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QUALITY OF PRENATAL CARE AND ITS INFLUENCE ON LABOR

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Abstract: Pregnancy and childbirth are phases full of insecurity and fear, making preparation for childbirth essential during prenatal care. The aim of this study was to evaluate the quality of prenatal care and preparation for childbirth. This is a cross-sectional study carried out in the rooming-in unit of the Hospital Maternidade São José (HMSJ). The participants were puerperae of normal childbirth of all age groups who met the inclusion criteria. Data was collected between August and November 2022. The SPSS - *Statistical Package for the Social Sciences* 21.0 program was used for statistical analysis, and the data was subjected to univariate analysis using the chi-square test. The study was submitted to the Human Research Ethics Committee of the University Center of Espírito Santo. Of the 169 puerperal women invited, 158 were interviewed. There was no statistical association between the quality of prenatal care and preparation for childbirth. The associated variables were: education level, gestational risk, prenatal care provider, guidance on labor, time of guidance, gestational age at delivery, information on the location of delivery, clarification of doubts about the route of delivery, choice of route of delivery, encouragement of normal delivery, receiving guidance on the signs of labor onset, information on non-pharmacological methods of pain relief. The research shows a low prevalence of preparation of pregnant women through prenatal care and no statistical association between quality of care and preparation for normal childbirth.

Keywords: Labor, Prenatal Care, Health Education, Obstetric Nursing.

INTRODUCTION

Pregnancy is a time of physical and emotional transformations, one of the most significant periods in a woman's life, characterized by expectations, insecurities and doubts, mainly related to the experience of childbirth. Prenatal care is a window of opportunity for the Unified Health System (SUS) to welcome pregnant women and act comprehensively in clarifying these anxieties, as well as promoting the health of these women (TOSTES and SEIDL, 2016; BRASIL, 2022a, 2022b).

The main objective of prenatal care is to facilitate the delivery of a healthy newborn, as well as to minimize maternal risks, by welcoming women from the beginning of pregnancy, promoting the maintenance of their well-being, preventing and detecting maternal and fetal pathologies, identifying pregnancies with an increased risk of morbidity and mortality for the mother and fetus, and providing information and guidance pertinent to the pregnancy-puerperal period and childbirth (BRASIL, 2013; LOCKWOOD and MAGRIPLES, 2022).

In order to guarantee qualified care, the Ministry of Health (MoH) has defined "ten steps for quality prenatal care in primary care" (Figure 1) (BRASIL, 2013).

The National Prenatal Card, instituted in 2014, allows primary care professionals to fill in data relevant to the health of pregnant women and guarantee continuous and comprehensive care for women. In this sense, one of the pillars of quality prenatal care is the correct recording of health indicators, which will serve as a parameter for future clinical conduct (ANDRADE *et.al.*, 2020).

The Ministry of Health advises the use of a pregnant woman's card, in accordance with the Prenatal Care Manual published in 1988, with the aim of keeping records of each appointment and allowing professionals to monitor compliance with the schedule of

10 STEPS for Quality Prenatal Care
1. start prenatal care in Primary Health Care by the 12th week of pregnancy (early screening)
2. Ensure the human, physical, material and technical resources necessary for prenatal care
3. Every pregnant woman should be guaranteed the timely request, performance and evaluation of the results of the tests recommended during prenatal care.
4. Promoting active listening to pregnant women and their companions, taking into account intellectual, emotional, social and cultural aspects, and not just biological care: "pregnant women's circles".
5. Ensure free public transportation for pregnant women to prenatal care, when necessary
6. It is the partner's right to be cared for (to have appointments, tests and access to information) before, during and after pregnancy: "partner prenatal care".
7. Ensure access to a specialized referral unit if necessary
8. Encouraging and informing about the benefits of physiological childbirth, including drawing up a birth plan
9. Every pregnant woman has the right to know and visit in advance the health service where she will give birth (linkage)
10. Women should know and exercise the rights guaranteed by law during the pregnancy and puerperal period.

Figure 1 - "The 10 Steps to Quality Prenatal Care in Primary Care"

Source: SOCIEDADE BENEFICENTE ISRAELITA BRASILEIRA ALBERT EINSTEIN. *Women's health in pregnancy, childbirth and the puerperium*. São Paulo, 2019.

laboratory tests, appointments and clinical-obstetric procedures, as well as facilitating continuity of care and better communication between those involved in the woman's care. It has also been established that at the first prenatal appointment, it is essential that the pregnant woman receives all the guidelines for a healthy pregnancy and thus contributes to adherence to appointments at future meetings (MELLO *et al*., 2022; MARQUES *et al*., 2021).

The recommendations of the Ministry of Health include starting prenatal care by the 12th week, at least 6 appointments, referral to the maternity ward, calculation of gestational age, uterine height, blood pressure, weight, fetal heartbeat, fetal presentation and tests: CBC, Fasting Blood Sugar, Human Immunodeficiency Virus (HIV), Venereal Disease Laboratory Test (VDRL), Blood Group and Rh Factor (ABO-Rh), Abnormal Sediment Elements (SSE), Hepatitis B Virus Surface Antigen (HBsAG), Toxoplasmosis, Hepatitis C Virus Specific Antibody (Anti-HCV), Cytopathology and at least one Ultrasound. It also recommends nutritional interventions, such as iron and folic acid supplementation. In a study of 23,894 puerperal women, 450 gave birth in hospitals in Espírito Santo and only 313 had a pregnancy card during hospitalization, showing that ultrasounds were the most frequently performed (93.9%), while histopathological examination of the cervix was the least (9.3%) (MARTINELLI *et al*., 2021).

The method used by Coutinho *et al.* (2010) uses as criteria for assessing the adequacy of prenatal care the start and number of visits made by pregnant women, the main procedures, as recommended by the Ministry of Health, and the analysis of essential laboratory tests (hemoglobin and hematocrit - Hb/Htc, ABO-Rh, fasting glucose, EAS and VDRL). It then classified as "adequate" care the presence of the following characteristics: beginning before 14 weeks of pregnancy; six or more consultations; at least five records of gestational age, uterine height, weight and blood pressure; four or more records of fetal heartbeat; at least two records of fetal presentation; plus one record of ABO-RH and Hb/Htc and two records of blood glucose, EAS and VDRL. On the

other hand, “inadequate” means the presence of at least one of the following criteria: onset after 27 weeks; two or fewer prenatal consultations; two or fewer records of gestational age, uterine height, weight, blood pressure or fetal heartbeat and no record of fetal presentation; in addition to the absence of laboratory tests. Finally, it classifies situations that do not meet the criteria for the aforementioned classifications as “intermediate”.

Data from the study carried out by França *et.al* (2016) and cited by Neves *et.al* (2020) showed that in 1986 the percentage of women who had one or more prenatal consultations was 78.7%, while in 2013 this figure increased by 18.7%, totaling 97.4%; most of them were seen in the first trimester of pregnancy, as recommended by the WHO (Figure 2). Mothers who completed seven or more consultations went from 49% in 1995 to 67% in 2015, according to Leal *et al.* (2018). Research has also revealed that equity has increased in almost all reproductive and maternal health indicators, which include: contraceptive use; prenatal care with one or more appointments; prenatal care with four or more appointments; first appointment during the first trimester of pregnancy; institutional delivery and caesarean sections (Figure 3) (FRANÇA *et.al.*, 2016 apud NEVES *et.al.*, 2020).

However, the quality of prenatal care services in Brazil is still a goal that needs to be fully achieved, since factors such as socioeconomic status, access to medical services and knowledge about the importance of follow-up are linked to failures in the well-being of the mother-child dyad. One study showed that the number of prenatal consultations below the recommended number or starting after six months of pregnancy was associated with women with lower socioeconomic status, unemployment and low schooling. (JONG *et.al.*, 2011 apud NEVES *et.al.*, 2020).

As elucidated by Donabedian (Moore *et al.,* 2015 apud Neves *et al.*, 2020) in his studies on health care, the triad “structure-work process-results” are understood as determinants of quality. In the current context, “structure” refers to the financial and physical resources that make up primary health care, with Basic Health Units (UBS) being the gateways for many pregnant women. The “work process” refers, in short, to the professional-patient relationship and the services provided; and the last component deals with the consequences generated in the assisted population.

It’s ideal for professionals to provide guidance during prenatal care on labor and delivery, to prevent distress, and to encourage the pregnant woman’s autonomy in choosing the route of delivery. Normal childbirth is recognized as a difficult time, but it is a physiological and beneficial process for the mother-baby binomial, except in situations that contraindicate it and require surgical intervention. Data has shown that there has been an increase in the number of caesarean sections in recent years, due to greater practicality and the lack of guidance on its real indications and the disadvantages of this modality, during prenatal consultations (CARVALHO *et al.*, 2020).

When analyzing the influence of prenatal care on labor, it can be seen that this is directly linked to the quality of the consultations received, since obstetric care guarantees early detection, management and treatment of both maternal and fetal health problems, as well as reducing morbidity and mortality rates. Health education is an important tool in the day-to-day care of pregnant women, since, in the absence of information about their rights, they are more likely to become vulnerable to obstetric violence and dissatisfaction during labor (MONTEIRO *et al.*, 2020).

In Brazil, 98% of births are institutionalized with unnecessary interventions, such as the use of enema, trichotomy, routine prophylac-

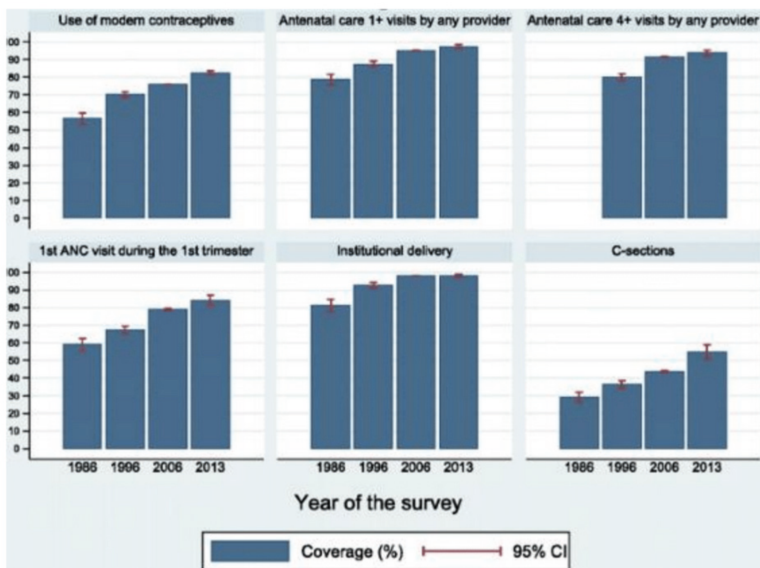

Figure 2 - “National coverage of six reproductive and maternal interventions, Brazil, 1986-2013.” SOURCE: INTERNATIONAL JOURNAL FOR EQUITY IN HEALTH. *Coverage and equity in reproductive and maternal health interventions in Brazil: impressive progress following the implementation of the Unified Health System in Brazil***.** Pelotas, 2016.

Colored dots: average coverage in each category (yellow: urban / green: rural). *Horizontal lines:* connect the average coverage in urban and rural areas. The distance between them is directly proportional to absolute inequality. Figure 3 - “National coverage of six reproductive and maternal interventions by area of residence, Brazil, 1986-2013”. SOURCE: INTERNATIONAL JOURNAL FOR EQUITY IN HEALTH. *Coverage and equity in reproductive and maternal health interventions in Brazil: impressive progress following the implementation of the Unified Health System.Brasil***.** Pelotas, 2016.

Guidelines offered evaluated	Practices carried out		p-value
	No	Yes	
Signs of risk when the pregnant woman should go to the health service	46 (22,7%)	157 (77,3%)	<0,001
Breastfeeding in the first hour of life	65 (32,0%)	138 (68,0%)	<0,001
Referral to hospital / maternity hospital / birth center for delivery	66 (32,5%)	137 (67,5%)	<0,001
Signs of early labor	80 (39,4%)	123 (60,6%)	0,003
Methods to relieve pain and facilitate the birth of the baby	109 (53,7%)	94 (46,3%)	0,04
Participation in pregnant women's groups	143(70,4%)	60 (29,6%)	<0,001
The right to a companion of your choice	145(71,4%)	58 (28,6%)	<0,001
Birth plan	185(91,1%)	18 (8,9%)	<0,001

Figure 4 - "Guidance offered during prenatal care self-reported by puerperal women in the context of good obstetric practice"

Note: ʻp-value of the Chi-Square test for comparing proportions (if p-value <0.05, the percentages of the levels of the factors evaluated differ significantly).

SOURCE: BRAZILIAN JOURNAL OF NURSING. Health care in the context of prenatal care and childbirth from the perspective of puerperal women. Recife, 2017.

tic catheterization, the valsalva maneuver during the second stage of labor and the perineal distension maneuver. It is therefore essential to understand good childbirth care practices and the consequent reduction in obstetric violence, in order to encourage practices based on scientific evidence, which will bring benefits in the humanized care of women. One study showed that professionals are aware of the importance of sensitivity and welcoming the pregnant woman, as well as including the family and individualizing each woman, always highlighting the importance of the pregnant woman's active participation in labour. With this, the Ministry of Health launched the Stork Network policy, which aims to reduce maternal mortality by guaranteeing women's rights (PEREIRA *et al.*, 2018; LANSKY *et al.*, 2019).

Regarding the Birth Plan (Figure 4) (MONTEIRO *et al.*, 2020), 91.1% of the women were unaware of it and did not carry it out, despite the fact that it is part of good obstetric practice, since it teaches pain relief methods, facilitates birth, provides information on skin-to-skin contact in the first hour of life, among others. In addition, the number of pregnant women who had prenatal care and chose cesarean delivery was considerable. This is due, among other things, to the lack of encouragement and incentives for normal childbirth during prenatal care and the lack of dialog between doctor and patient.

It is therefore essential that measures are taken to improve obstetric care in order to increase access, reduce inequalities and strengthen the relationship between pregnant women and the primary care network. In addition, it is essential that professionals are prepared and equipped with the skills and abilities to deal with the scenario of misinformation on the part of pregnant women (PEREIRA *et al.*, 2020).

MATERIALS AND METHODS

This is a cross-sectional study carried out in a philanthropic hospital located in Colatina - Espírito Santo, which is a reference for the Stork Network for maternal and child care and primarily treats high-risk pregnancies referred by thirty-three (33) municipalities in the center and north of the state. The participants in the study were puerperal women who had given birth normally, of all age groups, who were hospitalized in a rooming-in unit.

Puerperae whose fetus had died and those who had not undergone prenatal care were excluded. Puerperae who did not have a Pregnant Women's Handbook at the time of the interviews took part in the study, but did not have their prenatal care adequacy classified.

A total of 169 puerperal women were invited to take part, but 158 were interviewed. 5 were excluded due to fetal death and 2 due to lack of prenatal care, and 4 refused to take part in the survey

Data collection took place between August and November 2022, with the help of researchers trained in the use of the questionnaire and analysis of the Pregnant Women's Handbook to assess prenatal care. Participants were selected randomly, but all puerperal women with normal births who met the inclusion criteria and agreed to take part in the study were interviewed.

The interview was based on a semi-structured form with socio-economic data (age, education, marital status), obstetric data (parity, type of delivery), prenatal care information (gestational risk, number of visits, gestational age at the start of prenatal care, interval between the last visit and delivery, prenatal care classification according to Coutinho, the professional who carried it out, the municipality in which it was carried out, whether the woman was given advice on labor, the time at which she was advised, receiving information about the link with the place of delivery, being offered a visit to the maternity hospital, making a visit to the maternity hospital, clarifying doubts about the route of delivery, personal choice of the route of delivery during pregnancy, receiving encouragement for normal childbirth, guidance on the signs of the onset of labor, receiving information on non-pharmacological methods of pain relief, preparation for childbirth).

The Pregnant Women's Handbook was analyzed to classify prenatal care as "adequate", "intermediate" and "inadequate", following the proposed categorization of care according to Coutinho *et al.* (2010). The evaluation included gestational age at the start of prenatal care, the number of appointments made, the recording of laboratory test results and clinical-obstetric procedures.

The outcome variable was preparation for childbirth through prenatal care. The primary aim was to assess the relationship between the quality of prenatal care and preparedness for childbirth, although the other independent variables were also analyzed with the outcome variable.

The results were stored in an Excel spreadsheet and then exported to SPSS - *Statistical Package for the Social Sciences 21.0*. A univariate analysis was carried out using the chi-square test, with a significance level of $p<0.05$.

The study was approved by the Human Research Ethics Committee, under the Certificate of Submission for Ethical Appraisal (CAAE) number 60875122.6.0000.5062, in line with National Health Council Resolutions 466/12 and 510/2016 on research involving human beings, preceded by authorization from the institution involved. All participants who agreed to take part in the research read and signed the Informed Consent Form (ICF), as well as in the case of minors, meeting the criteria of the National Research Ethics Commission (CONEP).

RESULTS

Of the 169 puerperal women invited to take part in the study, 158 were interviewed. According to the established criteria, 5 were excluded due to fetal death and 2 due to lack of prenatal care. Four puerperae refused to take part. The highest percentage of puerperal women interviewed were aged between 18 and 35 (78.5%), had a high school education (48.7%) and were in a stable union (36.7%).

Table 1 shows the sociodemographic data (age, education and marital status) in a univariate analysis using the chi-square test.

There was no statistical significance in the age (p-value: 0.917) and marital status (p-value: 0.407) of the puerperal women when associated with preparation for childbirth. However, it is worth pointing out that most of the women who considered themselves prepared for childbirth, through the care provided during prenatal care, were in the 18 to 35 age group (47.6%). On the other hand, puerperal women under the age of 18 accounted for a higher proportion of those who were not prepared (58.3%). With regard to marital status, the majority of puerperae in stable unions considered themselves prepared for childbirth (53.4%), while the majority of single women (54.5%) and married women (58.9%) declared themselves unprepared.

There was an association between schooling (p-value: 0.041) and preparation for childbirth. Women with a primary level of education were more prepared for childbirth (53.3%), while those with a secondary level of education and higher education had a higher prevalence of not being prepared for childbirth (50.6% and 77.8% respectively).

With regard to the obstetric characteristics (parity, previous normal delivery or previous cesarean section) shown in Table 2, no significant associations were found in relation to preparation for childbirth.

Both primiparous and multiparous women thought they were less prepared for childbirth (56.3% and 51.1% respectively). However, patients with a history of previous normal childbirth had the highest prevalence of preparedness for childbirth (52.4%), while those without a history of previous normal childbirth were mostly unprepared for childbirth (59.5%).

Tables 3 to 5 show the association between the characteristics and actions of prenatal care, as well as the adequacy of this care, and preparation for childbirth.

The univariate analysis of the prenatal care characteristics block showed an association between the following variables: gestational risk (p-value: 0.001), the professional who carried out the prenatal care (p-value: 0.028), whether they received advice on labor (p-value: 0.000) and when they received advice (p-value: 0.000). The variables number of consultations (p-value: 0.949), gestational age at the beginning (p-value: 0.294) and interval between the last consultation and delivery (p-value: 0.261) were not statistically associated with preparation for childbirth.

In view of this, it can be seen that the majority of puerperal women at normal risk (64.80%), those who had their prenatal care carried out by a nurse and/or obstetrician (85.70%) and a doctor from the Family Health Strategy - ESF (56.60%) and those who received guidance on labor (78.50%) were prepared for childbirth.

Women who had never received any guidance on labor considered themselves to be unprepared (84.80%), while the presence of guidance throughout prenatal care showed a higher prevalence of preparedness for childbirth (86.80%).

There was no significant association between the quality of prenatal care and preparation for childbirth (p-value: 0.650). However, it can be seen that those classified as intermediate had a higher prevalence of no preparation for childbirth (57.00%), unlike those classified as adequate and inadequate, who had greater preparation (54.30% and 52.60% respectively).

Table 5 shows that the following variables were statistically associated with preparation for childbirth: gestational age at delivery (p-value: 0.020), whether received informa-

tion about the link with the place of delivery (p-value: 0.011), whether doubts about the route of delivery were clarified (p-value: 0.000), personal choice of mode of delivery during pregnancy (p-value: 0.011), whether they received encouragement for normal delivery (p-value: 0.000), guidance on the signs of early labor (p-value: 0.000) and information on non-pharmacological methods of pain relief (p-value: 0.000).

Thus, the puerperae with the highest prevalence of preparation for childbirth were: those with a gestational age at delivery greater than 37 weeks (50.70%), those who received information about the maternity hospital of reference for delivery (54.50%), those who reported having their doubts about delivery routes clarified during consultations (71.80%), those who had a personal choice for normal delivery (51.50%), those who received encouragement for normal delivery (65.90%), guidance on signs of early labor (65.70%) and non-pharmacological methods of pain relief (88.20%).

The offer of a visit to the maternity hospital (p-value: 0.593) and the visit (p-value: 0.389) were not relevant or associated with preparation for childbirth through the care provided during prenatal care.

Table 6 shows the municipalities in which the puerperal women declared that they received their prenatal care.

There was no association between the place of prenatal care and preparedness for childbirth (p-value: 0.366). However, most of the puerperal women interviewed (23.4%) had prenatal care in the municipality of Colatina/ES and 62.2% of them said they were prepared for childbirth. In relation to the other municipalities, 57.14% had a higher prevalence of not being prepared for childbirth through prenatal care.

DISCUSSION

In terms of sociodemographic characteristics, the Ministry of Health's Low-Risk Prenatal Care manual presents the age of the pregnant woman as an intermediate gestational risk stratifier when under 15 or over 35 years of age, which is a predictor of vulnerability, requiring preventive interventions or the care needed to protect the woman and the child (BRASIL, 2013). Teenage pregnancy brings social, educational, professional and psychological limitations and/or conflicts, and pregnant women in this age group are shown to have worse perinatal outcomes, causing insecurities and difficulties to hover over prenatal care and, consequently, childbirth (ABREU, 2010; GOMES e DOMINGUETI, 2021).

As for marital status, it is undeniable that childbirth is a great experience for the woman, the baby and the partner, and that the presence of a partner encourages quality prenatal care (REZENDE and SOUZA, 2012; REIS-MULEVA *et al.,* 2021). With regard to schooling, women with a higher level of education are more likely to have adequate prenatal care, with a high chance of starting early, an adequate number of appointments and the development of confidence to make decisions about their health and report their doubts about pregnancy and childbirth (REIS-MULEVA *et al.,* 2021). Despite this, this study showed that, with the exception of puerperae with no schooling, all of whom did not feel ready for childbirth, the higher the level of education, the less prepared they felt.

The obstetric characteristics evaluated were not associated with preparedness for childbirth. However, puerperae with previous experience, i.e. multiparous women with a previous normal birth, felt more prepared to give birth. Primiparous women and women with a previous cesarean section, for the most part, arrived at the hospital unprepared for childbirth. This data reinforces the need for grea-

VARIABLES		Prepared for Childbirth				p-value
		Yes		No		
		N	%	N	%	
SOCIODEMOGRAPHIC CHARACTERISTICS						
Maternal age	< 18 years	5	41,7%	7	58,3%	0,917
	18 to 35 years old	59	47,6%	65	52,4%	
	> 35 years	10	45,5%	12	54,5%	
Education	None	0	0,0%	3	100,0%	0,041*
	Fundamental	32	53,3%	28	46,7%	
	High School	38	49,4%	39	50,6%	
	Superior	4	22,2%	14	77,8%	
Marital status	Single	20	45,5%	24	54,5%	0,407
	Stable Union	31	53,4%	27	46,6%	
	Married	23	41,1%	33	58,9%	

Table 1 - Sociodemographic characteristics, univariate analysis (qualitative variables)

*Chi-square test (p<0.05)

VARIABLES		Prepared for Childbirth				p-value
		Yes		No		
		N	%	N	%	
OBSTETRIC CHARACTERISTICS						
Parity	Primipara	28	43,8%	36	56,3%	0,521
	Multiparous	46	48,9%	48	51,1%	
Previous normal birth	Yes	44	52,4%	40	47,6%	0,137
	No	30	40,5%	44	59,5%	
Previous cesarean delivery	Yes	7	35,0%	13	65,0%	0,256
	No	67	48,6%	71	51,4%	

Table 2 - Obstetric characteristics, univariate analysis (qualitative variables)

VARIABLES		Prepared for Childbirth				p-value
		Yes		No		
		N	%	N	%	
CHARACTERISTICS OF PRENATAL CARE						
Gestational risk	Habitual	35	64,80%	19	35,20%	0,001*
	High risk	39	37,50%	65	62,50%	
Number of consultations	0 a 2	1	50,00%	1	50,00%	0,949
	3 a 5	6	42,90%	8	57,10%	
	6 or more	67	47,20%	75	52,80%	
Gestational age at onset	Up to 13 weeks	60	46,90%	68	53,10%	0,294
	14 to 27 weeks	12	42,90%	16	57,10%	
	28 weeks or more	2	100,00%	0	0,00%	
Interval between last appointment and delivery	Up to 15 days	57	49,60%	58	50,40%	0,261
	More than 15 days	17	39,50%	26	60,50%	
Professional who performed	Nurse / Obstetrician	6	85,70%	1	14,30%	0,028*
	ESF doctor	30	56,60%	23	43,40%	
	Gynecologist and Obstetrician	12	35,30%	22	64,70%	
	More than one professional	26	40,60%	38	59,40%	
Guidance on labor	Yes	62	78,50%	17	21,50%	0,000*
	No	12	15,20%	67	84,80%	

The moment she was guided	None	12	15,20%	67	84,80%	0,000*
	1st quarter	5	62,50%	3	37,50%	
	2nd quarter	7	100,00%	0	0,00%	
	3rd quarter	17	65,40%	9	34,60%	
	All prenatal care	33	86,80%	5	13,20%	

Table 3 - Characteristics of prenatal care, univariate analysis (qualitative variables)

*Chi-square test (p<0.05)

VARIABLES	Prepared for Childbirth				p-value
	Yes		No		
	N	%	N	%	
CHARACTERISTICS OF PRENATAL CARE - QUALITY CLASSIFICATION ACCORDING TO COUTINHO					
Suitable	19	54,30%	16	45,70%	0,650
Inadequate	10	52,60%	9	47,40%	
Intermediate	43	43,0%	57	57,00%	
Not classified	2	50,0%	2	50,00%	

Table 4 - Classification of prenatal quality according to Coutinho, univariate analysis (qualitative variables)

VARIABLES		Prepared for Childbirth				p-value
		Yes		No		
		N	%	N	%	
CHARACTERISTICS OF PRENATAL CARE - GUIDANCE AND DELIVERY						
Gestational age at delivery	< 37 weeks	6	25,00%	18	75,00%	0,020*
	37 weeks or more	68	50,70%	66	49,30%	
Orientation: link to place of birth	Yes	55	54,50%	46	45,50%	0,011*
	No	19	33,30%	38	66,70%	
Maternity visit offered	Yes	9	52,90%	8	47,10%	0,593
	No	65	46,10%	76	53,90%	
The visit took place	Yes	6	60,00%	4	40,00%	0,389
	No	68	45,90%	80	54,10%	
Doubts about the route of delivery clarified	Yes	56	71,80%	22	28,20%	0,000*
	No	18	22,50%	62	77,50%	
Personal choice of delivery route	Normal	67	51,50%	63	48,50%	0,011*
	Cesarean section	7	25,00%	21	75,00%	
Encouraging normal childbirth	Yes	58	65,90%	30	34,10%	0,000*
	No	16	22,90%	54	77,10%	
Orientation: signs of labor	Yes	65	65,70%	34	34,30%	0,000*
	No	9	15,30%	50	84,70%	
Guidance: non-pharmacological methods of pain relief	Yes	45	88,20%	6	11,80%	0,000*
	No	29	27,10%	78	72,90%	

Table 5 - Characteristics of prenatal care, guidance and childbirth, univariate analysis (qualitative variables)

*Chi-square test (p<0.05)

ter attention and information from prenatal professionals, since the choice of caesarean section is often encouraged by fear and misinformation (MEDEIROS *et al.*, 2017; SANTOS *et al.*, 2019).

As for the characteristics of prenatal care, some variables were associated with preparation for childbirth, including gestational risk. In line with this information, a national survey carried out in 2017 showed that high-risk pregnant women had the greatest fear of childbirth during pregnancy, emphasizing, however, the lack of information provided to this group (CABRAL *et al.*, 2018).

Another variable associated with preparedness for childbirth was the professional who carried out the prenatal care. Pregnant women who were assisted by a nurse and/or obstetric nurse and a doctor from the FHS were more prepared for childbirth. This is due to the fact that Primary Care offers patients easy access to health services and continuity of care, which are some of the attributes of this model of care, so families establish a greater bond with professionals, who accompany them before, during and after prenatal care (FACCHINI *et.al.*, 2018).

Receiving guidance on labor during prenatal care was also an important factor in preparing pregnant women. Patients who received guidance felt more prepared for childbirth compared to those who did not. According to the study by Heim *et.al* (2019), women reported a lack of guidance during prenatal consultations, and showed interest in receiving information about care during pregnancy and non-pharmacological methods for pain relief in labor. In this context, it is important to implement alternative measures for better guidance during pregnancy.

With regard to when they received guidance on childbirth, the lowest rate of preparedness was found among those who received no guidance at all, while those who received guidance throughout prenatal care were more prepared for childbirth, followed by those who received information in the third trimester. In line with this data, the Ministry of Health's Prenatal and Puerperium Technical Manual states that guidance on labor in the third trimester, using simple and clear information, reduces anxiety and insecurity and prepares women for normal childbirth (BRASIL, 2006).

Regarding the number of consultations, two national studies showed contradictory results, since the one carried out in 2017 showed that women with more than 6 consultations mostly did not receive guidance on childbirth, while the one carried out in 2020 showed that guidance on labor was more frequent in pregnant women with more than 6 consultations (GONÇALVES *et al.*, 2017; MENDES *et al.*, 2020). The study by Medeiros *et al.* (2019) found that gestational age (GA) at the start of prenatal care had a direct influence on its quality. They also pointed out that the interval of up to 15 days between the last appointment and delivery was a determining factor in the efficiency of prenatal care.

The study found no association between the quality of prenatal care and preparation for childbirth, but it did show that the highest prevalence of lack of preparation was among those classified as intermediate and inadequate. In line with this data, a study carried out in 2017, which used the same method for classifying the quality of care and associated it with receiving guidance on labor, showed that the pregnant women who received the least guidance were classified as intermediate and inadequate (GONÇALVES *et al.*, 2017).

The method for classifying prenatal care used by Coutinho *et al.* (2010) and applied in the current study, uses as evaluation parameters the performance of recommended tests, the essential obstetric clinical examination, the number of consultations, as well as gestational age at the start of prenatal care. Howe-

VARIABLES	Prepared for Childbirth				p-value
	Yes		No		
	N	%	N	%	
MUNICIPALITIES					
Água Doce do Norte/ ES	1	33,3%	2	66,7%	
Águia Branca/ ES	0	0,0%	2	100,0%	
Aimorés/ MG	1	50,0%	1	50,0%	
Alto Rio Novo/ ES	0	0,0%	2	100,0%	
Baixo Guandu/ ES	3	27,3%	8	72,7%	
Barra de São Francisco/ ES	3	30,0%	7	70,0%	
Boa Esperança/ ES	5	55,6%	4	44,4%	
Colatina/ ES	23	62,2%	14	37,8%	
Ecoporanga/ ES	3	60,0%	2	40,0%	
Governador Lindemberg/ ES	5	55,6%	4	44,4%	
Itaguaçu/ ES	0	0,0%	2	100,0%	
Linhares/ ES	0	0,0%	2	100,0%	
Mantena/ MG	1	50,0%	1	50,0%	
Mantenópolis/ ES	0	0,0%	1	100,0%	
Marilândia/ ES	3	50,0%	3	50,0%	0,366
Montanha/ ES	4	33,3%	8	66,7%	
Nova Belém/ MG	0	0,0%	1	100,0%	
Nova Venécia/ ES	1	25,0%	3	75,0%	
Pancas/ ES	5	55,6%	4	44,4%	
Pinheiros/ ES	1	25,0	3	75,0%	
Ponto Belo/ ES	0	0,0%	1	100,0%	
Santa Teresa/ ES	1	100,0%	0	0,0%	
São Domingos do Norte/ ES	1	50,0%	1	50,0%	
São Gabriel da Palha/ES	5	100,0%	0	0,0%	
São Mateus/ES	1	33,3%	2	66,7%	
São Roque do Canãa/ES	3	60,0%	2	40,0%	
Sooretama/ES	0	0,0%	1	100,0%	
Vila Pavão/ ES	0	0,0%	1	100,0%	
Vila Valério/ ES	4	66,7%	2	33,3%	

Table 6 - Municipalities where prenatal care is provided, univariate analysis (qualitative variables)

ver, in addition to the criteria related to direct care, the Ministry of Health defines the 10 steps to quality prenatal care as: active listening to the pregnant woman and her partner, encouragement and guidance on the benefits of physiological childbirth and the right to know in advance and visit the maternity hospital of reference (BRASIL, 2013).

Furthermore, there is a need for methods to assess the quality of prenatal care that analyze not only technical procedures, but the consultation as a whole. Monteiro *et al.* (2020) argue that the adequacy of care needs to encompass the social aspects of pregnancy, clarifying doubts and offering guidance on routes of delivery, signs and symptoms of labor, hospital care and women's rights.

With regard to the characteristics of prenatal care, guidance and childbirth, only the variables offering a visit to the maternity hospital and making the visit were not statistically associated with preparedness for childbirth. However, women who did not receive this information and did not visit the maternity hospital were more unprepared. That said, in a national survey, all the pregnant women in-

terviewed emphasized the importance of visiting the maternity hospital, ensuring guidance on childbirth, greater safety, and prior knowledge about birth (POPOLLI *et al.*, 2018). In another study on the guided tour of the maternity ward, 100% of the pregnant women who went on the tour said they had all their doubts answered, especially about labor and breastfeeding (NUNES *et al.*, 2022).

Gestational age at delivery had an influence on preparation, which may be associated with the fact that most of the guidance is given at the end of pregnancy. In addition, a study by Mesquita *et al.* (2018) showed that experiencing premature labor can lead to negative feelings as a result of the presence of insecurity, fear and anguish that can interfere with the pregnant woman's experience. In addition, research by Misund *et al.* (2014) also showed that the gestational age of the child and the delivery were predictors of maternal stress levels and anxiety. Thus, women with premature births reported clinically significant psychological distress two weeks after delivery.

As in other national studies, in the current study, most of the women were advised about the place of reference for childbirth (POLGLIANE *et al.*, 2014; VIELLAS *et al.*, 2014; DOMINGUES *et al.*, 2012; GONÇALVES *et al.*, 2017). However, when this variable was associated with preparation for childbirth, it showed statistical significance. Unlike this result in one of the aforementioned studies, the association of the same variable with the provision of guidance for childbirth did not show a significant result (GONÇALVES *et al.*, 2017).

There is a predominance of women who have not received guidance on the signs of labor onset, as also observed in the study by Félix et al. (2019), which highlights a high percentage of pregnant women interviewed without this type of guidance. However, in the current study, those who received this guidance were more prepared for childbirth. Therefore, explaining the signs of early labor during prenatal care can prepare them for this moment, promoting greater safety, considering that a lack of information can generate unnecessary distress that can influence childbirth (AGUIAR *et al.*, 2020; RIBEIRO *et al.*, 2016).

In two nationwide surveys, pregnant women pointed to normal delivery as the route of choice, despite the increase in the number of caesarean sections in the country (MARTINS *et al.*, 2018. SILVA *et al.*, 2017). In addition, the clarification of delivery routes and the encouragement of normal delivery influenced the preparation of pregnant women, reinforcing the need for educational practices that influence the choice of delivery route and ensure that the professional observes the main doubts and lack of information present (SANTOS *et al.*, 2019).

As for non-pharmacological methods of pain relief, although there is little guidance on this subject during prenatal care, the study shows that patients who received this type of information considered themselves better prepared for childbirth. The results of a study on the use of these methods showed that they had a satisfactory effect, minimizing pain and promoting peace of mind and a better birth experience. However, there is a need for research to evaluate the spread of information about these methods in prenatal care, since the knowledge of pregnant women can influence the reduction of pain, fear and, consequently, caesarean section rates (DIAS *et al.*, 2018; HENRIQUE AJ *et al.*, 2018).

Given the unpreparedness of pregnant women in just over half of the municipalities, the lack of routine counseling and guidance during consultations stands out, since the study shows that these are factors that can directly influence preparation for childbirth. However, in relation to women who received all the guidance during prenatal care, a survey shows that Espírito Santo (ES) was among the states

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with values higher than the national proportion. Similarly, when assessing prenatal coverage in the greater Vitória metropolitan region (Cariacica, Fundão, Guarapari, Serra, Viana, Vila Velha and Vitória), educational activities were carried out by less than 20% of women, with no significant differences between the regions. However, this factor can interfere with the process of preparing for childbirth (NUNES et al., 2017; ESPOSTI et al., 2020).

CONCLUSION

In conclusion, this study shows a low prevalence of preparation of pregnant women through prenatal consultations, as well as no statistical association between the quality of care and preparation for normal childbirth.

The method used in the study to classify the adequacy of prenatal care is based on technical care criteria, such as the number of appointments, gestational age at the start of prenatal care and the performance of essential procedures and tests, and does not include the criteria of active listening and health education. However, the study shows that most of the factors that were statistically associated with preparedness for childbirth were those related to the professional who carried out the prenatal care, receiving guidance, the types of information provided during consultations, active listening to pregnant women, their choice of normal childbirth and encouragement during prenatal care for physiological childbirth.

In view of the above, it is understood that quality prenatal care is not only achieved by carrying out recommended procedures and achieving health indicators, but by a set of actions and services provided holistically to pregnant women and their families. However, the adequacy of prenatal care is ensured by combining appointments with health education, benefiting women and promoting their knowledge about their bodies.

The influence of the professional responsible for assisting the pregnant woman in preparing for childbirth is also noteworthy. Despite the scarcity of nurses and/or obstetric nurses in prenatal care, the study shows that pregnant women who were assisted by these professionals had a higher prevalence of preparation for childbirth. However, the importance of including these professionals in prenatal care is emphasized in order to encourage the empowerment of pregnant women and prepare them for normal childbirth.

It is therefore understood that preparation for childbirth is directly associated with health education, the transfer of evidence-based information and the perception of women's wishes and desires during pregnancy. This highlights the need for professionals who are prepared and trained for this role, since preparing for physiological childbirth makes it possible to transform this moment, which for many is defined as suffering, into a unique and pleasurable experience.

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