Objective: to characterize the actions of prenatal evaluation and diagnosis of susceptibility and health problems of pregnant women sent to specialized service. Method: descriptive, qualitative study, conducted with nurses and doctors, by observing prenatal records and consultations. The analysis was held by the Content Analysis Technique in the Thematic Analysis mode. The study had the project approved by the Research Ethics Committee, Opinion 206,916. Results: the professional investigated reproductive risk situations, focusing on biological aspects. Gestational classification and the referral of women to specialized service is related to the identification of previous morbidities and/or clinical-obstetric intervening. This action showed similarity among professionals, being guided by regulations of the National prenatal policy. There was some variation in the individual judgment conditions in the reproductive process. Conclusion: improved diagnostic action requires investment in technical and critical skills of workers, given the limits of being done, the technical and policy proposals and to know that it directs them giving new alternatives.

Descriptors: Prenatal Care; High Risk Pregnancy; Health Vulnerability; Family Health Program.

ABSTRACT

Objective: caracterizar as ações pré-natais de avaliação e diagnóstico das suscetibilidades e problemas de saúde de gestantes que foram encaminhadas ao serviço especializado. Método: estudo descritivo, qualitativo, realizado com enfermeiros e médicos, através da observação de registros pré-natais e de consultas. A análise foi pela Técnica de Análise de Conteúdo na modalidade Análise Temática. O estudo teve o projeto aprovado pelo Comitê de Ética em Pesquisa, parecer 206,916. Resultados: os profissionais investigaram situações de risco reprodutivo, privilegiando aspectos biológicos. A classificação gestacional e o encaminhamento de mulheres ao serviço especializado atrelaram-se à identificação de morbilidades prévias e/o intervenientes clínico-obstétricos. Essa ação apresentou similaridade entre os profissionais, sendo guiadas por normativas da política nacional de pré-natal. Houve certa variação no julgamento de condições individuais no processo reprodutivo. Conclusão: a melhoria da ação diagnóstica requer investimentos na capacidade técnica e crítica dos profissionais, face aos limites do feito, das propostas técnico-políticas e do saber que os orienta, para que protagonizem novas alternativas. Descritores: Cuidado Pré-Natal; Gravidez de Alto Risco; Vulnerabilidade em Saúde; Programa Saúde da Família.

RESUMEN

Objetivo: caracterizar las acciones pre-natales de evaluación y diagnóstico de las susceptibilidades y problemas de salud de gestantes, enviadas al servicio especializado. Método: estudio descriptivo, cualitativo, realizado con enfermeros y médicos, por la observación de registros pre-natales y de consultas. El análisis fue por la Técnica de Análisis de Contenido en la modalidad Análisis Temática. El estudio tuvo el proyecto aprobado por el Comité de Ética en Investigación, parecer 206,916. Resultados: profesionales investigaron situaciones de riesgo reproductivo, privilegiando aspectos biológicos. La clasificación gestacional y el envío de mujeres al servicio especializado se relacionaron a la identificación de morbilidades previas y/o intervenciones clínico-obstétricas. Esa acción presentó semejanza entre los profesionales, siendo guiadas por normativas de la política nacional de pre-natal. Hubo cierta variación en el juzgamiento de condiciones individuales en el proceso reproductivo. Conclusión: la mejora de la acción diagnóstica requiere inversiones en la capacidad técnica y crítica de los profesionales, dados a los limites de lo hecho, de las propuestas técnico-políticas y del saber que los orienta, para que protagonicen nuevas alternativas. Descriptores: Cuidado Pre-Natal; Embarazo de Alto Riesgo; Vulnerabilidad en Salud; Programa Salud de la Familia.
Here, one of the studies of a research conducted in units of the Family Health Strategy (ESF) and in a public referral hospital for prenatal women with higher risk pregnancies in Cuiaba, Mato Grosso (MT) is presented. It is about pre-natal care by professionals and pregnant women in situations where their health and/or the fetus are susceptible to problems or compromised by them, nominated in the biomedical model as pregnancies of higher risk. Here, it deals with the action assessment and diagnosis of that condition, in the pre-natal of the ESF.

The study was motivated by the systematic observation that the understandings of ESF workers and the judgment of the existence of susceptibility or adverse pregnancy outcomes are organized primarily around pathophysiological aspects. On the other hand, the relationship of inter-subjective and social aspects with the health of the pregnant woman is basically disregarded, especially in practice. There was also variation in the criteria used by professionals in the judgement of the unfavorable situation. Therefore, it is assumed that the presence of shortcomings related to the identification of gestational risk and vulnerability of women in prenatal of primary care.

Historically, the professionals responsible for prenatal consultations in primary care chose about which women will receive usual care and also special care in the service itself, in another reference, or both. That is, they elaborate diagnoses of susceptibility and women’s health problems with an ongoing pregnancy, and propose special care to be implemented by themselves, by the local staff and/or other services and subjects.

Guiding and marking how this practice should be made, the national health policy advocates the systematic classification of reproductive risk in prenatal - as usual or most at risk - according to probability respectively, lower or higher than the woman has or will have problems and/or her child. At most, the policy formalized by the Ministry of Health called the latest in high-risk pregnancies, given the emphasis on it. Under this policy, pregnancy, childbirth and the high risk of postpartum correspond to situations in which there is or there may be complications for preexisting conditions or events in one or more of reproductive moments, generated by organic, socioeconomic and unfavorable demographic factors.

In health care, the term risk refers to the person’s chances of becoming ill, since being carrier of some features. These chances are recognized in epidemiological studies of cause-effect relationship and statistical basis, that support clinical actions of identifying risks and preventive control, that is, risk is about the probability of an unfavorable outcome, of biological damage or a not desired phenomenon, based on scientific studies and interpretations of classical epidemiology.

Since the first half of the twentieth century, the concept of risk has become a valuable tool in research, practice and policy. The knowledge from epidemiological risk analyzes and calculations have contributed to preventing disease and protecting lives. However, this approach has acquired two characteristics that place it in a paradoxical position. On one hand, its pragmatic and probabilistic allows to expand, potentially permanent, the investigation of causal association between events of interest. On the other hand, its relation to biomedical validation and mathematical nature of its procedures and inferences compromise the objectivity of the social dimensions of health and disease.

Risk conceptual tool tends to migrate macro socio-demographic context level to the micro level of subjectivity, behaviors and personal characteristics, with implications for the clinic. In addition, the risks considered important, as well as the ways to address them, are socially and intersubjective instituted. That means, trimming some of them in care acts guided by social purposes privileged to prenatal in interrelation with interests, possibilities, experiences and options involved. Then it does not match the diversity and scope of the health needs of pregnant women.

In prenatal, for socio-historical reasons, the identification and control of risks are rooted from a biomedical technical and scientific reading, which prioritizes clinical and obstetric complications. The approach of the state of health of the pregnant woman dissociates from the complex that produces it. Therefore, the evaluation and diagnosis of what can compromise the reproductive and women’s health focus on individual aspects, isolated from the global process of life of women and socio-cultural and relational nature of reproductive health.

Despite its limits, the risk perspective has contributed to the preventive and clinical- obstetric control of maternal, fetal and neonatal morbidity and mortality, prenatal important objectives in the country. In turn, achieving these goals requires proper
assessment and diagnosis of reproductive risks, as well as the election and execution of appropriate practices when faced them and the problems caused of the prenatal primary care by professionals.

The incorporation of risk perspective in organic clinic is made by identifying risk factors, the most common in the general population and among pregnant women. They are personal or environmental habits exposure factors that are associated with increased possibility of diseases, although not enough to cause them, but modified, they can mitigate them.7 Moreover, the incorporation of the risk perspective is also done through the identification and meaning of signs and symptoms of medical complications.

According to the national policy of care during high-risk pregnancy2, professionals must classify factors that may affect the woman, pregnancy and the child, whether individual, obstetric, medical, emotional or socio-economic and should evaluate their possible repercussions and intervening if they can result in an unfavorable event, in order to reduce or avoid the risk or reduce or eliminate the possible adverse consequences, if present.

While addressing the reproductive risks are rooted in prenatal practice, there are few published studies, in the last five years, with some specificity.8-12 The actions of assessment and diagnosis of reproductive risks are shown into two other published studies, among the last seven years, made in other realities of the country. In them, from the point of view that the risk approach should be done well, the researchers point out that there are problems in qualifying action of the greater or lesser risk pregnancy.

One of the studies in Recife, Pernambuco, with women of two referral hospitals for high risk, which addresses the adequacy of prenatal care services of the Unified Health System (SUS), pointed out the existence of misclassification of gestational risk.13 Other study dealing with the appropriateness of referencing women for high risk, in the primary health Sobral, Ceará, also identified this same event, with consequent inadequate referrals of women to specialized services.14

The limits of risk approach on the social and inter-subjective dimension of reproductive health, although recognized and documented, especially in studies dealing with prenatal care from the perspective of integrality,15-7 do not discuss prenatal care in the face of sensitivities and the issues of reproductive health, from the reference to vulnerability of pregnant women. There is a gap in the academic literature, with regard to this issue.

The idea of vulnerability, located in the theoretical area of social epidemiology, try to extend the reading of risks and their unfolding in clinical practice, while not denying the importance of these. It aspires to articulate individual and contextual conditions that can leave people in fragile situations and expose them to illness and suffering. Its use search to extend the reading of individual susceptibilities to the social susceptibilities, which are configured also as targets of health actions.3

Despite the importance of this perspective, national policies aimed at reproductive health focus their concerns on the control of risks and complications, although the recent nominated Cegonha Network politics enter the assessment and classification of vulnerabilities of pregnant women as a component of assistance host.18

In the clinic pre-natal, assessment and diagnosis of susceptibility, from the perspective of vulnerabilities, should take into account the health of interfaces and women´s illness with the interrelation between socio-cultural, environmental, institutional, community, family, inter-subjective and physical aspects. From this point of view, actions to disease prevention and health promotion are important.

Reducing maternal, fetal and neonatal mortality and good quality of prenatal require addressing vulnerabilities to which the pregnant woman is exposed. When the health team identifies them, considering them in their clinical actions, the diagnosis of health increases and promotes the adoption of specific measures, most comprehensive and necessary, stating the consistent assistance with comprehensive care to health.11

Based on these, it is assumed the existence of weaknesses in evaluative and diagnostic actions of ESF prenatal in special health situation of pregnant women, which resulted in a diagnosis of major risk. Those women will have the risk approach as also the lack of focus on vulnerabilities. The knowledge produced contribute to the improvement of this critical and evaluative and diagnostic practice in ESF prenatal, both in the context studied, as in other similar situations.

**OBJECTIVE**

- To characterize the actions of assessment and diagnosis, in situations in which pregnant women have sensibilities and related health problems.
METHOD

The matrix research was characterized as descriptive and qualitative study. It was developed in five Family Health Units (USF) and in one referral hospital for monitoring women with high-risk pregnancy, all located in Cuiaba-MT. Women at higher risk of pregnancy diagnosis, made in USF, and professionals responsible for them were participating.

In the study presented here, five nurses and five doctors participated from the recognition of USF involved in diagnosis and referral of those women. The closing of participating from exhaustion was used.

The prenatal care in the USF participating offered: medical and nursing consultation, preceded by pre-consultation; home visits and active search for pregnant women, made by Community Health Agents; and possible actions of doctor and nursing and education and health promotion visits. The nurse made the first prenatal visit, and the subsequent were interspersed with the doctor. Women referencing to specialized services was carried out by both of them, through combining the action, when done by nurses. The specialized care had: obstetric screening; hospitalization for complications; and gynecological-obstetric clinic, for low and high risk.

Empirical construction took place from May to July 2013. Analysis of pre-natal records at USF were carried out (card and records of the participants and book control activities), to understand the investigated and made diagnosis. For this, a tested instrument with questions regarding the number of consultations was used, identification and classification of vulnerabilities and/or risk, and the registration of vulnerability and/or risk factors. Participant observation was conducted “as an observer” from previous integration of the researcher with the team. There was 16 doctor and 11 nursing consultations, made with women in different stages of pregnancy, using a pre-tested script directed to the understanding of the actions of assessment and diagnosis. Also professionals were interviewed with the help of a script with open questions about how they performed and interpreted the identification and susceptibility rating and health problems in prenatal care. The final numerical definition of the observations of consultations occurred from the completeness of information of interest to the research, as recommended for qualitative research19, corresponding to 32 hours.

RESULTS AND DISCUSSION

Among the participants, most were female and were between 26 and 39 years old. The length of stay of most doctors in USF was two to three months, with high turnover. The nurses had higher stay time between one year and five years except one of them (four months). Most professionals did not have training in reproductive health and specialization in Family Health or Public Health.

Following there are shown and discussed how doctors and nurses investigate and analyze the susceptibilities and health problems of pregnant women, highlighting the adopted methodological routine, which favor these actions, in which diverge, and the expressed perspective by reference to the risks and vulnerabilities approach.

♦ Prevalence of risk perspective in the diagnostic action on vulnerabilities and pregnant women health problems

In the studied USFs routinely, doctors and nurses investigated and analyzed the

The record of observations and interviews was done in a field diary. The last ones were also recorded in audio authorized by the participants and transcribed for analysis. They were stored the document data with a portable scanner.

The thematic content analysis was used.20 The documentary data were organized, from observations and interviews on the professional. There was a comprehensive reading material in increasing depth, geared to answer the question: what are the actions of assessment and diagnosis made? How are made? What perspective they show? It stood out the statements and topics of interest and the units of meaning present in it were gathered. Finally, the findings were classified into categories combined the empirical, theoretical and inductive reasoning. From this joint, the category inferred predominant perspective of risks in the diagnostic action on susceptibilities and health problems of pregnant women.

The study had its research project approved by the Ethics Committee in Research of the University Hospital Júlio Muller, Opinion 206,916, and respected the Resolution 196 of the National Health Council, in force at the time. It was requested the signature of the Consent Term (TCLE). For secrecy, the USF were identified from “A” to “E”, nurses as “N” followed by a number of identifier from 1 to 5, and doctors as “D” in the same way.

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reproductive risk of women assisted and not the vulnerabilities. In these actions, they privileged biological aspects to the detriment of contextual and relevant to women’s lifestyles. The classification of pregnancy as higher risk was harnessed, especially to identify previous morbidities and/or clinical-obstetric interventional.

The clinical parameters investigated by doctors and nurses were similar in the USFs studied, given their correspondence with the technically recommended by national health policy for pre-natal care.

Thus, certain risk factors and health problems were the subject of systematic research in the consultations, while others did not, whose evaluation is recommended. This is expressed in the anamnesis, physical examination, analysis of laboratory tests, obstetric diagnosis, and analysis, interpretation of findings and diagnostic definition, steps that integrate the clinical method, framework of modern medical practice.

A framework in the investigation of risk factors was the first visit made by the nurse. In it, he devoted more time to complete the history of life and health of women, guided by technical and regulatory instruments - the form of the Food and Nutrition Surveillance System (SISVAN), registration forms and the record of the assistance in the Monitoring System Prenatal (SISPRENATAL) and the Maternity Card. The classification of pregnancy as higher risk at that stage of the pregnancy monitoring was based primarily on the historical investigation, which has received more attention as compared to other actions of women’s follow-ups.

Generally, we identified (professional) risks at the first visit with the registration we do. We get the entire history, not only of the current pregnancy, but in past pregnancies, it she had some complication, because it was not normal, because it had to be cesarean section. We collect family history, if any patient in the family had TB (tuberculosis), leprosy, heart disease, diabetes. At the first visit, we check if she has these risks [...]. (N2 - USF B)

In subsequent women’s consultations, doctors and nurses assessed in particular possible medical problems that could result in maternal, fetal or neonatal morbidity or mortality. The risk classification of these consultations took place mainly from the complaints of women and information from physical examination and laboratory tests. The investigation of new data from the health history of a woman, for deepening and the resumption of the information collected was possible.

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The risk approach requires professionals who are aware of the risk factors and the occurrence of problems throughout pregnancy. This should be systematic and take in the continuing assessment of changes or new occurrences in order to recognize, at the appropriate time, the need for special care in the service itself, in reference services, and with the support of other features of social network.

Risk factors can be explored during prenatal, since professionals are vigilant in anamnesis and general physical exam and obstetric-gynecological exam. All anamnesis data important in the risk assessment need not be get in first appointment, since it is important the relationship of trust between the professional and the woman and the active participation in this consultation. Therefore, they should be resumed and deepened in the continuity of care, as deepening the relationship with the woman. In this sense, the methodology should be participatory.

On the other hand, there was a policy action, being the inflexible system adopted in which the professional managed the collection of data and then the demonstrations around the needs and also the decisions about the care to be performed with a focus on medical problems and not in women.

In the first anamnesis, nurses gathered woman’s identification data, family health, socio-demographic, health and obstetric of the first, current and previous history. They included, among others: name, age, hypertension and diabetes in the family, education, occupation, color, food, previous medical problems, number of pregnancies, births and children, obstetric events, interval, immunizations. As stated, this collection has as reference the items of the Maternity Card, the instrument of SISVAN and registration in SISPRENATAL.

In subsequent consultations, the anamnesis was eventually taken again by the professional, but there were complaints, test results, signs and symptoms of women and control of care actions performed.

(4th medical consultation, G5, P2, A2, 35 years old, 21 weeks of gestation - USF D). After receiving it in the office, professional initiates the consultation: M4: Did you do the ultrasound?
Woman: Yes, here it is.
Professional checks the exam and says it's okay and continues:
d4: In which months of previous pregnancies did you have abortions?
Woman: It was about two months.
D4: What were the causes?
Woman: The first was a shock because of the death of my mother, and the other for anemia, at least that's what they told me in HG.
D4: How old is your last child?
Woman: Five.
Professional calculates gestational age (GA) and informs. Continues:
D4: Have you taken the strengthening of tetanus?
Woman: Not yet, you told me you were asking it.
D4: So, you will take it today, here's the recipe. When you leave, go into the vaccine area. And, the flu vaccine, did you take it?
Woman: Yes.
D4: Are you taking ferrous sulfate and folic acid?
Woman: It finished two days ago.
D4: I'll make a new recipe; take it in the pharmacy. You cannot stop taking it, when you're done, you do not wait for the next consultation, with this same recipe you can get it.

Professional checks other routine test results, brought by the woman, and ask for more, explaining that they would be made every two months. Then, he asks for complaints and vaginal discharges. The woman denies them. He asks her to position on the table. During the physical examination he questions:

D4: Were your previous deliveries normal?
Woman: Yes.
D4: E abortions, did you do curettage?
Woman: Yes, there in HG.
D4: Do you think of tubal ligation?
Woman: I want.
The professional perform cardio-fetal heartbeat auscultation, measuring uterine height and ends the physical examination.
D4: Check the return at the reception.
Woman: All right. Could you give me a certificate of today's consultation?
D4: That's right. As soon as the exams get ready you bring them back.
The professional gives the certificate and the woman leaves the office.

The Ministry of Health\(^2\), in referring manual to the high-risk pregnancy, explains the gestational risk factors to be accompanied by health services, including the ESF. They are divided into two groups: previous and unfavorable factors to pregnancy (individual characteristics, socio-demographic conditions, reproductive history, medical conditions); and complications arising or which may arise in the course of pregnancy, making it a higher risk (exposure to teratogenic factors, obstetric disease and clinical conditions). In both sets medical aspects are situated and, with less emphasis, individual and social aspects.

Studies\(^{21-23}\) dealing with this issue, also highlight various medical order risk factors to be controlled in prenatal such as: unfavorable obstetric history (stillbirth, neonatal death, three or more consecutive miscarriages, final newborn with weight less than 2,500 grams or greater than 4,500 grams, hospitalization in the last pregnancy and previous surgeries, as conization and cerclage); problems on the clinical history (type 1 diabetes mellitus, kidney disease, heart disease, alcohol and drugs); conditions/complications of current pregnancy (multiple pregnancy, Rh isoimmunization, vaginal bleeding); and unfavorable age and education. In addition to the evidence given to these factors, which correspond to the ministerial technical guidance or justify them, others inter-subjective and social factors are also valued as complications in the marital status of women and non-realization of pre-natal and/or number of reduced consultations\(^22\), disorders of the family functioning; weakened networks support; ambivalent emotional situation; deficit of skills, among others that negatively affect maternal and fetal lives.\(^{21}\)

In the units studied, one of the characteristics of collection action of significant factors to diagnose greater risk, through anamnesis corresponded to the priority given to data of previous and current medical aspects, especially the pregnant woman.

Of behavioral risk factors, not medical family factors or social factors were eventually investigated in the consultations. In this sense, there was exploitation contingent of family interrelations and control of eating behavior:

(6\(^{th}\) consultation, first pregnancy, 16 years old, 27 weeks of gestation - USF E).

N5 (to investigate complaints and symptoms): And the nonsense things you were eating, did you stop? You have to eat well, eat breakfast, preferable fruits, healthier foods.
Woman: Just today I ate a biscuit and chocolate milk; I took money with my husband and bought them.
N5: And why do not you bought a banana?
Woman: Because my aunt was giving it to me. She said she would take some fruit for me.
N5: Who are you living with?

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**Woman:** With my husband, his mother and his grandfather.

**N5:** Do they work?

**Woman:** Only my husband; he maintains everyone. The old man spent all the money with alcohol.

**N5:** Do you relate well with the grandfather of her husband and your mother in law?

**Woman:** With my mother in law, yes. But, with the grandfather, I did not speak. He has hit on me.

**N5:** And you said that to your husband?

**Woman:** I spoke, he knows. Even my husband does not talk right to his grandfather.

**N5:** Do you stay home alone? Do you have lock in your room?

**Woman:** I’m not alone. Stay with my cousin, when only his grandfather is at home.

**N5** changes the subject questioning the practice of physical activities, checks the ultrasound examination, calculates the IG, the Probable Date of Birth (DPP) and asks for the physical examination. He does not talk about the issue again.

Another methodological step in the investigation of the risks was the physical examination. But, it was restricted to routine measurement of weight-height and calculating the Body Mass Index (BMI); blood pressure; uterine height and the auscultation of fetal cardio-beat. The breast examination and inspection of the lower limbs occurred only among some nurses.

Several important components of the physical examination were not hired or were possibly by the doctor and nurse. For example, the detailed clinical examination, the perception of static and fetal movements, pelvic exam, among others recommended according to gestational age.

(3rd consultation, first pregnancy, 15 years old, 25 weeks of gestation - USF D). D4 asks the woman lay on the stretcher. He does abdominal palpation and measuring the uterine height.

**D4:** 27 cm.

Continuing, he listens to the cardio-fetal heartbeat with a sonar. At the hearing, the woman says:

**Woman:** What a miracle, you can hear his heart, he did not run away from you (laughs).

**D4:** The heart of the baby is okay.

**M4** ends the physical examination, requests new tests and schedules the next appointment.

Despite these shortcomings, particularly relating to autonomy that the professional has during the consultation, physical examination is an important step in the evaluation of highest risk. The complete and well done physical examination is of great value in assisting because it allows validate or not the findings of history, identify unreported problems, increase diagnostics, plan and implement appropriate actions, monitor the progress of the findings and in the case of pregnant women, identify the real need for special care in pre-natal care.

Laboratory tests that are part of routine pre-natal care in Cuiaba - recommended by the World Health Organization (WHO) and the Ministry of Health - were asked and analyzed by all professionals, especially by doctors. They included: blood type and Rh factor, complete blood exam, fasting blood glucose, urine screening (EAS), serology for syphilis, rubella, cytomegalovirus, HIV (human immunodeficiency virus), hepatitis B and toxoplasmosis. All were asked at the beginning of pre-natal care. The blood exam, fasting blood glucose levels, the EAS, serology for syphilis, hepatitis B and HIV testing were also asked in the 3rd trimester of pregnancy. In the investigation of unexpected clinical events, one or more of these tests were repeated and others performed as the indirect Coombs, the stool for parasites, among others.

Other tests also recommended for pre-natal as fast testing for HIV diagnosis and screening for syphilis, hemoglobin electrophoresis in black pregnant women with a family history of sickle cell anemia or a history of chronic anemia, were not asked by professionals of the study.

For proper pre-natal care, the required technical procedures - clinical, obstetric, supplementary exams - must be performed correctly. Otherwise, there will be damage to the interpretation of the findings and in comparing them. The adequacy of the application and analysis, from known parameters, provides quality, speed and accuracy in the evaluation and diagnosis of risks, as well as decision-making relevant to the consultations.

The realization of additional tests, beyond the request and appropriate interpretation of professionals, requires a support network to prenatal diagnosis, enough, agile and efficient. That is, it is important the clinical ability of professional combined with conditions in the network of health services, which provide diagnostic action.

The diagnostic evaluation of vulnerabilities and women’s health issues is subject to workers’ references, and their clinical ability to identify and interpret situations, to judge its severity and importance, and to elect and accomplish what must be done. But also, it
depends on network structure, which is prioritized for local services and their work organization. An efficient support network must ensure, in the time required, not only laboratory tests and diagnostics, but also medicines, supplies, biomedical equipment, in addition to the own transport of women to specialized services when needed. Nurses and doctors must act in an integrated way, both in the identification and assessment of what can affect the woman, pregnancy and the fetus, towards greater chance of having an unfavorable outcome, as in recognizing and enabling or co-responsibility around the that pregnant women need to participate in their own care as well. Therefore, it is important that professionals know properly how to deal with not only the clinical and obstetrical aspects, but also with socioeconomic, cultural, institutional, family, behavioral and intersubjective aspects. In USF research participants, doctors and nurses, through the clinical judgment of information gathered and prioritized, concluded on the existence or not of factors, vulnerabilities and/or complications in women’s health and/or the fetus. That is, they translated the findings in the diagnosis of usual risk or higher risk pregnancy. That did not mean, however, the explanation of the diagnosis and its terms, to either the woman or the prenatal records. In this sense, the presence of unfavorable risk factors, particularly the collected from personal history and previous women’s health (socio-demographic data, behavioral data, clinical and previous obstetric data), seems to have significantly influenced the interpretations, and not resulted in specific behaviors or modified the usual routine care, particularly highlighting the perceived medical problems.

The presence of one or more factors to be investigated and controlled does not mean the immediate need for preliminary clinical resources with different technologies relevant to primary care, but require more attention from the ESF staff and, in some situations, most often to the woman in consultations and conducting home visits, as identified factor and the condition of the woman.2 This means that the professional, before vulnerabilities generator factors and problems, should value all findings and interpret them, even within the limits of what the adoption of risk perspective offers so that appropriate measures are taken.

In the diagnosis of medical problems that occurred differently. As they take precedence in work organization of USF, professionals routinely assessed, entered into and positioned regarding: Pre-existing morbidities (hypertension, toxoplasmosis, cytomegalovirus, rubella, hepatitis B and C, diabetes, and others); interventional clinical complications (anemia, recurrent urinary tract infections, obesity, among others); obstetric diseases (hypertension specific to pregnancy, placenta previa, fetal growth retardation, fetal distress, and others). This objectivity is expressed in prenatal consultations in medical records and records in the speeches of professionals.

Normally, the criteria is biological (of risk identification). So, it’s a hypertension, blood glucose change, change during auscultation, intrauterine growth is restricted or advanced, a result of ultrasound changed [...] (N5 · USF E) The diagnoses made and recorded in the medical records and the women referral data sheet to specialized service (of the study participants) were related in particular to one or more morphological and functional disturbances and/or aspects of obstetric history, such as dichorionic: twin pregnancy; pre-existing and current diabetes and high blood pressure; gestational diabetes and age greater than 35 years old; gestational diabetes; hyperthyroidism; IgG and IgM positive serology for cytomegalovirus; irregular vaginal bleeding during pregnancy and adolescence; excess of varicose veins in the lower limbs; epileptic framework; nephrolithiasis; high blood pressure during the pregnancy and neonatal death history; congenital microcephaly woman.

Professionals consider in higher risk definition, in addition to medical problems such as those presented above, other situations perceived as unfavorable: individual (woman’s age), the obstetric past (recent history of miscarriage, neonatal death), current pregnancy (twinning), plus some social aspects and family life of women. (Professional nurse citing the risks considered) Pregnant women who have hypertension in pregnancy, diabetes, obesity, hereditary issue, test results with urinary infections. Often they have other risks, which are associated with social issues, to living day to day. So, we try to identify them to reduce these risks. (N4 · USF D)

In the consultations, some aspect and also in records were possible to find, and it cannot be found implicated in the diagnosis and the adopted behavior. In short, the criteria used and referred for diagnosis were related to two sets of factors suggestive of a compromising...
pregnancy outcome: linked to the pregnancy itself and the identified pathophysiological conditions; and on individual characteristics of women.

Overall, among the factors considered for the usual diagnosis of risk or increased risk was found little variation among medical professionals and, similarly, among nurses. It was around the consideration to individual factors that professionals more diverged. In this sense, we found a twinning situation in which the professional referred the assessment and diagnosis of the degree of risk to specialized service. This experience also resulted in the diagnosis of gestational risk and referral of women at referral service. However, these interpretations vary among professionals. For others, this conclusion depends on the physical health conditions of the mother and fetus.

Doctors and nurses expressed that the woman’s age was a risk factor, if teenager. For some of them, this feature was enough to diagnose greater risk and referral of women to specialized service. Others considered that for this classification, the woman’s age should be associated with other unfavorable factors, such as rejection of pregnancy, lack of knowledge, difficulty in following pre-natal recommendations, alcohol consumption, tobacco and drugs, weakened family relationships.

Age was also considered higher risk factor, which required the support of specialized service in the case of the woman 35 years old or more; or this age and also concurrently, a physical and/or mental complication.

The Ministry of Health argues that adolescence is not a risk factor for pregnancy. But there is the possibility of psychosocial risk associated with the acceptance or not of pregnancy and other aspects, which can be translated in adherence, or not, with that recommended in pre-natal. That means, the peculiarities associated with age or stage of life must be collected and analyzed for proper diagnosis of major risk and the decision on the follow-up on another service. This perspective applies both to adolescent or older women, deemed inappropriate.

In the risk perspective, it is important to diagnose professionals to work with criteria as subsidies to different degrees of risk rating. This classification will guide the provision of care needed and where it will occur.

Despite the need to categorize the risk in different degrees, according to their possible consequences, there are no proposed parameters for this. This practice ultimately depend on the evaluation of each professional and explicit determinations in specific protocols. WHO shows the need for identification and assessment of risk factors that allow classifying pregnant women only in two groups: high and low risk.

There was only one study that ranks the elements to be considered when establishing the risk pregnancy, in 1970s. Its authors propose both the evaluation of certain aspects such as scoring, which together result in a value indicative of the intensity of gestational risk.

The first risk assessment systems have been based on observation and experience of the authors and, even today, there are doubts about the quality of them, especially the score-based, presenting the value of the precision problem assigned to each factor and the associations between them. Risk assessment is considered a difficult action:

The concept of risk is fundamentally probabilistic and the bonds that link risk factors to damage are not always defined. In some cases, for example, “fetal death” damage is clearly associated with a factor; But, there are other cases where the relationship is much more difficult to establish the ignorance factor or factors involved or the difficulty in establishing the individual weight of each one when the problem is multifactorial.

The Ministry of Health observed in a publication about high-risk pregnancy that despite the efforts to create a scoring system and tables to discriminate against pregnant women of higher and lower risk, we could not, so far, create a classification able to predict problems satisfactorily. Thus, working with known risk factors common in the general population and in pregnant women.

Despite these difficulties, the ESF professionals always have to take some risk rating criteria to determine the need to articulate other care levels, or to suit the local pre-natal routine to the needs of each woman. This means that these certainly are faced with uncertainties facing the multiplicity of risk factors and their possible consequences.

**CONCLUSION**

In the context studied, the predominant characteristic of action evaluation and diagnosis around the susceptibilities and health problems of pregnant women, pre-natal, was the realization of the risk perspective.

The practice has as substrate the biomedical model, based on knowledge of classical epidemiology, which presents...
limitations, especially with regard to the collection and approach to social and subjective questions related to health. However, the risk perspective has its importance, because historically has allowed the control of potential sources of harm to pregnancy health as well as control of their manifestations, especially through preventive measures and healing.

In the research, beyond the typical reductionism of this orientation, also found other shortcomings, expressed particularly in simplifying both the family health history and women as assessment of maternal physical condition and the fetus. Thus, first of all we need to invest in improving the quality approach on the agenda in their practice execution.

For this, one of the measures is to build and follow-up, by professional pre-natal care, flexible guidance of search and evaluation of reproductive risks, to be applied according to the specificities found, and not as a resource and generalizing mechanic.

However, one must also consider the limits of the risk perspective, the failure of their diagnostic possibilities on the scope of the health needs of women and their causes. These are not restricted to health problems recognized as risks or diseases, but also concern the vulnerabilities and their effects resulting from the inter-relationship between conditions and ways of life, subjectivity and biological processes. Investigating pregnant woman’s vulnerabilities will provide the achievement of broader health diagnosis and more suitable care activities.

Therefore, it is important to be related to critical knowledge of epidemiology, and the synthesis between these and the classic clinical knowledge. Creating new forms in practice access and understanding the intertwining of objective factors, subjective, social, cultural and production problems, giving space to women with their experiences, confrontations and own interpretations. In this sense, we need investment in the professional critical potential, the limits of what they do, the limits of policy proposals and the various knowledge that guide daily, to exercise leadership in creating new alternatives for pre-natal care.

Although the study results do not admit generalization, they allow the understanding of the connections between the findings and the collective contextual sense, and can be used to understand similar situations. The theme, however, requires further studies, in particular with regard to the creative construction of operational ways to the collection and interpretation of the social determinants of women’s health in the pre-natal clinic as well as the action on them.

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