first trimester were performed (fasting blood glucose; serology: syphilis, HIV, hepatitis B, hepatitis C and toxoplasmosis; urine I/ urine culture, blood typing and hemoglobin); weight and blood pressure were measured at all visits; height was measured at the first visit; uterine height (AU) was measured in all consultations from 12 weeks; supplementation of folic acid and ferrous sulfate was performed during prenatal care[7,9-10].

For analysis, the collected data were transcribed in a spreadsheet in Microsoft Office Excel®. After double typing and checking to solve any misconceptions, the data were transferred to the Statistical Package for the Social Sciences (SPSS), version 25, for descriptive statistical analysis of the variables. Subsequently, tables were made to present the results.

The project was submitted to the Research Ethics Committee of the Federal University of Mato Grosso do Sul (UFMS), through *Plataforma Brasil*, according to Resolution 466, of December 12, 2012, and approved under Opinion n. 3,678,518/2019. All participants signed the Informed Consent Form (ICF) in two copies.

## RESULTS

The study included 156 women who started prenatal care by SUS, 132 (84.6%) pregnant women who attended Basic Health Units and 24 (15.4%), maternity. Most of the pregnant/puerperal women were aged 20-35 years (n=118; 75.7%), brown (n=64; 41%), married (n=43; 27.6%) and had high school (n=53; 34%) (Table 1).

**Table 1.** Maternal sociodemographic characteristics. Brazil, 2019

| *Sociodemographic profile* | *n (%)* |
|---|---|
| **Age in years** | |
| Up to 19 years | 17 (10.9) |
| 20 - 35 years | 118 (75.7) |
| > 35 years | 21 (13.4) |
| **Self-reported color** | |
| White | 52 (33.3) |
| Black | 13 (8.4) |
| Brown | 64 (41.) |
| Indigenous | 2 (1.3) |
| Not filled | 25 (16) |
| **Marital status** | |
| Single | 23 (14.7) |
| Married | 43 (27.6) |
| Stable union | 38 (24.4) |
| Other | 10 (6.4) |
| Not filled | 42 (26.9) |
| **Education** | |
| None | 3 (1.9) |
| Elementary school | 27 (17.3) |
| High school | 53 (34.0) |
| College | 10 (6.4) |
| Not filled | 63 (40.4) |

Regarding prenatal care, 97 (62.2%) had their first early consultation; 116 (74.4%) started in the first quarter, 28 (17.9%) in the second quarter, and 2 (1.3%) in the third quarter (Table 2).

**Table 2.** Characterization of prenatal care. Três Lagoas, 2019

| *Prenatal care* | *n (%)* |
|---|---|
| **Early start of prenatal care** | |
| ≤ 12 weeks | 97 (62.2) |
| > 12 weeks | 50 (32.1) |
| Not filled | 9 (5.8) |
| **Prenatal start trimester** | |

| | |
|---|---|
| 1st trimester (8 – 14 weeks) | 116 (74.4) |
| 2nd trimester (15 – 27 weeks) | 28 (17.9) |
| 3rd trimester (> 27 weeks) | 2 (1.3) |
| Not filled | 10 (6.4) |

In relation to the weight measurement, 128 (82.1%) were properly evaluated and 131 (84%) had height measurement at the first consultation. Despite the fact that most of the pregnant women had the weight measured in all consultations, it is noteworthy that 109 (69.9%) did not have the nutritional monitoring chart filled out properly, followed by 45 (28.8%) unfilled (Table 3).

Regarding the measurement of blood pressure, UA, folic acid supplementation and ferrous sulfate, 154 (98%), 25 (16%), 25 (16%) and 22 (14.1%) had the variables classified as adequate, respectively. It should be noted that 109 (69.9%) booklets did not have information about the prescription of folic acid and ferrous sulfate, which leads to doubts whether there was a prescription and it was not recorded or whether women did not have supplementation during prenatal care (Table 3).

**Table 3.** Clinical and obstetric procedures offered to pregnant women. Brazil, 2019

| *Gestational follow-up* | *n (%)* |
|---|---|
| **Nutritional assessment** | |
| (weight measurement at every appointment) | |
| Yes | 128 (82.1) |
| No | 28 (17.9) |
| **Height performed at the 1st appointment** | |
| Adequate | 131 (84.0) |
| Inadequate | 25 (16.0) |
| **Nutritional monitoring chart** | |
| Adequate | 2 (1.3) |
| Inadequate | 109 (69.9) |
| Not filled | 45 (28.8) |
| **Blood pressure performed at all appointments** | |
| Adequate | 154 (98.7) |
| Inadequate | 2 (1.3) |
| **Uterine height measured in all consultations after the 12th week of pregnancy** | |
| Adequate | 25 (16.0) |
| Inadequate | 131 (84.0) |
| **Supplementation** | |
| Ferrous sulphate | 22 (14.1) |
| Folic acid | 25 (16.0) |
| Not filled | 109 (69.9) |

Table 4 shows the complementary tests performed during the first and third trimester of pregnancy. Considering that the completion of the results of examinations in the booklet is one of the main means used to prove the accomplishment of the same, the analyzed examinations were classified by its accomplishment and reactivity.

Concerning blood type by ABO system and Rh factor, 123 (78.4%) were performed. There was a higher frequency for blood type "O" positive (n = 57; 36.3%), followed by "A" positive (n = 42; 26.8%) and, notoriously, no frequency for type "B" negative. Fasting glucose was performed in 79.5% (n=124) of the cases (Table 4).

On the rapid tests performed at the first prenatal visit, six (3.8%) were reagents for syphilis, two (1.3%) for HIV, as well as for hepatitis C, and none for hepatitis B. The type I urine test was requested and noted in 90 (57.7%) of the booklets (Table 4).

Because there was no pattern in the results obtained from toxoplasmosis, or whether it was performed in the first or third trimester of pregnancy, the annotation of results was considered in order to evaluate its performance or not. In 98 (62.8%) of the cases, it was considered as performed (Table 4).

**Table 4.** Complementary exams carried out. Brazil, 2019

| *Complementary exams* | *n (%)* |
|---|---|
| **ABO/Rh System** | |
| Performed | 123 (78.4) |
| A+ | 42 (26.8) |
| A- | 5 (3.2) |
| B+ | 11 (7.0) |
| B- | - |
| 0+ | 57 (36.3) |
| 0- | 5 (3.2) |
| AB+ | 2 (1.3) |
| AB- | 1 (0.6) |
| No information | 33 (21.6) |
| **Blood count** | |
| Performed | 123 (78.4) |
| No information | 33 (21.6) |
| **Fasting blood glucose** | |
| Performed | 124 (79.5) |
| No information | 32 (20.5) |
| **Syphilis** | |
| Reagent | 6 (3.8) |
| Not reagent | 127 (81.4) |
| No information | 23 (14.7) |
| **HIV** | |
| Reagent | 2 (1.3) |
| Not reagent | 146 (93.6) |
| No information | 8 (5.1) |
| **Hepatitis B** | |
| Reagent | 134 (85.9) |
| Not reagent | 22 (14.1) |
| No information | - |
| **Hepatitis C** | |
| Reagent | 2 (1.3) |
| Not reagent | 95 (60.9) |
| No information | 59 (37.8) |
| **Type I urine and urine culture** | |
| Performed | 90 (57.7) |
| No information | 66 (42.3) |
| **Toxoplasmosis** | |
| Performed | 98 (62.8) |
| No information | 58 (37.2) |

## DISCUSSION

The analysis of indicators of prenatal care, through the pregnant woman's booklet, showed that most of them started prenatal care early, had weight and height evaluated in all consultations, but there was no follow-up through the nutritional graph in most cases. In addition, most of the complementary examinations of the first trimester were not performed or recorded, as well as the measurement of AU and supplementation of folic acid and ferrous sulfate.

An important indicator of prenatal care is early onset, since information on blood type, Body Mass Index (BMI) and infections that can be transmitted to the fetus should be obtained as early as possible. In this study, more than half of the instruments found the beginning of care until the 12th gestational week, as well as in studies conducted in Redenção-CE[11], Rio de Janeiro-RJ[12] and Lagarto-SE[13].

Regarding the clinical procedures offered to pregnant women during prenatal care, nutritional assessment is of paramount importance for the diagnosis of nutritional deficit and overweight from the beginning of pregnancy. One of the mandatory requirements is the weight measurement of the pregnant woman in every

consultation. With the height measured at the first consultation, it is expected that the BMI and nutritional status classification based on the gestational week will be calculated[5]. According to the analysis in relation to the weight measurement in each consultation and height of the pregnant women in the first consultation, the nutritional evaluation of most of the pregnant women was considered while the completion of the nutritional monitoring chart of the booklet based on BMI was inadequate.

A retrospective study, from the review of medical records, concluded that pregestational BMI and weight gain in pregnancy are associated with perinatal results. Thus, identifying obese pregnant women with inadequate weight gain is a fundamental measure of control and prevention of maternal-fetal morbidity and mortality[14].

In addition, the same chances of developing gestational diabetes for obese patients occur in patients with low or normal BMI at the beginning of pregnancy; therefore, there is a need to monitor the weight gain of pregnant women by the nutritional graph, weight at each appointment, so that information about BMI is entered according to gestational age, allowing a careful and sequential view of how weight gain occurs during pregnancy. Thus, the nutritional evaluation of the mother-child binomial becomes important in the prevention of perinatal morbidity and mortality, in the prognosis of fetal growth and development, and in the promotion of maternal and child health[15].

Blood pressure control detects early hypertensive states that cause maternal and perinatal risk. The adequacy of this item occurred through the registration in all consultations of each participant, being predominantly adequate, as well as the descriptive study developed in the interior of Ceará[11] and Rio Grande do Norte[16].

The UA measurement should be performed in all prenatal consultations after the 12$^{th}$ week of pregnancy, using an inelastic tape delimiting the uterine fundus and the upper border of the pubic symphysis. Its proportions indicate fetal growth and should be within the range that delimits the 10$^{th}$ and 90$^{th}$ percentiles of the uterine growth chart, according to gestational age[7]. In this study, it was predominantly inadequate, showing low completeness after the 12$^{th}$ gestational week, as presented in the study in São Luís-MA[14] and in different municipalities in the state of Paraná[17]. In the study in Fortaleza-CE, more than half of the medical records were considered adequate because there were five or more records of UA[10]. This data is essential to determine whether the uterus is within the normal gestational age and to evaluate the growth of the fetus.

Routine supplementation of iron and folate appears to prevent the installation of low hemoglobin levels in childbirth and postpartum. As for iron, it is advised that the intake is carried out one hour before meals. Iron supplementation should be maintained in the postpartum and post-abortion periods for three months. Folic acid has a strong protective effect against open neural tube defects and should be used routinely at least two months before and in the first two months of pregnancy[1]. The lack of vitamin supplementation can cause risks in the mother-child binomial. The low record found in this study may occur due to the fact that the professional does not note in its appropriate place and note in the "observation, diagnosis and conduct" part of the booklet, an item that was not evaluated in this study.

The request for complementary examinations is essential for the monitoring of prenatal care, allowing a more detailed monitoring of the health of the pregnant woman[1,6]. The request for these tests should occur already in the first consultation, and its performance should be during the first trimester, with repetition of syphilis, HIV, hepatitis B, blood glucose, urine I/urine culture, toxoplasmosis and complete blood count in the third trimester[5].

Rapid tests (HIV, syphilis, hepatitis B and hepatitis C) were non-reactive for most pregnant women. However, there were cases of reactivity for syphilis and hepatitis C. In studies in the interior of Ceará[11], Maranhão[14], Rio Grande do Norte[16] and Sergipe[13], there was completeness in the performance of these tests, but information on their reactivity was not inserted. According to protocols of the Ministry of Health[1,5], two serologies for HIV and syphilis are recommended. However, this study did not evaluate the gestational week in which the tests were performed, only their performance and

reactivity. Considering the reactivity of the tests as performed and lack of information as not performed, HIV had 94.9% coverage, and syphilis, 85.2%, similar results with coverage in the country, which was 88% and 79% of the tests for syphilis and HIV, respectively[18]. With regard to the relevance of monitoring these tests, a study conducted with 43 primary care health professionals showed that they had difficulties in diagnosing and treating syphilis in pregnancy, emphasizing that continuing education for the team is fundamental for proper management[19].

In more than half of the instruments evaluated, blood typing with Rh factor, blood count, fasting blood glucose and urine I/urine culture were performed. The value obtained from fasting glucose at the first consultation is the first evaluation of the pregnant woman's glycemic status, that is, a screening for gestational diabetes mellitus (GDM), which helps to detect glucose tolerance in advance[5]. Urine I/urine culture tests are part of the complementary tests that must be requested at the first consultation and repeated in the third trimester of pregnancy[5]. It is important to highlight that it is through them that the detection of urinary infection occurs, one of the main infections that can affect the pregnant woman, which can compromise the kidneys and even cause premature labor. If two or more episodes are repeated, the pregnant woman should be referred to her referral hospital for evaluation[1].

The Ministry of Health recommends serological screening of toxoplasmosis during pregnancy, especially in regions with prevalence of cases, noting the possibility of reinfection due to the genetic diversity of the parasite. The main objective is the identification and monitoring of susceptible pregnant women during pregnancy for the prevention of acute infection and fetal transmission[1,18]. From the results obtained from toxoplasmosis, it was considered the annotation of results as a reference of accomplishment or not. More than half of the instruments evaluated were considered as examinations, although the manuscript record did not have a standard writing.

From the results obtained in this study, the analysis of the prenatal care process through information from the pregnant woman's booklet is partially adequate. Results of examinations and procedures performed depend on nursing and medical professionals to follow a quality prenatal care.

The completion of the booklet is essential for prenatal care, as it is a way to ensure continuity of care, since, through registration, prevention measures can be adopted to avoid complications, unexpected perinatal outcomes and proceed to a healthy pregnancy.

Given this perspective, it is noted that a record of quality of care provided during prenatal actions denotes continuity of more effective gestational care, ensuring that the mother-child binomial has favorable outcomes both in childbirth and birth and in the postpartum period, avoiding that often this woman and this baby do not receive adequate care for lack of important records.

Since this study used secondary data through the pregnant woman's booklet, it is configured as a limitation not confirming that these procedures, such as request for tests and prescription of supplements, were not performed or performed and not noted. In addition, the evaluation of the care process occurred through procedures, request for tests and supplementation. Aspects such as humanization of care, professional-pregnant relationship and guidance in an individual or collective way could not be analyzed. However, the pregnant woman's booklet is a document that must transit between the levels of care, so that different teams easily understand information relevant to the quality of prenatal care and that can impact therapeutic decisions and procedures performed, including in childbirth and postpartum.

## CONCLUSION

This study concluded that there is a need to improve the care process during prenatal care. The analysis of the pregnant woman's booklet showed that many essential data are not filled in an appropriate way, such as nutritional assessment, complementary tests, UA and vitamin supplementation.

It is important to keep detailed records of tests and consultations in the pregnant woman's booklet and that there is a need for improvements in the conduct of this assistance

by health professionals, so that it is organized and qualified to prevent perinatal complications. It is suggested that periodic training be performed to health professionals in order to promote awareness and improvement of care in relation to process indicators in the service and monitoring evaluation of prenatal care.

The present study contributed to the identification of deficiencies during the analysis of the prenatal care process and can serve as a basis for reflection of professionals who work in this care, in addition to the development of strategies for their eradication.

## ANÁLISE DE ASPECTOS DO CUIDADO PRÉ-NATAL POR MEIO DE INFORMAÇÕES DA CADERNETA DA GESTANTE


### RESUMO

**Objetivo**: analisar aspectos do processo de cuidado pré-natal por meio de informações da caderneta da gestante. **Método**: trata-se de uma pesquisa descritiva, quantitativa, com coleta de dados realizada no período de setembro a dezembro de 2019, em Unidades Básicas de Saúde, maternidade e urgência e emergência obstétrica de um hospital vinculado ao Sistema Único de Saúde, em um município da região Centro-Oeste. Os dados foram analisados por meio de estatística descritiva. **Resultados**: foram coletados dados de 156 cadernetas de gestantes. A maioria das mulheres iniciaram precocemente o pré-natal, tiveram peso e altura avaliados em todas as consultas. Contudo, grande parte dos exames complementares do primeiro trimestre não foi realizada ou anotada, assim como ocorreu com a aferição da altura uterina e a suplementação de ácido fólico e sulfato ferroso. **Conclusão**: há necessidade de melhora do processo de cuidado durante o pré-natal. Dados essenciais para o cuidado pré-natal não foram preenchidos de maneira adequada.


**Palavras-chave**: Cuidado Pré-Natal. Gestantes. Mortalidade Materna.

## ANÁLISIS DE ASPECTOS DEL CUIDADO PRENATAL MEDIANTE INFORMACIÓN DE LA LIBRETA DE LA GESTANTE


### RESUMEN

**Objetivo**: analizar aspectos del proceso de cuidado prenatal mediante informaciones de la libreta de la gestante. **Método**: se trata de una investigación descriptiva, cuantitativa, con recolección de datos realizada en el período de septiembre a diciembre de 2019, en Unidades Básicas de Salud, maternidad y urgencia y emergencia obstétricas de un hospital vinculado al Sistema Único de Salud, en un municipio de la región Centro-Oeste. Los datos fueron analizados por medio de estadística descriptiva. **Resultados**: fueron recogidos datos de 156 libretas de gestantes. La mayoría de las mujeres iniciaron temprano el prenatal, tuvieron peso y altura evaluados en todas las consultas. Sin embargo, gran parte de los exámenes complementarios del primer trimestre no fue realizada o apuntada, así como ocurrió con la medición de la altura uterina y la suplementación de ácido fólico y sulfato ferroso. **Conclusión**: hay la necesidad de mejorar el proceso de cuidado durante el prenatal. Datos esenciales para el cuidado prenatal no han sido rellenados adecuadamente.


**Palabras clave**: Cuidado Prenatal. Gestantes. Mortalidad Materna.

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