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# Nurses' perspective on prenatal care under the Family Health Strategy

Perspectiva dos enfermeiros sobre a assistência pré-natal no âmbito da Estratégia Saúde da Família

Perspectiva de los enfermeros sobre la asistencia prenatal en el ámbito de la Estrategia Salud de la Familia

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**Abstract: Objective:** to evaluate prenatal care from the perspective of nurses within the scope of the Family Health Strategy. **Method:** descriptive, exploratory study with a quantitative approach, conducted with 29 nurses in 20 Family Health Strategies in 2016. Data collected through a questionnaire was analyzed with the aid of the Statistical Package for Social Sciences for Personal Computer program. **Results:** it was emphasized that 55.2% of nurses considered human resources insufficient. It was observed that 41.4% of the units had a rapid test for Syphilis and Human Immunodeficiency Virus; 69% material for gynecological examination, which was performed by 55.2% of professionals. **Conclusion:** the assessment of prenatal care, from the nurses' perspective, made contributions to the recognition of the limits and possibilities for adherence to prenatal care as recommended by the Ministry of Health, with a view to reducing risks to maternal and fetal health.

**Descriptors:** Nursing; Prenatal care; Primary health care; Family Health; Public health

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**Resumo: Objetivo:** avaliar a assistência pré-natal na perspectiva dos enfermeiros no âmbito da Estratégia Saúde da Família. **Método:** estudo descritivo, exploratório de abordagem quantitativa, realizado com 29 enfermeiros em 20 Estratégias Saúde da Família no ano de 2016. Analisou-se os dados coletados por meio de questionário com o auxílio do programa *Statistical Package for Social Sciences for Personal Computer.* **Resultados:** ressaltou-se que 55,2% dos enfermeiros consideraram insuficientes os recursos humanos. Foi observado que 41,4% das unidades possuíam teste rápido para Sífilis e Vírus da Imunodeficiência Humana; 69% material para realização de exame ginecológico, sendo este realizado por 55,2% dos profissionais. **Conclusão:** a avaliação da assistência pré-natal, na perspectiva dos enfermeiros, apresentou contribuições para o reconhecimento **dos limites e possibilidades para a adesão ao pré-natal conforme recomendado pelo Ministério da Saúde, com vistas à redução de riscos à saúde materno-fetal.**
**Descritores:** Enfermagem; Cuidado pré-natal; Atenção primária à saúde; Saúde da família; Saúde pública

**Resumen: Objetivo:** Evaluar la asistencia prenatal en la perspectiva de los enfermeros en el ámbito de la Estrategia Salud de la Familia. **Método:** Estudio descriptivo, exploratorio de abordaje cuantitativo, realizado con 29 enfermeros en 20 Estrategias Salud de la Familia en el año de 2016. Se ha analizado los datos recogidos por medio de cuestionario con el auxilio del programa *Statistical Package for Social Sciences for Personal Computer.* **Resultados:** Se ha resaltado que 55,2% de los enfermeros consideraron insuficientes los recursos humanos. Ha sido observado que 41,4% de las unidades poseían test rápido para Sífilis y Virus de la Inmunodeficiencia Humana; 69% material para realización de examen ginecológico, siendo esto realizado por 55,2% de los profesionales. **Conclusión:** La evaluación de la asistencia prenatal, en la perspectiva de los enfermeros, presentó contribuciones para el reconocimiento **de los límites y posibilidades para la adhesión al prenatal conforme recomendado por el Ministerio de la Salud, con el objetivo de la reducción de riesgos a la salud materno fetal.**
**Descriptores:** Enfermería; Cuidado prenatal; Atención primaria a la salud; Salud de la familia; Salud pública

## Introduction

Prenatal care comprises a set of actions aimed at women's health in order to reduce maternal and fetal morbidity and mortality. The dynamics of care involves the biopsychosocial perspective, being an event that crosses the biological dimension and implies the recognition of physiological conditions, psychosocial, economic and access to health information, enabling the prevention and early treatment of pregnancy disorders, which are influenced by the personal history of the pregnant woman and her obstetric past, in which the context of the pregnancy, the age, the bond with the partner and the current moment are essential to understand the pregnant-puerperal cycle.[1-2]

In Brazil, adequate prenatal care is more frequent among white women (87.8%) who have had prenatal care in the private network. The regions of the country with the lowest frequencies

are: North (69.5%) and Northeast (76.1%), respectively, while the Southeast region has the highest frequency (86.3%).[3]

Despite the reduction in maternal mortality, between 1990 and 2015, the number of deaths worldwide is still alarming. According to the Pan American Health Organization (PAHO), in 2018, approximately 830 women died daily as a result of events related to pregnancy and childbirth, with 99.0% of these deaths in low and middle income countries. In Brazil, despite the reduction in maternal mortality, as of 2016 there was a considerable increase in the number of cases.[3] The monitoring of pregnant women in the context of Public Health demands the early identification of undesirable events, multi-professional assistance and enhancement of the continuous record of assistance in the prenatal cards of the pregnant woman.[4]

With a view to improving maternal health, the United Nations (UN), in 2015, launches a global agenda that brings together goals for sustainable development to be achieved by the year 2030. The perspective is that, based on integrated actions that address the promotion of health and well-being, the maternal health rate will be reduced to less than 70 deaths for every 100,000 live births worldwide.[5]

In the search to achieve the objectives agreed worldwide, as well as to guarantee health to women during the pregnancy-puerperal period, in Brazil prenatal care is a right recommended by the Unified Health System (UHS) and has primary health care (PHC), preferably covered by the Family Health Strategy (FHS), a gateway to longitudinal care for low-risk pregnant women, with monthly consultations up to the 28th week, biweekly between 28th and 36th weeks and weekly from the 36th until delivery.

In addition, during the prenatal period, the partner's right to be cared for through consultations, laboratory tests and access to health education practices is guaranteed. This attention to women contributes to the favorable perinatal and maternal outcome, due to the identification of risk factors that can cause complications to pregnancy, in addition to allowing

the detection and timely treatment of complications.[6-7]

In order to promote maternal health, it is necessary to comply with the recommended number of prenatal consultations, to ensure the prevention, diagnosis and treatment of intercurrent diseases of pregnancy and the establishment of a maternal immunization program. Adequate prenatal care is given by incorporating welcoming conducts and building spaces for groups of pregnant women, to share experiences, feelings, fears, expectations and doubts, in order to meet the main complaints and demands to promote a care plan individual and group support.[6,8-9]

In view of the need to face problems related to assistance during pregnancy, the Humanization Program for Prenatal care and Birth (HPPB) was implemented in Brazil. This program aims to ensure the improvement of access, coverage and quality of monitoring, in addition to the provision of assistance during childbirth and the puerperium (to pregnant women and the newborn), to achieve an integrated, qualified and humanized obstetric care.[10]

As a complement to PHPN, the federal government has been implementing the Stork Network Program since 2011, which aims to foster the implementation of a new model of health care for women and children, from childbirth to 24 months of age. The aim is to organize the Maternal and Child Health Care Network to guarantee access, reception, resolution and reduce maternal and child mortality, with emphasis on the neonatal component.[10]

In this program, the nurse is highlighted in terms of low-risk prenatal care, since it serves the majority of pregnant women in the FHS. Therefore, this study was the basis for low-risk prenatal care according to what is recommended by the Primary Care Notebook (PCN) of the Ministry of Health (MH), in order to evaluate the attributes that impact the reduction of unfavorable obstetric results. The quality of care for pregnant women is closely related to the health levels of mothers and babies, and its investigation is a powerful guiding tool for managers and health professionals.[6]

Despite wide coverage, prenatal care in Brazil still presents a context of inequities and a

low supply of adequate care, especially among black women living in the poorest regions of the country.[3] Given the above, it is necessary to evaluate the execution of care and actions that aim at comprehensive care in an equitable way within the UHS and in the context of the Northeast region of the country. Thus, it presents itself as a research question: how prenatal care is offered from the perspective of nurses within the scope of the FHS? This study aimed to: evaluate prenatal care from the perspective of nurses within the scope of the FHS.

## Method

This is a descriptive, exploratory study with a quantitative approach, carried out in the Sanitary District II (SD II) of the city of Recife, Pernambuco (PE), Brazil. The population consisted of 42 nurses assigned to the 20 FHS and the sample consisted of 29 participants (seven professionals refused to participate in the research; four were on sick leave and two were on vacation). Those who met the following inclusion criteria were invited to participate in the research: exercise their activities in the FHSs belonging to the SDII. Those on vacation and those on sick leave during the research period were excluded.

For collection of primary data, a questionnaire prepared by the researchers with open and closed questions was used, with a total of 58 questions, elaborated from the PCN: attention to low-risk prenatal care, edited by the MH,[6] focusing on the attributions of the nursing professional in the care of pregnant women.

The questionnaire was organized considering the following variables: Profile of nurses (age, sex, training institution, postgraduate courses and length of experience in PHC); Organization of services, planning and programming (physical structure of the units, human resources, equipment and materials available at the FHS, the planning and programming of activities); Reception (form of reception of the pregnant woman and her companion); Prenatal care (pregnancy diagnosis, classification of gestational risk, first and subsequent consultations,

assessment of nutritional status, gynecological examination and collection of materials for oncotic colpocytology, clinical breast examination) and Educational actions (topics covered and the way these activities are developed).

The research data collection was carried out from October to November 2016. The collection time was extended to 60 days, because some FHS had to be visited more than twice, due to the difficulty in locating the nursing professional, who was on home visits or in other activities.

Data analysis was performed by building a database in the Statistical Package for Social Sciences for Personal Computer (SPSS-PC),[11] version 22. The purpose of using this program was to obtain agility in the interpretation and analysis of the information collected. After coding, data was analyzed statistically from which its relative and absolute frequencies were obtained. The tables were presented using the Excel 2010 program.

The research was guided by ethical aspects and legal implications according to the National Health Council of nº. 466, of December 12, 2012 which approves the guidelines and standards for research involving human beings and approved by the Ethics Committee of the Oswaldo Cruz University Complex Hospital, Cardiology Emergency Room of Pernambuco, on 08/09/2016 with Opinion nº 1,716,887.

## Results

The participants in the present study were aged between 26 and 65 years, with the majority belonging to the age group of 26 to 45 years (51.7%). There was a predominance of female nurses (96.6%), graduated from a public university (62.1%), with title of specialists / residents (93.1%).

Table 1 shows that 75.9% of respondents were dissatisfied with the FHS physical area. When consulted about human resources, more than half (55.2%) answered that they are not sufficient for adequate care. As for material resources, 69.0% have material for gynecological

examination. Regarding the efficiency of the referral and counter-referral system, 20.7% of nurses considered the system to be efficient. During prenatal consultations, 100.0% of the participants answered that they perform a risk classification. When asked if they frequently consulted the Low Risk Prenatal PCN, 34.5% answered that they did not.

**Table 1** - Distribution of the frequency of aspects related to the adequacy of the organization of services, planning and programming of prenatal activities. Sanitary District II, Recife, Brazil, 2016.

| Variables | n | % |
|---|---|---|
| **Adequacy of the physical area** | | |
| Yes | 7 | 24.1 |
| No | 22 | 75.9 |
| **Human Resources** | | |
| Yes | 13 | 44.8 |
| No | 16 | 55.2 |
| **Material resources** | | |
| Gynecological Table | 29 | 100.0 |
| Spotlight | 28 | 96.6 |
| Sphygmomanometer | 28 | 96.6 |
| Adult scale | 27 | 93.1 |
| Flexible and inelastic measuring tape | 22 | 75.9 |
| Sonar Doppler | 22 | 75.9 |
| Gestogram or Obstetric Disc | 22 | 75.9 |
| Material for gynecological examination | 20 | 69.0 |
| **Efficiency of the Reference and Counter-reference system** | | |
| Yes | 6 | 20.7 |
| No | 23 | 79.3 |
| **Gestational Risk Classification** | | |
| Yes | 29 | 100.0 |
| **Use of the Primary Care Notebook** | | |
| Yes | 18 | 62.1 |
| No | 10 | 34.5 |
| Did not answer | 1 | 3.4 |

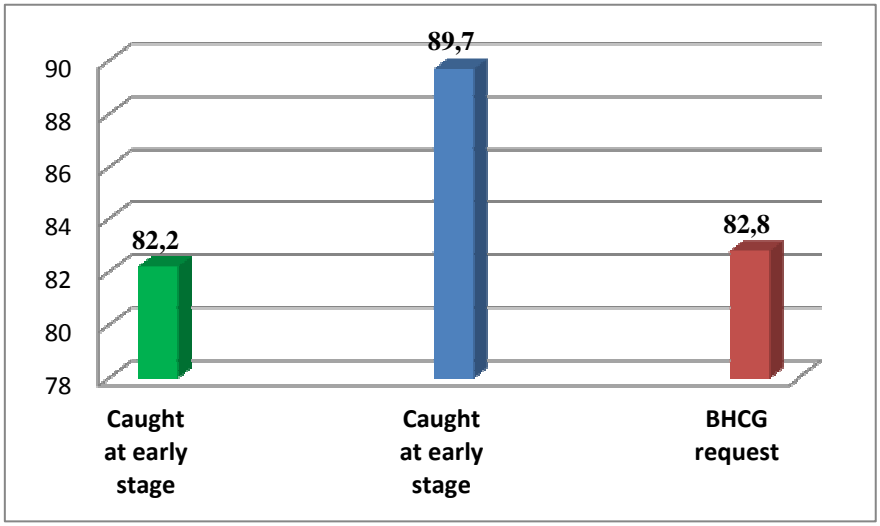
Source: Primary data

Regarding the immediate reception of pregnant women, it was observed that 7.0% of the participants answered that they do not. Regarding the reception of the woman's companion for participation in prenatal care, 96.6% of the professionals answered that they do so.

Graph 1 shows the distribution of items related to prenatal care in relation to early

uptake and the diagnosis of pregnancy by offering a rapid pregnancy test and requesting the Beta Human Chorionic Gonadrotopin (BHCG). It was observed that 82.2% of pregnant women were caught early by the professionals and that in more than 80.0% of these women were asked to prove pregnancy tests.

**Graph 1** - Distribution of the characteristics of prenatal care, in relation to early uptake, and pregnancy diagnosis in the FHS of the DSII, Recife, 2016.




Source: primary data

Table 2 shows the results related to filling out the prenatal clinical form, registering the reference maternity on the pregnant woman's card, prenatal consultations and performing preventive exams. It is observed that the majority of nurses reported completing the prenatal clinical form, requesting complementary exams and registering the reference maternity (93.1%, 93.1% and 79.3%, respectively).

**Table 2** - Distribution of characteristics of prenatal care provided by nurses in the FHS of the SDII, Recife, 2016.

| | **n** (Yes) | **%** (Yes) |
|---|---|---|
| **Completion of the PN Clinical record** | 27 | 93.1 |
| **Request for Complementary Exams** | 27 | 93.1 |
| **Reference maternity registry** | 23 | 79.3 |
| **First consultation** | | |
| Anamnesis | 28 | 96.6 |
| Vitamin supplementation | 29 | 100.0 |
| Interwoven consultations with the Doctor | 25 | 86.2 |
| Offer fast testing for syphilis / HIV* | 12 | 41.4 |
| **Subsequent consultations** | | |
| Targeted Physical Exam | 29 | 100.0 |
| Control of vaccination schedule | 29 | 100.0 |
| Evaluation of laboratory tests and others | 29 | 100.0 |
| Assessment of emotional state | 29 | 100.0 |
| Active search | 28 | 96.6 |
| Assessment of nutritional status | 25 | 86.2 |
| **Preventive tests** | | |
| Oncotic cytology | 16 | 55.2 |
| Clinical breast examination | 28 | 96.6 |

*HIV: *Human Immunodeficiency Virus*

Source: Primary data

Regarding the complementary tests requested in the first consultation, as recommended by the Low Risk Prenatal CAB, the most cited regarding the request were: blood count (86.2%), blood typing and Rh factor (86.2%), fasting blood glucose (86.2%), serologies that include screening for syphilis and or Venereal Disease Research Laboratory (VDRL) (89.7% ), anti-HIV (Human Immunodeficiency Virus) (89.7%), toxoplasmosis (86.2%), serology for hepatitis B (HbsAg) (82.8%) and urine summary (82.8%). Those cited less frequently were: urine culture (75.9%), hemoglobin electrophoresis (58.6%), obstetric ultrasound (51.7%) and parasitological stool examination (27.6%). The question about the complementary exams was not answered by 10.3% of the participants.

Regarding the targeted and specific physical examination, clinical and obstetric, it was found that 100% of nurses refer to their performance. Among the most frequently performed

procedures are the control of blood pressure, obstetric palpation and measurement of uterine height, auscultation of heartbeat and verification of edema. When asked about what educational activities, 89.7% of nurses reported that they perform individual activities and 13.8% of respondents did not answer about activities in groups and waiting room as described in Table 3.

**Table 3** – Distribution of educational activities and topics addressed in groups in Family Health Units in the Sanitary District II, Recife-PE, Brazil 2016.

| Variable | n | % |
|---|---|---|
| **Educational activities** | | |
| Individual | | |
| Yes | 26 | 89.7 |
| No | 3 | 10.3 |
| In group and waiting room | | |
| Yes | 15 | 51.7 |
| No | 10 | 34.5 |
| Did not answer | 4 | 13.8 |
| **Theme of educational activities** | | |
| Breastfeeding | 29 | 100.0 |
| Healthy Habits | 28 | 96.6 |
| Family Planning | 27 | 93.1 |
| Newborn care | 27 | 93.1 |
| Importance of Prenatal care | 26 | 89.7 |
| Signs of Labor | 26 | 89.7 |
| Risks associated with pregnancy and childbirth | 25 | 86.2 |
| Self-medication risks | 25 | 86.2 |
| Risks of alcohol and drugs | 25 | 86.2 |
| Sexual activity and STI / AIDS prevention* | 24 | 82.8 |
| Rights of the pregnant woman and the father | 22 | 75.9 |
| Domestic and sexual violence | 16 | 55.2 |

* STI: Sexually Transmitted Infections / AIDS: Acquired Immunodeficiency Syndrome
Source: primary data

Among the various educational themes that should be addressed in prenatal care, the following stand out: guidelines on breastfeeding (100%), followed by guidelines on healthy habits, family planning, newborn care, prenatal importance, among others. The themes such as the rights of the pregnant woman and the father and domestic and sexual violence were the least addressed (Table 3).

## Discussion

In the present study, it was possible to analyze the quality of the prenatal care process in the city of Recife from the perspective of FHS nurses located in the SDII. To this end, the recommendations in the Low Risk Prenatal PCN were used as a reference, which deals with the organization of the work process, the health service and planning aspects, established by the MH to monitor pregnant women with low gestational risk and possible complications. In addition, aspects related to health promotion, special pregnancies and legal aspects related to pregnancy, childbirth / birth and the puerperium were evaluated.[10]

In this research most of the participants were female. It is evident the female predominance in nursing and the context of women's participation in health care activities. This aspect may be related to its insertion in the labor market and the possibilities of activities outside the domestic scope, given the assistance nature and role of caregiver historically assigned by society.[12]

In the studied scenario, low adherence to the National Program for Improvement of Access and Quality of Primary Care (PIQC) was identified. The small adherence to the strategic focuses of prenatal care, to the strategic initiatives and programs of the MH, such as Stork Network and Pact for Life, can contribute to risks of morbidity and mortality and adverse maternal and child outcomes that could be avoided.[13]

Regarding the organization of services, planning and programming, the lack of adequate infrastructure and insufficient human resources was highlighted. These difficulties alluded to by these nurses may reduce the quality of care provided to the population, as they hinder care, comprehensive monitoring and problem solving. In addition, the inadequacy of some physical spaces, their unavailability, due to the low number of rooms for service and limited spaces for group activities, are factors that hinder the quality of care.[14]

A study carried out at the national level showed inadequacy of the infrastructure of the

primary care network that offers prenatal care in all geopolitical regions of Brazil. In addition, he mentioned the precariousness of the adequacy of clinical actions for the quality of care and insufficient management capacity of the teams to guarantee access. There was also a direct relationship between adequacy of infrastructure and social contexts with higher Municipal Human Development Index and income.[15] The monitoring of the pregnant woman and the mother / child binomial occurs in a longitudinal way, and the environment is suitable for carrying out the detailed physical examination, during the nurse's consultations, a fundamental strategy to reduce maternal and neonatal morbidity and mortality.[8]

With regard to equipment and materials, health units must have at least: table and chairs for consultations; gynecological table; two-step ladder; light focus; anthropometric scale for adults; sphygmomanometer; clinical stethoscope; Pinard's stethoscope; measuring tape; specula; Cheron forceps; instruments for collecting material for Pap smear; gestogram or obstetric disc; and Doppler sonar (if possible).[6]

Data referring to material equipment showed that most FHS have the materials as recommended by the MH, and in 24.7% there was an absence of Doppler sonar, Pinard's stethoscope (37.9%) and collection materials for oncotic colpocytology (COC)(31%). Corroborating with a study from Ceará, in which the conceptions of pregnant women and nurses about prenatal care in PHC were evaluated, there was a lack of materials in the FHS, to check fetal heartbeat.[7] Most FHS have two teams and prenatal care is scheduled, due to the unavailability of the device for each team, the teams have to share, the professional has to leave the room and get the sonar with the other professional who is also in attendance.

Considering the issues related to the classification of gestational risk, management can be considered high, since all professionals performed it, corroborating with the literature.[15] The MH advises that the classification of gestational risk should be carried out in the first and subsequent consultations, in addition to ensuring access to the reference service for pregnant

women classified as at risk.[10]

Regarding the mechanism for coordinating care in the referral and counter-referral system, it is worth mentioning the low efficiency reported by nurses, in relation to the care for pregnant women. The results found corroborate with other studies.[15-16] The low efficiency of the referral and counter-referral process is indicative of failures in the dynamics of referrals and the return of information by specialists who participate in the service network, thus, improvements in the management of this process are necessary in order to ensure the effectiveness of longitudinal monitoring of pregnant women during prenatal care.[17]

The implantation of the electronic medical record can make prenatal care viable, especially for the referral and counter-referral system, as it allows the flow of information between the health services of the different levels of care.[16] In this sense, the link between the FHS and the other health reference centers must be guaranteed for comprehensive care for pregnant women during prenatal care, childbirth and the puerperium, within the scope of primary care and in maternity hospitals, as defined by the local manager.

In addition, it is essential that all pregnant women are oriented / referred to specialized care when they have clinical / obstetric complications or when in labor. These health care centers must provide a counter-reference to the unit of origin for continuity of care, in a comprehensive and longitudinal manner by the FHS of their territory.

About regular use during PCN consultations Attention to Low Risk Prenatal Care, it was observed that for most nurses this document is an important tool for conducting care. It is noteworthy that most professionals had specialization in the field of public health and have worked for more than 11 years in the FHS. Theoretical-practical basis based on standardized assistance, with consultation to the PCN, are fundamental for comprehensive assistance.[10]

The MH recognizes the organizational structure as a fundamental point to ensure a safe practice during prenatal care. In this perspective, a facilitating environment for integrated

health actions that consider aspects related to physical plant, human and material resources, laboratory support, and access to medication, registration instruments and the reference and counter-reference system is recommended.[15]

The ambience in health refers to the treatment given to the physical space, understood as a social, professional and interpersonal relations space that should provide welcoming, resolute and humane care. The quick reception is a guarantee of care for all newborns and all pregnant women and puerperal women who seek the FHS, recommended for effective prenatal care.

In the results, it was observed that 93.1% of the professionals immediately welcomed all pregnant women and women who had recently given birth. The quick reception is a guarantee of care for all newborns and all pregnant women and puerperal women who seek the FHS, recommended for effective prenatal care.[6]

Reception, as recommended in the humanization policy, implies the reception of women, since their arrival at the FHS.[16] Thus, the construction of the bond is important for a satisfactory prenatal care. Welcoming is, first of all, an ethical action to be performed by all members of the multi-professional team for qualified listening, in order to meet the needs of the pregnant woman. This action also implies the flow of work processes, teams, services and networks, aimed at the conception of the expanded clinic.

Considering early uptake, the diagnosis of pregnancy through the offer of rapid testing and BHCG request obtained satisfactory results in relation to the adequacy of prenatal care. This assistance includes the diagnosis of pregnancy, either by offering a quick test, or by requesting the BHCG in the face of signs of presumption and probability presented by the patient, these tests were implemented by the MH, through the stork network, to increase the early capture of pregnant women, as it speeds up the process necessary for the confirmation of pregnancy and the beginning of prenatal care.[6]

In this research, the frequency of reference maternity records mentioned on the pregnant

women card was higher than 79%. In another study, similar records were found, 87.3% of the mothers reported having received information about the reference maternity. Failure to do so may lead pregnant women to travel to health facilities at delivery or in case of emergencies.[15]

Prenatal screening for Sexually Transmitted Infections (STIs) is highly relevant. Detection of HIV and syphilis during prenatal care is essential to control vertical transmission.[15]

It is recommended that low-risk prenatal consultations be interspersed between the doctor and the nurse.[3] The results showed that 13.8% of professionals reported that there were no appointments interspersed with a doctor, however, teamwork in prenatal care in primary care contributes to the sharing of knowledge and comprehensive care. Thus, interspersed consultations could favor decision-making for better targeting of consultations, request for additional tests, case discussion, in addition to educational actions with themes aimed at reducing maternal and child morbidity and mortality.

With regard to the Pap smear exam, the results found showed that 44.8% of professionals do not perform it during pregnancy. According to the MH, this examination should preferably be carried out on the 7th month of gestation according to the individualized indication.[6]

The prevention or diagnosis of cervical cancer during pregnancy is recommended by the MH, especially for women with delayed preventive follow-up. However, many women still do not undergo the examination during pregnancy, out of shame or fear, embarrassment, difficulty in communication, discomfort among other factors and therefore, they may miss the opportunity for prevention.[6]

Performing the breast exam is important during pregnancy, as it allows the observation of changes and transformations during the pregnancy period. Modifications such as increased pigmentation of the areola and nipple, presence of visible superficial veins, presence of sebaceous glands in the areola, colostrum and anomalies that may hinder lactation, among others, and should therefore be practiced from the first consultation.[6] Another study carried out in the

Northeast region found that 50% of nurses performed the breast exam of pregnant women.[8]

It was evidenced that 90% of the pregnant women were satisfied with the nurse's care. However, it is essential to carry out other research that considers an empirical analysis about the performance of prenatal care, through permanent education with a view to qualifying care through action-reflection-action of their practices.[18]

Nurses must also be able to carry out home visits aimed at expanding assistance to the PN, when necessary, to avoid possible complications. In order to improve the quality of prenatal care, it is important to offer continuing education for managers, with an emphasis on the essential skills of prenatal care.[15-17] The implementation of permanent health education strategies must prioritize the critical-reflexive nature of the assistance anchored to the PHC precepts, agreed with the Stork Network and the knowledge and practices of the multidisciplinary team with a view to the quality of comprehensive care during prenatal care.[19]

## Conclusion

The evaluation of prenatal care, from the perspective of nurses in the FHS scope, presented contributions to the recognition of the limits and possibilities for adherence to prenatal care. This adherence, as recommended by the MH, aims to reduce risks to maternal and fetal health, considering the context of social vulnerability of a health district in the northeast of Brazil.

The unsatisfactory quality of prenatal care was evidenced, due to inadequate infrastructure, insufficient human and material resources, ineffective referral and counter-referral systems, in addition to the delay and failure to perform the recommended exams. Such findings refer to the social determination of the health-disease process and the need to share responsibility with the State, health professionals and health users in facing maternal and perinatal morbidity and mortality.

The permanent qualification of nurses for prenatal care must enable a satisfactory and humanized experience, which considers the meanings of motherhood and provides opportunities for health promotion and prevention of diseases and injuries.

A possible limitation was the performance of data collection in only one SD, with an emphasis on nurses and aspects related to prenatal care in this area. On the other hand, the results made it possible to evaluate the quality of the participants' assistance, which enabled comparisons with other studies. Further research is recommended related to the importance of permanent education practices for nurses for qualified prenatal care.

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