REUFSM
REVISTA DE ENFERMAGEM DA UFSM

UFSM
Rev. Enferm. UFSM - REUFSM
Santa Maria, RS, v. 9, e15, p. 1-19, 2019
DOI: 10.5902/2179769232336
ISSN 2179-7692

Original Article Submission: 23/04/2018 Aprovação: 05/12/2018 Publication: 01/08/2018

Prenatal care of usual-risk pregnant women: potentialities and weaknesses

Pré-natal da gestante de risco habitual: potencialidades e fragilidades

Prenatal de la gestante de riesgo habitual: potencialidades y fragilidades

Andressa Arraes Silva[I], Mara Julyete Arraes Jardim[II], Claudia Teresa Frias Rios[III]
Lena Maria Barros Fonseca[IV], Liberata Campos Coimbra[V]

Abstract: Objective: to know the potentialities and weaknesses in the prenatal consultation of habitual risk. **Methods:** qualitative study, developed with twenty pregnant women who underwent prenatal care at Primary Health Care in the city of São Luís in 2017. Data analysis used the Thematic Analysis based on the parameters recommended by the Ministry of Health. **Results:** the reception, the easy access, the examinations and the groups of pregnant women are configured as prenatal potentialities. The lack of organization of the units, of essential drugs, of material resources, the long time to start consultations and the accomplishment of the examinations constituted weaknesses. **Conclusions:** the assessment of prenatal care from the users' perceptions brought contributions to interventions in the weaknesses of health services to pregnant women, according to the recommendations of the Ministry of Health. **Descriptors:** Prenatal care; Humanization of assistance; Office nursing

Resumo: Objetivo: conhecer as potencialidades e fragilidades na consulta pré-natal de risco habitual. **Método:** estudo qualitativo, desenvolvido com vinte gestantes que realizaram o pré-natal na Atenção Primária à Saúde do município de São Luís, no ano de 2017. Para análise dos dados utilizou-se a Análise Temática com base nos parâmetros preconizados pelo Ministério da Saúde. **Resultados:** o acolhimento, o fácil acesso, a realização de exames e os grupos de gestantes configuram-se como potencialidades do pré-natal. A falta de organização das unidades, de medicamentos de uso essencial, de recursos materiais, o tempo prolongado para início das consultas e para as realizações dos exames consistiram em fragilidades. **Conclusões:** a avaliação da assistência pré-natal a partir da percepção das usuárias trouxe contribuições para intervenções nas fragilidades dos serviços de saúde às gestantes, e o atendimento de acordo com o que está preconizado pelo Ministério da Saúde.
Descritores: Cuidado pré-natal; Humanização da assistência; Enfermagem no consultório

[I] Nurse. MSc in Nursing. State University of Maranhão. Bacabal-MA, Brazil. E-mail: andressinha_arraes5@hotmail.com. ORCID: https://orcid.org/0000-0002-1699-5597

[II] Nurse. MSc in Nursing. State University of Maranhão. Coroatá-MA, Brazil. E-mail: mara_arraes@hotmail.com. ORCID: https://orcid.org/0000-0002-2428-9123

[III] Nurse. PhD in Collective Health. Federal University of Maranhão. São Luís-MA, Brazil. E-mail: ctfrios@hotmail.com. ORCID

[IV] Nurse. PhD in Biotechnology. Federal University of Maranhão. São Luís-MA, Brazil. E-mail: lenabarrosf@gmail.com. ORCID: https://orcid.org/0000-0002-6499-1005

[V] Nurse. PhD in Public Policies. Federal University of Maranhão. São Luís-MA, Brazil. E-mail: liberatacoimbra@gmail.com. ORCID:

Resumen: Objetivo: conocer las potencialidades y fragilidades en la consulta prenatal de riesgo habitual. **Métodos:** estudio cualitativo, desarrollado con veinte gestantes, que realizaron el prenatal en la Atención Primaria a la Salud, del municipio de São Luís, en el año 2017. Para análisis de los datos, se utilizó el Análisis Temático, con base en los parámetros determinados por el Ministerio de Salud. **Resultados:** la acogida, el fácil acceso, la realización de exámenes y los grupos de gestantes se configuran como potencialidades del prenatal. La falta de organización de las unidades, de medicamentos de uso básico, de recursos materiales, el tiempo prolongado para el inicio de las consultas y para la realización de los exámenes consistieron en fragilidades. **Conclusión:** la evaluación de la asistencia prenatal, a partir de la percepción de las usuarias, aportó contribuciones para intervenciones en las fragilidades de los servicios de salud a las gestantes y para garantizar la atención de acuerdo con lo que está determinado por el Ministerio de Salud.
Descriptores: Atención prenatal; Humanización de la atención; Enfermería de consulta

Introduction

Prenatal follow-up of usual risk consists of the care to pregnant women without individual sociodemographic and obstetric-history related risk factors, illness or disease that may interfere negatively in the evolution of pregnancy. Both doctors as nurses can perform it, in the Primary Health Care (PHC) network, considered entrance doors of pregnant women to prenatal services. The Family Health Strategy (FHS) is characterized as a care model geared to the development of individual and collective actions, monitoring and promotion of humanized prenatal care. The Nurse, professional member of the FHS team, must be able to identify risk and harmful situations to the health of the pregnant woman that interfere with the quality of prenatal care.[1]

Although the quality of prenatal care directly relates to the decreased degree of maternal and infant morbidity and mortality, it remains a global concern, particularly in developing countries, in indices of maternal and neonatal death from pregnancy and delivery, demonstrating fragility in prenatal care.[2]

The development of the prenatal care in the PHC can result in strengths or weaknesses in assistance, topics currently discussed in the context of the Family Health Strategy, with a view to the planning of the work of professionals, especially in the area of women's health. Potentialities relate to the force and importance, and can be seen as a determinant factor for an assistance offered in a systematized, articulated, and resolutive way, ensuring the principles of integrality

and humanization. The weaknesses related to prenatal care can be understood as an assistance that is little resolutive, due to the adoption of practices fragmented in the care to pregnant women, in addition to insufficient human resources, communication failures and unavailable material resources, resulting in a deficiency in quality of care.[3]

There is a consensus that the Brazil, in the past 20 years, has made significant progress in reducing maternal mortality with the elaboration of policies and programs aimed at women's health, which intensified from the institution of the *Programa de Humanização do Pré-Natal e Nascimento* (PNHP - Program for Prenatal and Birth Humanization) in 2000, by the Ministry of Health (MOH). The goal was to reduce the high rates of maternal and perinatal morbidity and mortality, increasing access to prenatal care, establishing criteria to qualify the consultations (minimum number of six consultations during pregnancy and in the postpartum period), in addition to promoting minimum package of laboratory tests, educational activities, risk classification and institutional links.[4] As regards the prenatal care, its access should be easy and performed by welcoming behaviors that integrate actions of promotion, prevention and health care to the pregnant woman and the baby at all care levels. The capacitation of professionals involved in this assistance is also fundamental to achieving care quality.[5]

The efforts with the development of the PNHP were not enough to produce resolutive effects. Therefore, the MOH established the *Rede Cegonha* (RC), with the purpose of ensuring the woman the right to reproductive planning and humanized care to pregnancy, delivery and the puerperium, as well as the right of the child to a safe birth and healthy growth and development. Its principle is to organize the Network of Attention to Maternal and Child Health, assuring access, reception and reduction of maternal and child mortality.[6]

These concerns are based on knowledge about the rates of maternal and neonatal mortality in Brazil and in the certainty that the weaknesses are a reflection of the quality of care provided

to pregnant women during the prenatal, delivery and birth. If health services expanded the sexual and reproductive rights for women and guaranteed a safe and respectful obstetric care, 95% of maternal deaths in the world could be avoided.[7] In order to improve the quality of prenatal care, it is necessary to reorganize the work process in order to ensure the expansion of access, in addition to empowering the human resources, providing reception and full support for pregnant women and their families. This support should begin with educational actions with the objective of increasing the level of guidelines for pregnant women regarding human rights, risks and complications in pregnancy and childbirth, encouraging their empowerment.[8]

Therefore, the research is justified by the importance of the opinion of pregnant women regarding the consultation and other aspects of prenatal care, as well as the care perceived by them as an indicator in the assessment of the quality of prenatal care in Primary Health Care. For this study, the authors sought to answer the following question: What are the potentialities and weaknesses, in the experiences of pregnant women, found in the prenatal consultation of usual risk that interfere with the quality in Primary Health Care?

The objective of the study was to know the strengths and weaknesses in prenatal consultation of usual risk, in the experiences of pregnant women.

Method

This is a descriptive research, with qualitative approach, performed with 20 pregnant women attended to in the PHC of a sanitary district in the city of São Luís, Maranhão. Data collection was carried out in the period from July to September 2017, through semi-structured interviews, whose instrument was developed and tested in advance, containing objective questions relating to sociodemographic, economic and obstetric data and questions regarding the opinions of pregnant women about the prenatal consultations. The models of services included in this study were: Mixed Unit, Health Center and the Family Health Strategy.

The participants were approached at health services during the prenatal consultation, by means of the service professional. The inclusion criteria were: usual-risk pregnant women (including under 18 years and over 35 years, once a large number of women in this age group use the prenatal services in the PHC); from the 30th week of pregnancy who had attended at least three prenatal consultations (believed to be a sufficient number for them to be able to analyze the received assistance); pregnant women without a history of mental disorder, and with the notebook of pregnant women.

All interviewees were informed about the objectives and other aspects of the research and asked, after the clarifications, to sign the Informed Consent Form or the Permission Form, for children under 18 years, along with the guardian's authorization, ensuring a voluntary participation and maintaining the privacy regarding the data provided. To ensure anonymity, the women were identified by the abbreviation of the word pregnant women (*gestante* in Portuguese) followed by a number corresponding to the order of the interview (GESTA.01).

The data were interpreted using the Thematic Analysis[9] and analyzed based on the parameters of adequacy of prenatal care recommended by the MOH.[1,4-6,10-11] The research followed the standards established by Resolution 466/2012 of the National Health Council[12], whose data collection occurred only after approval of the Research Ethics Committee of the Federal University of Maranhão (UFMA) under opinion number 1.999.550, on 04 April 2017.

Results and discussions

Sociodemographic and obstetric aspects of the pregnant women

The analysis of the sociodemographic characteristics of the 20 pregnant interviewees showed that the majority was in the age range from 26 to 35 years, and two of these women were under 18 years. In relation to marital status, 10 reported living in a stable union, 5 were married

and 5, single. The absence of a partner or companion in prenatal consultations may lead to an increased risk for illness, psychological stress and anxiety related to motherhood, causing a greater possibility of developing premature births.[10]

In relation to race, 16 pregnant women self-reported brown-skinned. According to the MOH brown-black skinned pregnant women are more prone to develop hypertension and diabetes due to their biological predisposition.[1] In terms of family income, the majority reported one to two minimum wages and only one reported not having usual income. Health professionals must be attentive to the socioeconomic conditions of their users and the possible health risks arising from low family income, such as low weight of the newborn, premature births, among other complications during pregnancy.[13] When questioned about their schooling, the majority reported complete secondary school and one, complete higher education. The low level of schooling associated with low socioeconomic level favors the later onset of prenatal care, the high level of absenteeism and the adoption of inadequate dietary habits during the gestational period.[14]

The analysis of obstetric data of pregnant women showed that 16 were in their first pregnancy, five were in their second pregnancy, two were in the third and two were in the fourth pregnancy. Regarding the deliveries already experienced by pregnant women in this study, 12 were natural and 3 were cesarean deliveries. According to the MOH, one of the criteria for the effectiveness of prenatal care relates to the incentive to normal delivery and reducing unnecessary cesarean deliveries.[1] Regarding the choice of the type of delivery, the nurse is responsible for disseminating, during the pre-natal, the benefits and advantages related to normal childbirth, which is part of a physiological process, with low rates of infection when compared to a cesarean delivery.[2]

When asking to multiparous women if they had attended prenatal care in the previous pregnancy, all responded positively. Most of them attended intercalated prenatal consultations

between nurse and doctor, as recommended by the Ministry of Health.[1] From the analysis of the messages issued by pregnant women in this study, taking as basis the parameters of adequacy of prenatal care as recommended by the MOH, two thematic categories emerged: potentialities that qualify the prenatal consultation and weaknesses found by pregnant women in the prenatal consultation.

Potentialities that qualify the prenatal consultation

The PNHP establishes that all pregnant women assisted by the Unified Health System has the right to worthy and quality access and service during their pregnancy, delivery and puerperium. This assistance should be carried out in a humane, organized and safe way. Every health unit must receive the pregnant woman with dignity, by means of welcoming conducts.[4]

A high-quality prenatal care needs to be built by means of linked practices that involve the subjective, social, economic and cultural dimensions of pregnant women and their families. It is of fundamental importance that the multidisciplinary team develop the care to pregnant women since the discovery of pregnancy up to the puerperal period, integrally. This articulation of multidisciplinary knowledge tends to awaken new visions for the practice of prenatal care, which potentiates the assistance.[15] Based on the potential of prenatal care, in this category was possible to know the perceptions of pregnant women regarding the consultation developed in the PHC. The proper care of professionals configures a potential to the interpersonal relationship, as can be seen in the following statements:

> *They all meet me greatly, I have never been ignored, nor mistreated, neither by the employees, nor by doctors, nurses.* (GESTA.15)

> *The way the nurses treat me, they help me when I am in pain. The professionals from the reception are very polite, which is a great aspect for me.* (GESTA.06)

> *The nurse met me very well and explained all my tests clearly.* (GESTA.03)
>
> *The nurses are very kind, they ask, answer your doubts, they gave me their What's App number so that we can keep in contact in case something happens, they prescribed some medicines. I have nothing to complaint about. (GESTA.20)*
>
> *A positive point of this place is the service, which is wonderful, I like it a lot, the nurses talk, we feel very welcomed. (GESTA.14)*

The statements show that pregnant women are satisfied with the reception provided by the healthcare professional in prenatal consultations, characterizing a potentiality. According to the MOH, the reception represents a guideline of the PNHP and should be part of all health care to pregnant women. It implies in active listening of users, in the ethical conducts of professionals, recognition of the role of women in the resolution of problems and sharing of knowledge.[4]

A study[16] of prospective cohort of live births with gestational age from 23 to 31 weeks, birth weight from 500 to 1.499g, without malformations, was conducted at 19 public maternity hospitals in nine capital cities in Northeast Brazil, in the period from July to December 2007. The authors highlight that the quality of prenatal care, according to pregnant women, is linked to the integral assistance of the nurse. This assistance shall be provided in a humanized way through listening, look, touch and conversation about the health of the pregnant woman and her baby, providing information necessary for it to feel safe and have all questions answered.

The adherence of pregnant women to health services that offer prenatal consultation is influenced mainly by the empathy that they feel from professionals and the Health Unit. The humanized care and the reception are directly related to the construction of bonds, allowing for proper monitoring of the pregnancy. The professionals involved in care should be prepared to ensure the comprehensiveness of care, supported by good interpersonal relationship.[17] Some of

the women reported having chosen that determined health service to carry out their pre-natal due to the easy scheduling of consultations and access. These data were characterized as potentialities found in prenatal care, according to the following statements:

> *the service is fast, we schedule the consultations and it always work out, the doctors are never absent.* (GESTA.17)
>
> *here, it is near my home, it is easier for us to schedule the appointment, and they always treat us well.* (GESTA.18)
>
> *here is near home, the nurse is very kind, comprehensive, she talks to us nicely. When we get to the reception, they give us priority too. (GESTA.09)*
>
> *this new test thing, of the Rede Cegonha, which is for free for us, is great..* (GESTA.05)
>
> *many people have difficulty to get the test result, to schedule, I have no problem. All the tests I underwent I was able to schedule and receive on the same day, I have always undergone all tests. I was welcomed in all my consultations.* (GESTA.08)
>
> *this thing of free laboratory tests is wonderful.* (GESTA.04)

The easy access to health services reported by pregnant women is a potentiating determinant for the adherence to the pre-natal. These statements are in accordance with the recommendations of the MOH, which states that all pregnant women should be met in their coverage area. Health teams are responsible for ensuring the continuity of prenatal care to all pregnant women, the coverage area of the health units, which carry out the pre-natal.[1]

The speech of GESTA.05 highlights the importance of the RC as one of the strategies that favor the qualification of prenatal care. According to Decree 1,459/2011, RC, in its component I, one of the healthcare actions in pre-natal is: provision of examinations requested by professionals

during the consultation and access to results at an opportune time that should be guaranteed by the Health Units.[6]

The pregnant women in this study that benefited from the activities in the groups of pregnant women considered essential their integration in the group during the prenatal period. They stated that the discussions of various topics by professionals of the multiprofessional team were very enriching, supplying the gap left during the consultation such as the rights of pregnant women, maternity reference for delivery, breastfeeding and dental monitoring, which were highlighted as potentialities in the statements below:

> *I find the group important, we exchange knowledge and our doubts are answered, we get to know about many things we did not know about. They advised us to read the notebook of pregnant women, which says a lot about our rights.* (GESTA.14)

> *It is good here because we have lectures in which they guide us, I did not know about them, the nurse told me about it, that i show I started to come to the lectures, I like it a lot and I have also learnt a lot. It is further guidance, you do not become mother suddenly, this guidance will last for our child and ourselves.* (GESTA.12)

> *in the lectures, I have learnt a lot because we had dentists, speech and language therapist, nurses. Today, it was about breastfeeding, I like it and encourage the others to participate too.* (GESTA.20)

> *about the meeting of pregnant women, it changed many things in my life, because I used to have doubts about pregnancy, which were answered in this group.* (GESTA.18)

> *in the group I participated during the lecture, they guided me about everything, you know? Since the beginning of the pregnancy, until the delivery, they explain everything, I like it so much.* (GESTA.06)

> *here, we have meetings with prgnant women that are great moments when we can all learn together. We can visit the maternity hospital where we are going to give birth. (*GESTA.16)

> *the group is wonderful, because we learn about baby care in the first days of life, we cannot use pacifier, baby bottle, the importance of breastfeeding and the care with the nipple, that we should not use soap, only the breast milk to hydrate.* (GESTA.13)

The statements show that women's participation in the groups of pregnant women allows for the approximation and the strengthening of the bond with the health unit and allows professionals to develop their role as educator. These meetings of pregnant women aim to guide their actions, raising discussions and answering questions about the gestational period, in order to cover their needs. In addition to being a moment of exchange of experience, the group of pregnant women allows these women to be multipliers of knowledge.[18] One highlights the importance given by pregnant women to the guided use of the Notebook of Pregnant Women as facilitator and intensifier for good prenatal follow-up once it contains fundamental issues, such as their rights: labor, social, student, priority in health services, to receive information and to visit the reference maternity hospital before delivery, to have a companion during labor, delivery and postpartum, in the UHS.[11]

This category presented the potentialities of prenatal consultation pointed out by pregnant women, referring to easy access to health services and good interaction with the professional. The quality of prenatal care was based on the care provided by health professionals, with the nurse as one of the professionals responsible for improving the care provided to women.

Weaknesses found by pregnant women in the prenatal consultation

This category evidenced several aspects that can be considered as weaknesses in prenatal care. Most pregnant women highlighted the lack of organization of health services for prenatal

care, such as lack of nursing office to meet the pregnant women and the prolonged waiting time to begin consultations, the lack of guarantee and difficulty to schedule complementary tests; unsatisfactory physical structure and the lack of essential medicines for use in pregnancy, as can be seen:

> *it is bad because they are not organized. When I was waiting in line, they made a huge mess because the room was supposed to be only for pregnant women, but there were several other appointments. People get here 6, 5 in the morning and the other person who gets here at 9 goes first, then they schedule an appointment for 7 o'clock, but begin the consultations at 8 or 9 o'clock.* (GESTA.02)

> *to be honest, the prenatal here is not that good, because they lack materials for a thorough consultation, such as metric tape to measure the belly.* (GESTA.08)

> *in relation to the place, it is not good, because of the structure, the ventilator is not always working, we often lack chairs to sit, because it is often overcrowded. It is the same thing with appointments, they take too long to schedule the consultations.* (GESTA.07)

> *we need to undergo pap smear, but they do not have it, and when they do, it takes about two months to get it ready; we need a faster test, but they do not have it. There is laways something missing, a water cooler, toilet paper, no flush water. The doctor prescribed ferrous sulphate and folic acid, but we have to buy it, even though there is a pharmacy in the office, but it has always lacked medicines since the beginning of my pregnancy.*(GESTA.16)

> *the pre-natal is not that good because I do not have enough information on my delivery.* (GESTA. 19)

The statements demonstrate dissatisfaction of pregnant women about the lack of care for their rights of citizenship, by both health management as professionals, which may reflect the lack of punctuality and attendance of pregnant women in prenatal consultation. These findings are contrary to what the MOH determines, in which all states and municipalities must have a

network of services organized for the development of such assistance, considering the following criteria: units that provide pre-natal care must be linked to maternity/hospitals, in accordance with the definition of the local manager; human resources must be guaranteed, as well as physical, material and technical resources for pre-natal, delivery and postpartum, establishing the minimum criteria for the operation of the PHC and maternity; ensuring care for all pregnant women who seek health services; ensuring the accomplishment of complementary tests for the assessment of the health condition of pregnant women and their newborn.[5]

The statements of pregnant women highlighted as a weakness the lack or deficiency of an essential equipment for the prenatal care, the Doppler Sonar, which aims to monitor the fetal vitality. Although all pregnant women reported that the most awaited and desired moment is the auscultation of their baby's heartbeats, they often felt disappointed for lacking an equipment or having a defective one, which prevented hearing the cardiofetal beats:

> *a negative point is that equipment to hear the baby's heartbeats, which keeps changing from a room to another.* (GESTA.14)

> *the bad thing is that the consultations is quick, they have never examined me, only to check the baby's heart, which could not be heard because the machine was not working.* (GESTA.17)

> *that machine to hear the child's heart, whcih we do not have in the offices. I think each office should have one*. (GESTA.09)

> *the bad thing is the ultrasound, because they request it today, but we only get to schedule in the next month through the UHS, but we end up not doing it on the right date, we need to disburse the money to do it, and I think the government could pay for it.* (GESTA.04)

The lack or deficiency of an evaluation of fetal vitality, as well as the obstetric physical examination, are aspects of extreme importance in monitoring of pregnant women. This reality is not specific of the study site, but a trend in the health system as a whole. The findings exposed

are similar to what was found in another study conducted in the municipality of Rondonópolis,[17] where there was a shortage of materials in the BHU for completion of prenatal care, such as Doppler Sonar or Pinard stethoscope which serve to check the cardiofetal beats. The units also had a single equipment, which was divided for all the teams.

Another weakness demonstrated in the statements was the access to obstetric ultrasonography through the UHS, once the interviewees reported difficulty to schedule the exam and the long wait to receive the results. This fact prevented pregnant women from undergoing the examination and having the result in time for evaluation in the next prenatal consultation. The obstetric ultrasound, as well as the laboratory tests, are part of the prenatal routine recommended by the MOH.

These data are compatible with what was found in the Family Basic Health Units in the city of Fortaleza, where there was dissatisfaction regarding the implementation of obstetric ultrasonography, dueto the need to seek private clinics for immediate result, generating discomfort for pregnant women who use the public health services, thus interfering in the quality of prenatal care. Such problems do not depend on the professional's good work, but on the link between health administrators and managers, so as to prioritize and organize the laboratory assistance, so that they can meet in a timely manner the needs of the pregnant woman.[16]

Other weaknesses detected in the speeches of pregnant women, which are indispensable for the development of prenatal care, were related to infrastructure and the insufficient number of professionals for the completion of the consultations:

> *the bad aspect regards the structure. I see many old things, already deteriorated, in the offices; we can see that the equipment is not good.* (GESTA.06)

> *I think that the structure is a negative point, we have not enough chairs for all pregnent women and other people who need the service. There is no ventilation on the outside.* (GESTA.14)
>
> *it is bad we do not have a ventilator outside, it is too hot for us to bear, too sultry.* (GESTA.13)
>
> *a pretty bad aspect is that we do not have a ventilator in the waiting room.* (GESTA.20)
>
> *the water is bad, strange, the facilities are bad, we have no AC here, we should have at least a ventilator.* (GESTA.19)
>
> *too many people for few nurses. Sometimes, we come on the day but there are no more schedules.* (GESTA.05)
>
> *a negative point is the small number of nurses, we need more nurses and doctors in here. (*GESTA.18)

The statements demonstrate the shortage of human and material resources for the efficient development of work in the PHC. These contradict the PNHP, which establishes that a humanized assistance consists of providing quality service with linkage between technological advances and reception, improving care environments, working conditions of health professionals and with enough professionals to meet the demand in the BHU. Therefore, when there is unsatisfactory working conditions, there is also a difficulty to operationalize a qualified care.[19]

According to the MOH, for prenatal care to be developed effectively, health services need to have adequate physical area to meet pregnant women and their companions, with satisfactory conditions of hygiene and ventilation; minimum equipment and instruments for reception, listening and qualified consulting, such as table, chairs, gynecologic table, metric tape, Sonar Doppler, basic medicines and vaccines.[1]

According to the perceptions of pregnant women, it was possible to identify several weaknesses in prenatal care, such as lack of organization of health services, poor physical structure, and lack of human and material resources. The intervention of health institutions in the resolution of the weaknesses detected is a factor that contributes strongly to the improvement of the quality of prenatal care in the PHC.

Final thoughts

The statements of pregnant women showed that the potentialities found in prenatal care in the surveyed sanitary district were characterized by reception, support, active listening, clarification of doubts, nursing consultation, easy access to the BHU, access to exams though *Rede Cegonha*, access to groups of pregnant women, although the latter has been limited to a small number of pregnant women.

With regard to the weaknesses in prenatal care, there was lack of organization of the PHC for prenatal care, lack of material resources to carry out the consultation, of essential medicines for use in pregnancy and specific nursing office; prolonged waiting time to begin consultations; delay and non-accomplishment of examinations; poor infrastructure and insufficient number of professionals.

Despite the potentialities found in the prenatal service offered by the PHC, the weaknesses outlined in the perception of pregnant women, who pointed out them more easily. Considering potentialities and weaknesses in the operationalization of prenatal care, although most pregnant women were satisfied with the prenatal consultation, the data reveal many limitations in various aspects concerning the parameters of adequacy of prenatal care, recommended by the MOH.

As limitation, difficulties to include participants due to the specificity of the sample, once they are pregnant women in the third quarter. However, seizing the experiences of pregnant

women about prenatal care, as well as the importance and understanding of care consistent with this health practice was transformer, broadening the understanding of reality as its accomplishment in prenatal care. The evaluation of prenatal care from users' point of view is an excellent tool for the analysis of the quality of health services directed to pregnant women. Thus, they contribute to the awareness and training of professionals involved in prenatal management and assistance and to the development of new researches related to the implementation of actions and strategies recommended by the MOH, promoting the improvement of services of assistance to pregnant women.

References

1. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Atenção ao pré-natal de baixo risco. Brasília (DF): Ministério da Saúde; 2012.

2. Mascarenhas PM, Silva GR, Reis TT, Casotti CA, Nery AA. Análise da Mortalidade Materna. Rev Enferm UFPE Online [Internet]. 2017 [acesso em 2017 out 10];11(11):4653-62. Disponível em: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/download/231206/25208.

3. Ferreira ABH. Dicionário da língua portuguesa. 5ª ed. Curitiba: Positivo; 2010. 2222p.

4. Brasil. Ministério da Saúde. Portaria n. 569, de 1 de junho de 2000. Institui o Programa de Humanização no Pré-Natal e Nascimento no âmbito do Sistema Único de Saúde [Internet]. 2000 [acesso em 2017 nov 20]. Diário Oficial da União, Brasília (DF); 2000 jun 01. Seção 1, p. 4-6. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2000/prt0569_01_06_2000_rep.html.

5. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Pré-natal e puerpério: atenção qualificada e humanizada. Brasília (DF): Ministério da Saúde; 2005.

6. Brasil. Ministério da Saúde. Portaria n. 2.351, de 5 de outubro de 2011. Altera a Portaria nº 1.459, de 24 de junho de 2011, que institui, no âmbito do Sistema Único de Saúde (SUS), a Rede Cegonha [Internet]. 2011 [acesso em 2017 dez 05]. Diário Oficial da União, Brasília (DF); 2011 jul 27. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt2351_05_10_2011.html.

7. Rosand GB, Slinning K, Roysamb E, Tambs K. Relationship dissatisfaction and other risk factors for future relationship dissolution: a population-based study of 18.523 couples. Soc Psychiatry Psychiatr Epidemiol. 2014;49(1):109-19.

8.Barreto CN, Ressel LB, Santos CC, Wilhelm LA, Silva SC, Alves CN. Prenatal care in the voice of pregnant women. Rev Enferm UFPE Online [Internet]. 2013 [acesso em 2017 out 10];7(5):4354-63. Disponível em: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/view/11674/13850.

9.Bardin L. Análise de Conteúdo. Lisboa: Edições 70; 2009. 281p.

10. Brasil. Ministério da Saúde. Secretaria de Atenção a Saúde. Departamento de Ações Programáticas Estratégicas. Gravidez, parto e nascimento com saúde, qualidade de vida e bem-estar. Brasília (DF): Ministério da Saúde; 2013.

11. Brasil. Ministério da Saúde. Caderneta da Gestante. 3ª ed. Brasília (DF): Ministério da Saúde; 2016.

12. Brasil. Ministério da Saúde. Resolução 466, de 12 de dezembro de 2012. Aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos [Internet]. 2012 dez 12 dez [acesso em 2017 out 10]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/cns/2013/res0466_12_12_2012.html.

13. Alkema L, Chou D, Hogan D, Zhang S, Moller AB, Gemmill A, et al. Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group. Lancet. 2016;387(10017):462-74.

14. Santos JO, Pacheco TS, Oliveira PS, Pinto VL, Gabriellone MC, Barbieri M. The obstetrical and newborn profile of postpartum women in maternities in São Paulo. Rev Pesqui Cuid Fundam [Internet]. 2015 jan [acesso em 2017 out 10];7(1):1936-45. Disponível em: http://www.seer.unirio.br/index.php/cuidadofundamental/article/view/3547/pdf_1432.

15. Santiago CMC, Sousa CNS, Nóbrega LLR, Salees L, Morais F. Assistência pré-natal e as práticas desenvolvidas pela equipe de saúde: revisão integrativa. Rev Pesqui Cuid Fundam [Internet]. 2017 jan [acesso em 2017 out 29];9(1):279-88. Disponível em: http://www.seer.unirio.br/index.php/cuidadofundamental/article/view/4184/pdf_1.

16. Castro ECM, Leite AJM, Guinsburg R. Mortalidade com 24 horas de vida de recém-nascidos pré-termo de muito baixo peso da Região Nordeste do Brasil. Rev Paul Pediatr. 2016;34(1):106-13.

17.Oliveira JCS, Fermino BPD, Conceição EPM, Navarro JP. Assistência pré-natal realizada por enfermeiros: o olhar da puérpera. Rev Enferm Cent-Oeste Min. 2015 maio-ago;5(2):1613-28.

18.Campos ML, Veleda AA, Coelho DF, Telo SV. Percepção das gestantes sobre as consultas de pré-natal realizadas pelo enfermeiro na atenção básica. J Nurs Health. 2016;6(3):379-90.

19. Feliciano NB, Pradebon VM, Lima SS. Enfermagem no pré-natal de baixo risco na estratégia Saúde da Família. Aquichan. 2013;13(2):261-9.

Autor correspondente
Andressa Arraes Silva
E-mail: andressinha_arraes5@hotmail.com
Endereço: Avenida 01, quadra 30, casa 09, COHAB 2
CEP: 65700000

Authorship contributions

1 – Andressa Arraes Silva

Main author, participating since the research planning until the elaboration of the product submitted as article.

2 – Mara Julyete Arraes Jardim

Analysis and organization of the data for arrangement of final information of the article.

3 – Claudia Teresa Frias Rios

Data analysis and interpretation, writing and critical review of the article.

4 – Lena Maria Barros Fonseca

Advisor, participating sicne the research planning until the elaboration of the submitted article.

5 – Liberata Campos Coimbra

Data analysis and interpretation, writing and critical review of the article.

How to cite this article

Silva AA, Jardim MJA, Claudia Rios TF, Fonseca LMB, Coimbra LC. Prenatal care of habitual- risk pregnant women: potentialities and weaknesses. Rev. Enferm. UFSM. 2019 [Acess at: 2019 jun 15];vol ex:p1-p19. DOI:https://doi.org/10.5902/2179769232336