Journal of Nursing
Revista de Enfermagem
UFPE On Line
ISSN: 1981-8963

ORIGINAL ARTICLE

BORN ALIVE IN 2015: A REFLECTION OF PRIMARY CARE

NASCIDOS VIVOS EM 2015: UM REFLEXO DA ATENÇÃO PRIMÁRIA

NACIDOS VIVOS EN 2015: UNA REFLEXIÓN DE LA ATENCIÓN PRIMARIA

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ABSTRACT

Objective: to analyze the profile of live births in the context of prenatal care. ***Method:*** this is a quantitative, descriptive study about live births in the year 2015, in which secondary data were collected from the Department of Informatics of the Health System of the Ministry of Health. Sociodemographic data of the mother and related to pregnancy, place of birth and data on the postnatal baby. Results were presented in the form of tables and figures. ***Results:*** it was recorded that, in 2015, there were 100,672 live births in Goiás and that the majority of births had the following characteristics: cesarean delivery (67.5%); male sex (51.2%); race / brown color (58.2%); birth weight between 3000 and 3999 grams (63%); with no abnormalities at birth (90%) and Apgar score at 1 and 5 minutes between 8 and 10, with 87.2% and 90%, respectively. ***Conclusion:*** it is pointed out that the data in Goiás were similar to those in other Brazilian States. It is assessed that prenatal care is intended to reach all classes and places, but inequalities between the regions of the country are still evident, and more attention is needed to this vulnerable public. ***Descriptors:*** Prenatal; Live Births; Primary Health Care; C-section; Prenatal care; Postpartum Period.

RESUMO

Objetivo: analisar o perfil dos nascidos vivos no contexto da assistência pré-natal. ***Método:*** trata-se de um estudo quantitativo, descritivo, acerca dos nascidos vivos no ano de 2015, no qual se coletaram dados secundários disponíveis no Departamento de Informática do Sistema Único de Saúde do Ministério da Saúde. Analisaram-se dados sociodemográficos da mãe e relacionados à gravidez, ao local de ocorrência do nascimento e dados referentes ao bebê pós-nascimento. Apresentaram-se os resultados em forma de tabelas e figuras. ***Resultados:*** registrou-se que, no ano de 2015, houve 100.672 nascidos vivos em Goiás e que a maioria dos nascimentos apresentou as seguintes características: parto cesáreo (67,5%); sexo masculino (51,2%); raça/cor parda (58,2%); peso ao nascer entre 3000 e 3999 gramas (63%); sem presença de anomalias no nascimento (90%) e índice de Apgar no 1º e 5º minutos entre oito e dez, com 87,2% e 90%, respectivamente. ***Conclusão:*** aponta-se que os dados em Goiás foram semelhantes aos de outros Estados do Brasil. Avalia-se que a assistência pré-natal tem o propósito de atingir todas as classes e lugares, mas ainda se evidenciam as desigualdades entre as regiões do país, sendo necessária uma maior atenção a este público vulnerável. ***Descritores*****:** Pré-Natal; Nascidos Vivos; Atenção Primária à Saúde; Cesáreo; Cuidado Pré-Natal; Período Pós-Parto.

RESUMEN

Objetivo: analizar el perfil de los nacidos vivos, en el contexto de la asistencia prenatal. ***Método:*** se trata de un estudio cuantitativo, descriptivo, acerca de los nacidos vivos en el año 2015, en el cual se recolectó datos secundarios disponibles en el Departamento de Informática del Sistema Único de Salud del Ministerio de Salud. Se analizaron datos sociodemográficos de la madre y relacionados con el embarazo, el lugar de nacimiento y los datos relativos al bebé post-nacimiento. Se presentaron los resultados en forma de tablas y figuras. ***Resultados:*** se registró que en el año 2015 hubo 100.672 nacidos vivos en Goiás y que la mayoría de los nacimientos presentó las siguientes características: parto cesáreo (67,5%); sexo masculino (51,2%); raza / color parda (58,2%); peso al nacer entre 3000 y 3999 gramos (63%); sin presencia de anomalías en el nacimiento (90%); y el índice de Apgar en el 1º y 5º minutos entre 8 y 10, con el 87,2% y el 90%, respectivamente. ***Conclusión:*** se apunta que los datos en Goiás fueron similares a los otros Estados de Brasil. Se estima que la asistencia prenatal tiene el propósito de alcanzar todas las clases y lugares, pero aún se evidencian las desigualdades entre las regiones del país, siendo necesaria una mayor atención a este público vulnerable. ***Descritores*****:** Prenatal; Nascidos Vivos; Atención Primaria la Salud; Cesario; Cuidado Prenatal; Período Post-Parto.

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INTRODUCTION

Primary Health Care (PHC) is focused on live births, prenatal and puerperal care, welcoming the woman from the beginning to the end of her gestation and ensuring the guarantee of maternal and neonatal well-being.[1]

It is emphasized that the expansion of primary care in Brazil occurred on a large scale through the implementation of the Basic Health Units (BHU), later titled Family Health Strategy (FHS). It is worth noting that FHS principles govern the promotion, prevention, recovery, rehabilitation and maintenance of community health, with each unit representing a part of the population, so that all can be treated.[2]

It is considered that, in relation to the live births, all the principles that govern the FHS fall within what the woman needs in the gestation, the delivery and the puerperium. It is pointed out that the promotion of the health of the mother and her baby must include all the related preventions, knowing how to identify from the first attention and the first contact to the possible complications in this period, classifying the pregnancy as low or high risk.[3]

The Humanization in Prenatal and Birth Program was applied, seeking greater attention to women in pregnancy, with the following principles: every pregnant woman has the right to access to a dignified and quality care during pregnancy, delivery and puerperium ; the patient has the right to know and have guaranteed access to the maternity in which she will be attended at the time of childbirth, as well as the right to attend childbirth and the puerperium performed in a humanized and safe manner, in accordance with the general principles and conditions established in medical practice; every newborn has the right to neonatal care in a humanized and safe way.[2]

The rights and duties for the pregnant woman and the baby were also established, with emphasis on the duty to start prenatal care until the 12th week of gestation and to ensure that at least six prenatal visits , a consultation in the puerperium, laboratory tests, HIV testing, tetanus vaccine application, educational activities, gestational risk classification and a specific care for pregnant women with potential risk of morbidity and mortality, guaranteeing the link and access to the unit of reference for outpatient and/or hospital care.[2]

It is considered extremely important, in this initial moment of the discovery of the pregnancy, that the woman be hosted by a specialized care, through the primary health care available in the public health network. The Stork Network was created by the Ministry of Health in order to provide humanized assistance to women and children, from prenatal to postpartum, guaranteeing access and reception in health services, aiming to reduction of maternal and neonatal.[2]

It is observed that the quality of the prenatal care offered directly contributes to the reduction of maternal and infant mortality, and the records of the Department of Informatics of the Brazilian Unified Health System (DATASUS) show some obstetric problems that would be avoidable if health promotion would have more scope and reach the entire population.[4] It is suggested that the promotion of health education should be carried out throughout the period of pregnancy and in the postpartum period. The nurse is identified as the professional in charge of primary care, acting in strategic areas, in education groups, promotion and prevention of health, seeking the humanization and trust of their patients, which enables a greater contact not only with the woman but with the whole family.[5]

The identification of the profile of live births resident in Goiás allows the collection of data and information to assist the development of public policies that are more focused on reality, since this type of study has the essential role to support the planning, implementation and evaluation of policies and actions of the Unified Health System (UHS) aimed at improving the quality of care for pregnant women and children in Primary Health Care.

OBJECTIVE

- To analyze the profile of live births in the context of prenatal care.

METHOD

This is a quantitative, descriptive, population-based study of live births in the State of Goiás, Brazil. Data was extracted from databases from UHS information systems, and the study population comprised all live births in the year 2015.

The information on live births was obtained from the database of the Live Birth Information System (SINASC) made available by DATASUS at the electronic address http://www.datasus.gov.br. Data was organized in Microsoft® Excel program spreadsheets for further analysis.

Data on age, schooling and marital status, place of birth, birth weight, Apgar test at 1st and 5th minutes, presence of abnormalities, gender, race/color, type of delivery, type of pregnancy, number of consultations performed during prenatal care and duration of gestation.

A descriptive analysis of the data was performed and the results were presented in tables and figures, according to the variables of the characterization of live births.

This study was carried out from a secondary source database, available for public research, and was therefore not submitted to any Ethics Committee. It should be emphasized that the study was based on the guidelines and regulatory standards established in NHC Resolution 466/2012, taking into account the ethical and scientific foundations required.

RESULTS

A total of 100,672 live births were recorded in Goiás in 2015, and the characteristics are shown in Tables 1 and 2 respectively.

Table 1. Characterization of live births. Goiânia (GO), Brazil, 2015.

Variables	n	%
Mother's age		
10 to 14 years	774	0.8
15 to 19 years	17,007	16.9
20 to 24 years	26,443	26.3
25 to 29 years	26,248	26.1
30 to 34 years	19,276	19.1
35 to 39 years	8,906	8.8
40 to 44 years	1,887	1.9
45 to 49 years	102	0.1
50 to 54 years	12	0.0
Age ignored	17	0.0
Place of birth		
Hospital	100,271	99.6
Another health establishment	140	0.1
Home	159	0.2
Other	102	0.1
Duration of gestation		
Less than 22 weeks	35	0.0
From 22 to 27 weeks	378	0.4
From 28 to 31 weeks	888	0.9
From 32 to 36 weeks	9,006	8.9
From 37 to 41 weeks	85,371	84.8
42 weeks or more	2,886	2.9
Ignored	2,108	2.1
Total	**100,672**	**100.0**

Table 2. Characterization of births. Goiânia (GO), Brazil, 2015.

Variables	n	%
Type of pregnancy		
Unique	98,424	97.8
Double	1,929	1.9
Triple or more	81	0.1
Ignored	238	0.2
Type of birth		
Vaginal	34,304	34.1
C-section	66,101	65.6
Ignored	267	0.3
Sex		
Male	51,515	51.2
Female	49,103	48.7
Ignored	54	0.1
Race/skin color		
White	24,990	24.8
Black	2,926	2.9
Yellow	637	0.6
Brown	58,614	58.2
Indigenous	64	0.1
Ignored	13,441	13.4
Birth weight		
Less than 500g	114	0.1
500 to 999g	468	0.5
1000 to 1499 g	631	0.6
1500 to 2499 g	7,120	7.1
2500 to 2999 g	24,811	24.6
3000 to 3999 g	63,382	63.0
4000g or more	4,144	4.1
Ignored	2	0.0
Total	**100,672**	**100.0**

It can be seen, in Figure 1, the number of prenatal consultations.

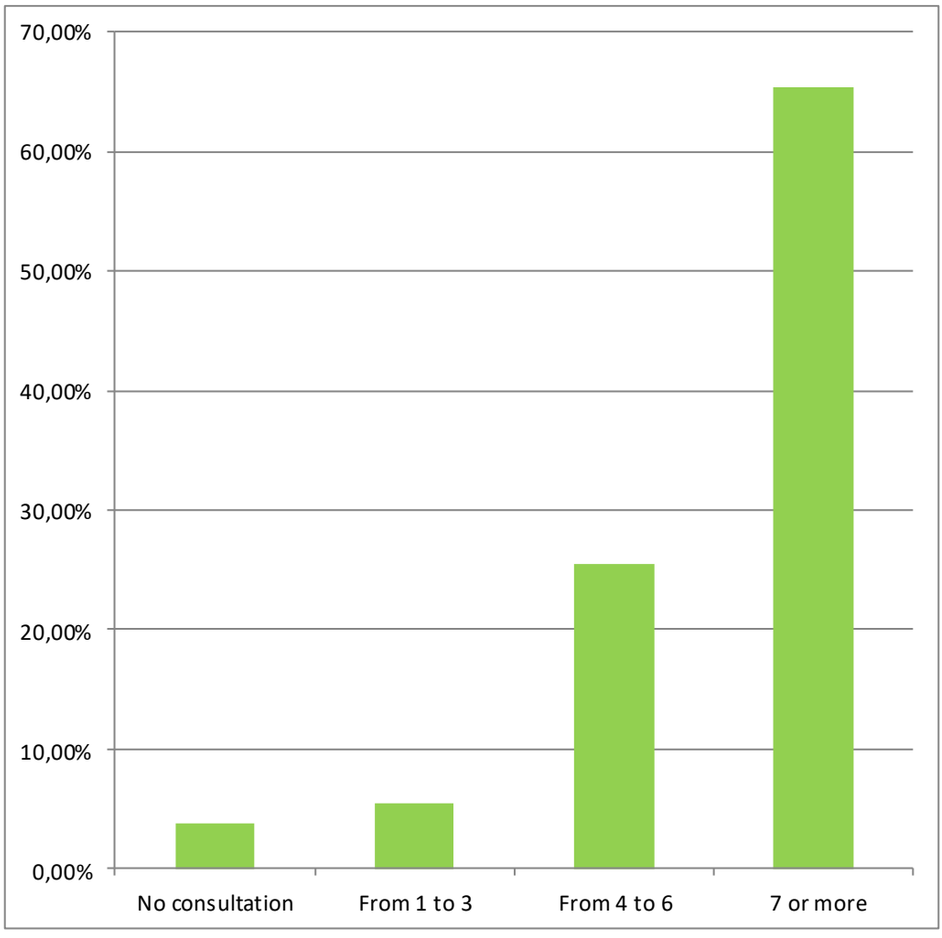

Figure 1. Number of prenatal consultations performed by mothers of live births. Goiânia (GO), Brazil, 2015.

Figure 2 shows the schooling of mothers.

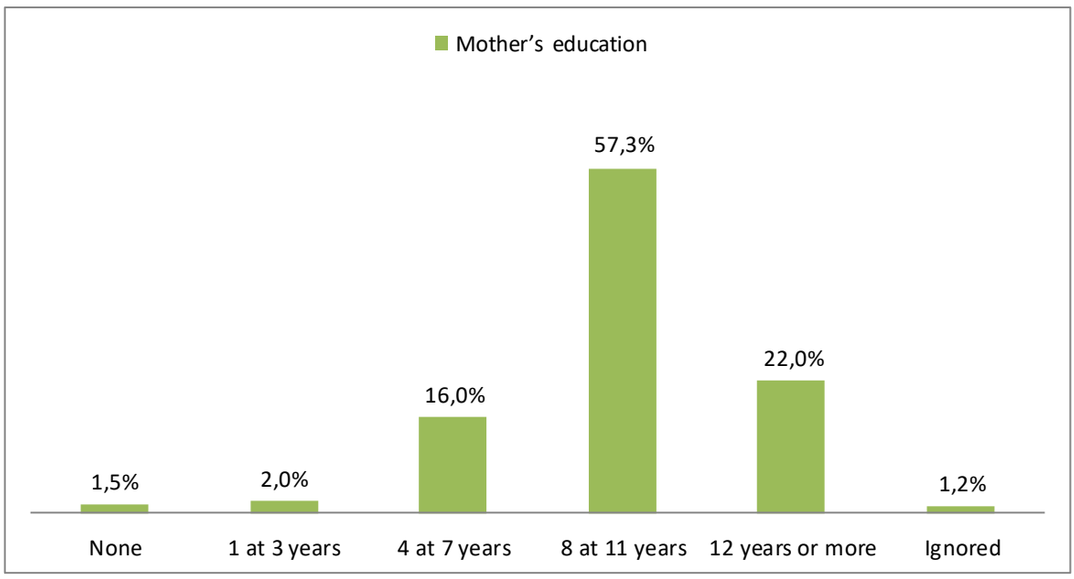

Figure 2. Maternal education. Goiânia (GO), Brazil, 2015.

The marital status of the mothers is shown in figure 3. Goiânia (GO), Brazil, 2015.

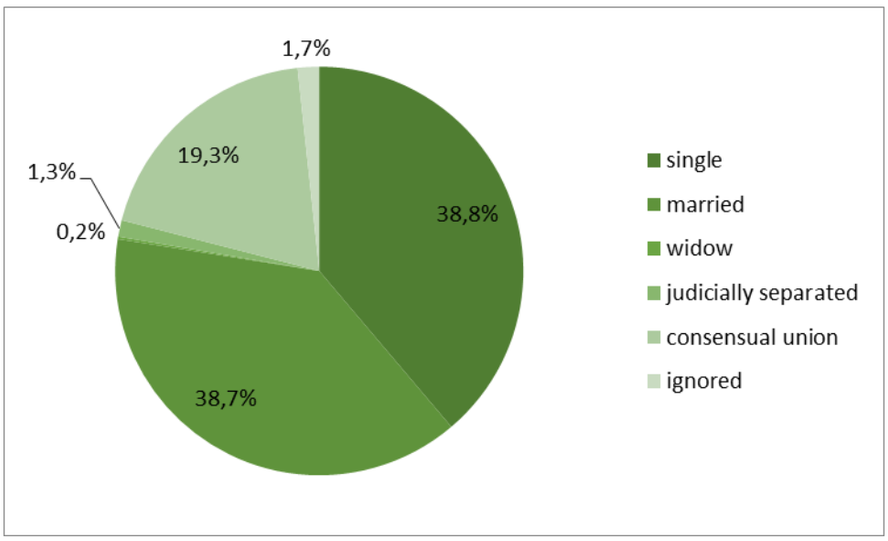

Figure 3. Marital status of mothers of live births. Goiânia (GO), Brazil, 2015.

DISCUSSION

During the study period, the characterization of live births, as well as prenatal consultations, marital status and schooling of mothers, among other variables, were observed. The data analysis was optimistic, stable and able to meet the objectives proposed in Primary Health Care, being able to subsidize the planning of maternal and child care.

It is considered as extremely important that the pregnant woman be guaranteed the performance of prenatal care, both quantitatively and qualitatively, with increasing assistance, investing in continuing education for the basic care teams, instituting and implementing measures that really work and accessible to the population.[6] It is understood that health goes much beyond a service, integrating the result of several joint actions, such as working conditions, food, housing, basic sanitation, education and the environment. It is pointed out that Primary Health Care must encompass socio-economic and cultural processes in order to achieve, in a unified way, all.[7]

The FHS was conceived with the purpose of excluding assistance only under the medical vision, expanding a project in which an entire multidisciplinary team is included, with nurses, psychologists, nutritionists, social workers, among others. It is recognized that the humanization of teamwork, promotion, prevention, recovery and rehabilitation of health is the main focus of the FHS.[8]

Women's health care needs to be understood much more broadly, so that their rights are respected in all spheres, with particular emphasis on safety, social security and education.[9]

The Stork Network was created with the aim of guaranteeing women's rights, with the priority being a quality and humanized prenatal care with attention to the child's health from birth to 24 months of life, as well as a targeted follow-up for adequate family planning.[10]

It was found that the data from Goiás correlated with the epidemiological profile of puerperae and newborns treated in the maternity hospital of a reference hospital in the interior of Rio Grande do Sul, that the most frequent age in the gestation period is between 21 and 35 years and 99.6% of infants are born in hospitals after gestations lasting from 37 to 41 weeks (75.16%). It was also observed that 48.1% of live births were primigravida and were born by cesarean section (59.24%). It was reported that more girls were born, with a percentage of 51.9% and 60.9% of live births, weighing between three and four kilos. It was noted that 65.9% of married mothers declared that they were married.[11] Another author, who also analyzed data from Rio Grande do Sul in previous years, obtained results similar to those found in Goiás, and found a direct and statistically positive relationship between low maternal schooling and the frequency of prematurity.[12]

It is added that the data from Goiás correlates with the epidemiological profile of the parturients of a public hospital, located in the city of Picos, Piauí, that the average age of pregnant women was between 20 and 35 years. It is verified that 99.6% of the babies were born in hospitals after pregnancies that last from 37 to 41 weeks (95.1%). The prevalence of cesarean delivery (61.9%) was also observed. It is emphasized that more than 70.6% of the women performed at least six prenatal consultations, 48% had Elementary School I completed and, regarding marital status, 34.4% were married and 39.9% were married and 39,9% were in a stable union.[13]

In a cross-sectional study carried out in 2012 in two public maternity hospitals in São Paulo, data similar to those collected in this study were found, such as the predominant age group between 21 and 25 years (35.1%), follow- in which 68.6% of the women had more than six consultations, and a rate of 93.6% of deliveries that occurred between 37 and 41 weeks. It should be noted, however, that the study revealed a higher rate of vaginal delivery, of 58.3%, which diverges from that found in this study, in which the highest frequency was cesarean delivery.[14]

Another study was carried out, that also obtained results similar to this one, in Santa Catarina, with data collected during four years. It was pointed out that the predominant age group of pregnant women was between 20 and 34 years old (68.13%) and that, in terms of marital status, 56.83% were single. It was revealed that the most frequent schooling was eight years of study (69%) and prenatal care was predominant with seven or more consultations (81.8%), as well as the male sex in infants, with 51.9%; however, as in the previous study, there was a predominance of vaginal deliveries, with 53.64%, which diverges from this research.[15]

It is noteworthy that, by linking work to data across Brazil, all government programs that encompass women's and children's health have unique objectives: to reduce maternal and child morbidity and mortality rates. It is noted that, over the years, there has been a reduction in this morbidity and mortality, but there is still much to improve in the sense of unifying care. It is suggested that health strategies need to be seen in a political way, in order to become humanized and target the population, so that social programs can become effective.[16]

It is noted that women's health and care for the live births of other countries, when compared to Brazil, go far beyond the programs implemented. It is necessary to direct the funds and set goals so that the proposals are truly carried out, with emphasis on the population. It is noted that there are few places in the world where there are unique public and free health networks, most of which are done through private initiatives such as Brazilian health plans. One must take into account the fact that many are first-world countries and have exclusive working capital for humanization and health actions.[17]

It is reinforced that this study is based on epidemiological data within the State of Goiás, comparing also to other States of Brazil, to obtain a broad view of the researched topic.

CONCLUSION

The objective of this study was to outline the epidemiological profile of live births in Goiás and to reflect the quality of care in Primary Health Care. It is evaluated that the epidemiological data collected in this research may contribute to the planning, management and evaluation of public policies related to maternal and child care. It can be noticed that the data found were very close to those found in other studies carried out in Brazil. It is argued that many policies should still be appropriate to the current reality and that information should be qualified and presented

to future mothers, so that the choices made by them are really grounded. It is observed that adherence to prenatal consultations is increasing, but it can still improve in the sense of reaching 100% of pregnant women. The cesarean section is highlighted as a cause of concern and has increased over the years, being the choice of the great majority of pregnant women.

It is concluded that prenatal care in Brazil is aimed at reaching all classes and places, but inequalities between the regions of the country are still evident, as well as a serious social problem related to misappropriated funds. It is pointed out that the strategies to facilitate the process are constantly implemented by the UHS, with the premise that prenatal care is essential in the control of the morbidity and mortality of live births.

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Submission: 2018/06/29
Accepted: 2019/01/21
Publishing: 2019/03/01

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