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Nursing care management for the quality of prenatal care in Primary Health Care[a]

Gestão do cuidado de Enfermagem para a qualidade da assistência pré-natal na Atenção Primária à Saúde

Gestión del cuidado de Enfermería para la calidad de la atención prenatal en Atención Primaria de Salud

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Abstract

Objective: to understand the meaning of Nursing care management for the quality of prenatal care in the view of Primary Health Care nurses. **Method:** a qualitative research developed with Grounded Theory and Edgar Morin's complex thinking. Participant observations and individual semi-structured interviews were conducted with 11 primary care nurses. Data analysis: open, axial and selective coding/integration and organization by NVIVO® software. **Results:** the central phenomenon "Promoting Nursing care management in Primary Health Care" showed that Nursing care management performed by nurses contributes to promote the autonomy of pregnant women, the quality of care, the protagonism and empowerment of mothers in the process of pregnancy, delivery, birth and breastfeeding, involving the participation of the family/support network in care. **Final considerations and implications for the practice:** care management performed by nurses seeks to accommodate the singularities of pregnant women/families and promote singular, multidimensional, continuous, vigilant, systematized and integrated care, valuing the subjectivity and the protagonism of women, based on the principles of maternal autonomy and empowerment. It is recommended the adequate dimensioning of personnel, the performance of health actions in an integrated/networked way, the effective communication between the different levels of care, and the intensified preparation for the physiological birth, the puerperium, and breastfeeding.

Keywords: Primary Health Care; Prenatal care; Nursing care; Obstetric Nursing; Quality of health care.

Resumo

Objetivo: compreender o significado da gestão do cuidado de Enfermagem para a qualidade da assistência pré-natal na visão de enfermeiras da Atenção Primária à Saúde. **Método:** pesquisa qualitativa desenvolvida com a Teoria Fundamentada nos Dados e o pensamento complexo de Edgar Morin. Realizaram-se observações participantes e entrevistas semiestruturadas individuais com 11 enfermeiras da atenção primária. Análise dos dados: codificação aberta, axial e seletiva/integração e organização pelo *software* NVIVO®. **Resultados:** o fenômeno central "Promovendo a gestão do cuidado de Enfermagem na Atenção Primária à Saúde" evidenciou que a gestão do cuidado de Enfermagem realizada pelas enfermeiras contribui para promover a autonomia das gestantes, a qualidade dos cuidados, o protagonismo e o empoderamento maternos no processo de gestar, parir, nascer e amamentar, envolvendo a participação da família/rede de apoio nos cuidados. **Considerações finais e implicações para a prática:** a gestão do cuidado realizada pelas enfermeiras busca acolher as singularidades das gestantes/famílias e promover o cuidado singular, multidimensional, contínuo, vigilante, sistematizado e integrado, valorizando a subjetividade e o protagonismo da mulher, pautado nos princípios da autonomia e empoderamento materno. Recomendam-se o dimensionamento de pessoal adequado, a realização das ações de saúde de forma integrada/em rede, a comunicação efetiva entre os diferentes níveis de atenção e a preparação intensificada para o parto fisiológico, o puerpério e a amamentação.

Palavras-chave: Atenção Primária à Saúde; Cuidado pré-natal; Cuidados de Enfermagem; Enfermagem Obstétrica; Qualidade da assistência à saúde.

Resumen

Objetivo: comprender el significado de la gestión de la atención de enfermeira para la calidad de la atención prenatal desde el punto de vista de las enfermeras em la atención primaria de salud. **Método:** investigación cualitativa desarollada según la teoría fundamentada en datos y el pensamiento complejo de Edgar Morin. Marco teórico-metodológico:. Se realizaron observaciones de los participantes y entrevistas semiestructuradas individuales con 11 enfermeras de atención primaria. Análisis de datos: codificación/integración abierta, axial y selectiva y organización mediante software NVIVO®. **Resultados:** el fenómeno central "Promover la gestión de la atención de enfermería en la atención primaria de salud" mostró que la gestión de la atención de enfermería realizada por enfermeras contribuye a promover la autonomía de la gestante, la calidad de la atención, protagonismo y el empoderamiento. embarazo, parto, nacimiento y lactancia, involucrando la participación de la familia/red de apoyo en el cuidado. **Consideraciones finales:** gestión del cuidado que realiza el enfermero busca acoger las singularidades de la gestante/familia y promover un cuidado singular, multidimensional, continuo, vigilante, sistematizado e integrado, valorando la subjetividad y protagonismo de la mujer, con base en los principios de autonomía y empoderamiento materno. **Implicaciones para la práctica:** se recomienda el tamaño adecuado del personal, la realización de acciones de salud de manera integrada/en red, la comunicación efectiva entre los diferentes niveles de atención e preparación intensificada para el parto fisiológico, puerperio y lactancia materna.

Palabras clave: Primeros auxilios; Cuidado prenatal; Cuidado de enfermera; Enfermería obstétrica; Calidad de la asistencia sanitaria.

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INTRODUCTION

Nursing care management represents a challenge for nurses who work in the obstetric area. An adequate and quality nursing care management involves not only administrative actions, but also care actions, and brings to the nurse the responsibility to plan his/her care actions together with the nursing team, so that together they can execute them in a humanized and effective way to users and their families.[1]

In the context of Primary Health Care (PHC), nurses are responsible for providing differentiated care to individuals and their families, seeking respect and resolution of their problems in a timely, singular, and multidimensional manner, together with the health team of the unit to which they are linked. In addition, the Nursing actions performed under the intersectoral perspective are relevant for the management of qualified Nursing care, since intersectoral actions culminate in the implementation of public policies aimed at promoting the health of individuals, families, and the community.[2]

In the context of prenatal care, the management of Nursing care exercised by the nurse has as peculiarities to provide comprehensive assistance to pregnant women and their families and in welcoming them at health centers/basic units, in prenatal consultations, and in prenatal care as a whole. The professional-user bond is essential to increase the confidence of pregnant women and promote the continuity of maternal and fetal care.[3]

The national survey, conducted in Brazil between 2011 and 2012, showed that although the country has excellent prenatal care coverage (98.7%), only 73.1% of pregnant women had the minimum number of six consultations.[4] As for the quality of prenatal care in the country, in general, it is inadequate. And this is due to the fact that many pregnant women still do not perform the minimum number of six consultations recommended by the Ministry of Health, by the failures in the care of health professionals and by the discontinuity of prenatal care and, furthermore, due to regional inequalities in the country, which have repercussions on the access and quality of prenatal care.[5]

Another national study showed that although 89% of pregnant women had six or more prenatal visits, only 15% of pregnant women had adequate quality prenatal care. Younger women, with lower family incomes, from the North and Midwest regions, from municipalities with smaller populations and lower Human Development Indexes (HDI) had the worst prenatal care.[6]

Prenatal care is a programmatic action carried out mainly in primary care and is directly related to the levels of health of the mother-child binomial and to obstetric outcomes, and about 90% of Brazilian pregnant women perform their prenatal care in the primary health care network.[5]

Also according to the national survey conducted in Brazil between 2011 and 2012, 88.4% of pregnant women performed their prenatal care with the same professional, mainly a physician (75.6%). However, when considering the North and Northeast regions of Brazil, 50% of prenatal consultations were performed by nurses.[4] In another study conducted in the Florianópolis PHC (SC, Brazil), most pregnant women had more consultations with nurses than with physicians[7] and they also alleged a preference for the professional nurse because they consider this professional to be more humanized and empathetic, who explains and listens more, allows them to express their feelings and transmits security.

With a view to improving the quality of women's and children's health care, including prenatal care, joint efforts between the Ministry of Health and the World Health Organization have culminated in the development of more equitable and humanized policies and programs. Some actions in this sense are of utmost importance because they emanate the roots of a movement in favor of quality and humanization. They are: the National Policy for Women's Health Care; the Prenatal and Birth Humanization Program; the National Pact for the Reduction of Maternal and Neonatal Mortality; the National Policy for Obstetric and Neonatal Care; the Millennium Development Goals; the Sustainable Development Goals; the Stork Network; the National Policy for Children's Health Care (NPCHC) and the Apice On Project - Improvement and Innovation in Obstetric and Neonatal Care and Teaching.

Contemporary challenges present the need to plan and deliver quality nursing and health care aimed at maternal satisfaction in ways that provide a positive pregnancy experience, an effective transition to labor and delivery, and positive motherhood, including maternal self-esteem, competence, and autonomy.[8] In this sense, it is essential to understand how nurses, based on the management of nursing care, contribute to subsidize the planning, organization, coordination, evaluation and care in PHC with a view to providing a positive and healthy pregnancy and maternity/paternity.

This study is a cut from the master's thesis entitled "The meaning attributed to the management of nursing care for the quality of obstetric and neonatal care by nurses in primary health care in Florianópolis", authored by Tamiris Scoz Amorim, under the guidance of Professor Doctor Marli Terezinha Stein Backes, of the Graduate Program in Nursing of the Federal University of Santa Catarina, support year 2017, whose objective was to understand the meaning of the management of Nursing care for the quality of obstetric and neonatal care in the view of primary care nurses of Florianópolis (SC, Brazil).

This article presents as a research question: "What is the contribution of Nursing care management to the quality of prenatal care?". In response to this question, the objective was to understand the meaning of Nursing care management for the quality of prenatal care in the view of PHC nurses.

METHOD

Qualitative research, guided by the theoretical and methodological framework of Grounded Theory (GT), in the Straussian version,[9] and supported by Edgar Morin's complex thinking.

The research was conducted in the municipality of Florianópolis (SC, Brazil), located in the southern region of the country, with a population of about 485,838 residents, 11,169 of whom were children from zero to four years old.[10] The Family Health Strategy (FHS) reaches around 100% coverage in the municipality, in its

50 health centers. Municipal nursing protocols and programs for women's and children's health have also been instituted.

The choice of participants was intentional and followed the precept of theoretical sampling. Inclusion criteria were: 1) to be a nurse of the Municipal Health Secretariat of the city; 2) to have more than six months experience; 3) to have expertise in care management, obstetrics and/or women's health. Nurses on vacation, on medical leave, and in residency status were excluded from the study.

Data collection was carried out through theoretical sampling in the period from September 2016 to September 2017. The data collection techniques were: participant observations in Health Centers and in the Municipal Health Secretariat and semi-structured interviews with the guiding question: "What does Nursing care management mean to you for the quality of obstetric and neonatal care in primary care?".

The entry into the field occurred through participant observation with the objective of observing how each nurse performed the management of Nursing care in PHC. Observations were performed by the main researcher in three scenarios: in prenatal nursing consultations, in meetings of a group of pregnant women (from September to December 2016), and in PHC nurses' meetings. For this, a printed, standardized, and specific script was used in which the main researcher recorded the information in a field diary at each moment of observation.

Based on the data from this observation, contacts were made with the health districts and then with the coordinators of the health centers in order to send individual invitations to the nurses by e-mail (institutional e-mail) obtained from the coordinators. After receiving positive feedback, we proceeded to schedule the interviews, which took place at the participants' workplace, in a reserved room. At this moment, the interviewee got to know the researcher, the research objectives, and the terms of consent were reinforced, making room for clarifications. After the consent of the participants, the interviews were audio-recorded using a voice recorder application and transcribed in full by the main researcher in a Word® document. The average duration of these was 45 minutes.

Theoretical data saturation was reached with 11 interviews and four participant observations. The steps of collection, analysis, and theory building occurred in alternating sequences through open coding, axial coding, and integration. NVIVO 10® software was used for data organization.

In open coding, all observations and interviews were analyzed individually, line by line. The data were separated into distinct parts and constantly compared in terms of similarities and differences in search of the emerging categories. In axial coding, the categories arising from the open coding were classified and associated with their respective subcategories. In the selective coding, the phase of data integration, we used the analytical mechanism called "paradigm" advocated by Corbin and Strauss[9] as a facilitating tool that helped organize the data. These were systematically grouped around the components "conditions," "actions-interactions," and "consequences," based on the emerging connections.

The theoretical sample comprised 11 primary care nurses. Of these, five were nurses of the FHS team, three coordinated the unit, two were managers of the Municipal Health Secretariat, and one played the role of care nurse and unit coordinator concomitantly. All had, as expertise, specialization in Obstetrics, Family Health and/or Health Management.

The Research Ethics Committee granted a favorable opinion by CAEE: 43112415.5.0000.0121, July 13, 2015. The Informed Consent Terms were read in full and signed by the researcher and interviewee. To identify the participants, the capital letter "N" for nurse and a number corresponding to the sequence in which the interviews were conducted were used [N1, N2... N11].

RESULTS

From the analysis of the data from this research, a substantive theory was elaborated, also known as the central phenomenon: "Promoting Nursing care management in Primary Health Care. It sustains that the use of Nursing clinical protocols for women's health care based on scientific evidence has directly contributed to the transformation in the performance of primary care nurses. This transformation occurs in the field of interactions and the encounter between pregnant woman-nurse-family, with greater emphasis on the Nursing consultation, a moment in which the nurse is driven by their philosophical attributes of care and, for such, directs a different look at the family context and centered on the woman.

> *To look at that pregnant woman in a family context, that needs to approach not only the detailed physical exam, which is important. But the whole social aspect of the pregnant woman, her insertion in the family, how the family behaves with that pregnancy, what is the father's behavior, the collaboration in this gestation process. So, it is to understand that this pregnancy is a family affair*. [...] *They* [nurses] *have a very careful look with the pregnant woman. They have this expanded look, which is not simply to mechanically perform exams, diet orientation, without knowing the reality of this patient. Advising to eat such and such a thing, when she doesn't even have rice and beans at home*. (N4)

In the nurses' view, the protocols advance the expansion of clinical practice and resolutivity. With clinical protocols, nurses have greater assurance in clinical practice. In the municipality, the implementation included training with nurses from the network, discussions of scientific evidence, and the establishment of criteria necessary to consider a pregnant woman at usual risk.

> *We have our women's health protocol and it covers, it expands our clinic a little more. So, for some symptoms, like nausea and vomiting, we can take Diminitrate, and*

> *I can take Paracetamol. So, the Diminitrate, I think is the most important, because there was a lack of medicine, and then you had to go to the doctor's door, leave the appointment, interrupt the appointment*. (N9)

> *These protocols were fundamental for many people who were afraid to come to an appointment to see a pregnant woman. Now, they feel more comfortable because they have had training. We did a lot of training with the network. We discussed what a more humanized care was. What are the criteria to consider a pregnant woman as low risk. That you feel secure to conduct that low-risk pregnancy as a nurse*. (N4)

On the other hand, the conditions/contradictions that recur in this component of prenatal care refer to the feeling of withdrawal from the Nursing consultations felt by the nurses who coordinate the unit. These nurses only see the user in specific moments, such as spontaneous demand, during the reception, or when one of the FHS team members is absent.

> *I am working more in the coordination of the health center. I attend to pregnant women in moments of reception, spontaneous demand consultations, not those consultations scheduled monthly because I don't have a schedule for that.* (N4)

According to the participants, the lack of a complete and sufficient team is recurrent in the municipality. The conjunction between a high demand for care, the lack of an adequate number of professionals (human resources) and the nurse's accumulation of tasks (overload) is contradictory to the movement of quality and resoluteness.

> *It interferes that we don't have the human resources. Working with one doctor in the health center, or without a doctor in the health center, with two nurses to deal with all this! With a dentist part time. It is complicated! And how does this affect the attention to pregnant women? In a huge way because you overburden the colleague, or the nurse, or the doctor, or the team*. (N4)

Social vulnerability is another daily challenge in prenatal care. The nurses reported that they deal with complex bio-psychosocial experiences of care, such as: abortion attempts; unwanted and/or unplanned pregnancies; teenage pregnancies; unemployment and hunger.

> *That is the biggest challenge for the health professional, is an unwanted pregnancy, doing prenatal care correctly. Breastfeeding, sometimes, is not very easy. There are pregnant women who don't want to breastfeed and they don't breastfeed*. [...] *there are puerperae who have a little postpartum depression, some listen to the advice of the older ones*. (N11)

> *Our challenge is the other, it is the mother who did not accept the pregnancy, it is the mother who has no family support. Who got pregnant, but the father of the child left. You have the social issues where the mother is hungry, the mother has no job, that is our challenge*. (N4)

The conditions/contradictions generate actions and interactions by the nurses that can be positive or not. In this sense, nurses understand the importance of prenatal care and offer a longer consultation time, besides being ahead of the schedule to improve the continuity of care.

> *Our pregnant women always leave with their appointments ready, from two months ahead, so they hardly ever come back to the reception. If* [the pregnant woman] *schedules her appointment with me, I already schedule it for the doctor and with me again. Then she will only make a hole if she misses mine, because I am the one that makes the appointments*. (N2)

The prenatal care nurses understand that pregnancy is a special stage in the life of the woman and her family. In this sense, they refer that one should work in favor of maternal protagonism, valuing the subjective aspects of care and the uniqueness of the woman. And that it is necessary to work in accordance with the physiology of the process of pregnancy, labor, birth, and breastfeeding and break with a biomedical care model focused on exams and medication. In this sense, nurses strive to offer nursing care that can free women from a profile expected by society, focusing on what is good for them and contributing, in the end, to a respectful transition of labor and birth as close to the physiological.

> *There are people who started with a work process that was very focused on the medical-centric issue. To the question of medicine, medication, or that mechanical thing of seeing the pregnant woman, asking for an exam, giving medicine, and scheduling the next appointment*. (N4)

> *We live in a society that gives us very few options, that represses us a lot, that makes us a model that we will never be able to be and that is based on consumption and money, on having. Yeah, and so, when you live in a consumer society, you want to have and have and have not think that things are simpler than that. And people, I see, are very anesthetized when it comes to feeling. And I think that is why we have such a high rate of cesarean sections. Nobody wants to feel!* [...] *When I get a woman to come to me for prenatal care and she can be the protagonist of her delivery, she can deliver by herself, and the professionals only assist her and let her give birth, and she gives birth to this child and comes here and says to me: "It was the most beautiful thing in my life! I am very happy! That's what I wanted*. (N2)

Regarding the clinical approach in prenatal care, the interviewees mentioned that there is a care for the woman and her family to live this moment with tranquility. Also, that the nurses are responsible for taking care of all the usual risk prenatal care performed in the Unified Health System (UHS) in the municipality. And that among the activities performed; there is room for subjective issues, with a focus on qualified listening, monitoring of information systems, clinical care, and prenatal care with the prescription of medications, routine test requests, according to the nursing protocols of the municipality.

> *I focus a lot on the pregnancy process itself and on the complete prenatal care, with the exams and consultations. A good preparation from the beginning so that there are no problems. Not that there are no problems, but for the pregnant woman to have a calm pregnancy. She has to have a calm pregnancy.* (N11)

During prenatal visits, the purpose of promoting maternal autonomy and empowerment appears when nurses work to value the social and family context of the pregnant woman, as well as to provide quality guidance, deconstructing myths about pregnancy, labor and birth.

> *We talk a lot about how it works. Anyway, many questions about wrong things that are shown on TV, that we see on soap operas and how they are afraid of normal birth. And this is something that has to be worked on from the beginning, the birth routes.* (N8)

For the interviewees, the purpose of Nursing care management is to plan and offer health activities and actions to users in an interconnected manner. According to them, in other times, they have had better results regarding the adhesion of pregnant women and companions to the group for pregnant women and the visit to the maternity hospital when these two activities were offered together. Currently, according to the study participants, this is not happening due to lack of human resources and nurses' work overload.

> *We planned the meetings, offered some things so that they could adhere to the group, we even visited the maternity hospital*. (N 3)

Regarding the preparation for childbirth, the interviewees mentioned that, in primary care, it is surrounded by care and guidance for the woman to experience this moment calmly and safely. For this, according to them, the woman needs to know her rights and what will happen to her so that she can have an informed choice.

> *I work in a logic of natural childbirth, vaginal, humanized and so on, of empowerment!* (N 2)

> *I think that the person has to start from herself. If she wants a normal birth, we will work on that. If she wants a C-section and doesn't want a normal birth, we will explain normal birth and we will explain a C-section for her to be well informed*. (N11)

In this sense, one of the nurses' strategies is to start building the birth plan with the woman in the third trimester of pregnancy. At this moment, the woman can think about the type of birth she would like to have, who she wants as a companion, what can happen to her, what an episiotomy is, among other issues.

> *I usually talk, advise about birth planning, when it's towards the end, from the middle to the end: you have the right to say I want such and such a person with me...* .(N 9)

However, nurses realize that childbirth generates anxiety in pregnant women. Because of this, they have noticed that some pregnant women, for being too worried about the birth, do not take advantage of prenatal consultations to learn more about the gestational process itself and also do not prepare for the puerperium. According to the participants, they end up returning to the childcare consultations very frustrated or with doubts and difficulties in breastfeeding.

> *Many only think about the time of birth and don't think about the after, you know, and then they get depressed, with a lot of difficulty to breastfeed, a little lost. And this has to be focused even in our consultations, that we try to talk to them, but they are very focused, as I told you, on the delivery*. (N10)

As for guidance on childbirth, there seem to be conflicts between the expectation (and desire) of pregnant women and what the health services can offer. The interviewees call attention to the fact that childbirth occurs at another level of care and, therefore, those professionals are the ones who will care for the mother-child binomial. Thus, the nurses reported the importance of the multidimensional approach, including the emotional factors of the women because they create expectations and return frustrated when the birth does not occur the way they wanted.

> *You end up letting the pregnant woman choose because if something happens, as it has already happened* [...]. *So, then, what will they say: "It was the nurse at the clinic who forced her to have a normal delivery!"*. (N11)

> *We usually talk about the signs of labor, about the mucus plug, which comes out days before delivery, which is like a jelly that comes out, but is not the bag breaking. You don't need to go to the maternity hospital until you have an effective contraction. We prepare her well* [...]. *There are many who go with a very high expectation that it will be a normal birth, and at the time, it's not a normal birth, you know? And this has to be worked out very well with*

them too, this expectation, that they get very frustrated, a huge frustration like that. (N10)

Regarding communication between the reference and counter-reference systems, the interviewees reported that there is no good communication between the maternity ward and primary care. The information about labor and birth, for example, is known only by the woman's report and the data in the child's notebook. Similarly, the construction of birth plans of pregnant women together with primary care professionals seems not to be respected by maternity professionals.

I don't know how maternity hospitals are receiving birth plans. In the old days, we used to give the birth plan, we had a checklist. The doctor would tear it up and throw it away, not even read it. He would laugh at the birth plan and leave it aside. (N9)

As for welcoming teenage pregnant women, with unwanted pregnancy and/or experiencing several precarious socio-environmental situations, the nurses seek to work in favor of life, carrying out awareness and support work, besides all the necessary orientations and care with a view to humanization.

There were two pregnant women who had attempted abortions in the beginning, and it was even difficult to talk to them! We always try to work in favor of life. Even trying to make them accept this pregnancy was not easy. Yes, but today they are happy with the pregnancy, with all the work we did, and they are following the prenatal care very well. (N11)

Another consequence of the movement of change in the nurse's performance is the valorization of the attention given by this professional, signified as a preference and a greater feeling of security and being at ease with the nurse's care, felt by the woman. In this sense, the nurse's sensitive gaze, the touch, the care, the zeal, the affection and the attention are differential characteristics of Nursing care. This is because, in the universe of the study, nurses establish a relational care between woman-nurse that has a direct impact on the quality of care.

Patients prefer to consult with nurses than with doctors. Because we already have an autonomy for the issue of medications, ordering exams. So, the nursing care is more, it has a much longer time, it is warmer, more affectionate. (N8)

The attention that we give to pregnant women is greater, so, they understand that we care more, we touch more, we examine, we see the fetal position, we examine, we do all that physical examination. So, they like it better in this sense. Because the doctor has less time, it is a more mechanized thing. (N9)

As well as professional empowerment, the satisfaction and preference for nurses' appointments are also a result of all this mobilization, the studies of scientific evidence, and the expansion of the nurse's clinic in primary care. And it also directly influences the empowerment of women.

So, if I have an empowerment, if I empower my patients, if I instruct them, if I foster, stimulate and bring, to her, the best that I can offer, I think I will have a good result in the end. (N2)

The interviews showed that prenatal care goes far beyond the care provided at that moment. It is during the gestational process that the child is being formed, physically and emotionally. The value of the care, the environment, and the bond that is built will be decisive for the birth of a healthy child with a harmonious future.

When a child comes from a stressful environment, you will receive a child whose emotional state is completely altered, everything goes wrong, it's no use. You accompany a pregnant woman who is calm and you accompany a pregnant woman with problems, plus other social problems that she has. You see the difference clearly in the child. (N11)

In the experience of this last interviewee, the healthy or unhealthy behavior that the child will have later on is related to the environment where the mother lived during pregnancy. Once again, this reinforces how important the study nurses' sensitive look at social and vulnerability issues is, thinking about the quality of care and the future of humanity.

DISCUSSION

Currently, there is a need, at the national level, to improve the access of pregnant women to health services, as well as to strengthen the link between the pregnant woman and the maternity hospital of reference for the delivery.[4] According to the Born in Brazil Survey, the Brazilian model of prenatal care is more focused on valorization of the service and the professional instead of being centered on the woman.[11] In this aspect, this study advances by showing that the central phenomenon of the research contributed to break with this model. In the municipality, prenatal care is fundamentally focused on the empowerment of pregnant women, mainly in the promotion of good practices of pregnancy care, such as the construction of the birth plan, the promotion of physiological birth, the promotion of exclusive breastfeeding, the offer of a woman-centered care and the best available evidence.

The interaction of the components conditions and actions/interactions culminates in expected or real results that, in this study, are characterized by the fact that prenatal care promotes a healthy and harmonious pregnancy and a respectful labor and birth through which it is understood that the woman was the

protagonist, which is a consequence of a quality prenatal care based on the principles of autonomy and maternal empowerment.

It is noted, in this study, that primary care nurses are responsible for promoting the management of nursing care in prenatal care from a humanized and qualified model. It is believed that the empowerment and autonomy of professionals for the performance of prenatal care in UHS are the fundamental steps for this intent.[12]

It is known that the assistance and care provided by nurses during prenatal care are associated with greater satisfaction among pregnant women and are related to professional competence, humanization, listening, and consideration of subjectivity, patience, and dedication of these professionals.[7] In this study, this differential is emanated in the offer of warm and human care in which the touch and the expanded look at the context of subjective and objective care needs and the use of technical and philosophical contributions from the science of care are fundamental to the management of nursing care. In this sense, it was perceived in this study that when nurses transform their care by incorporating an expanded look at the conditions of social vulnerability, health actions may represent a step towards the offer of more equitable health services. In this way, the understanding of sociocultural conditions in decision making can serve to confront the barriers in the offer of health care and nursing care in maternal and child health care programs.[13]

In this study, the Nursing Care Systematization (NCS) was also a catalyst to bring about the necessary changes in the performance of primary care nurses. Through the implementation of a permanent nursing commission, several training sessions were held with the nurses of the network, and nursing protocols were developed. These actions, together, converged to the implementation of the Nursing process in primary care in the city. This occurred through the understanding of the theoretical and philosophical meanings of health care models that have, as an archetype, the FHS and the understanding of the NCS as a proposal for systematization of care, a fact corroborated by other scholars.[14]

In the municipality, two instruments that contribute to nursing care management have been instituted: the Primary Care Clinical Practice Guide (PACK) and the Women's Health Protocol since 2010. Both are essential for planning and decision making on the conducts in the care of the usual risk pregnant woman. It is through these instruments that prenatal routines, test requests, and drug prescriptions are established. The elaboration of the Nursing protocol for women's health care was one of the fundamental conditions to ensure the comprehensive care of the needs of users.

An analysis of the professional competencies developed in prenatal care shows that one of the ways to enable quality care is the appropriate use of nursing protocols.[15] These, although necessary in prenatal care, do not exempt nurses from being aware of the peculiarities of each pregnant woman, since the effectiveness of care goes beyond what is standardized. Thus, it is essential that nursing professionals update themselves, provide safe care, and are competent in the planning and implementation of their actions.[16]

From the results of this study, meanings also emerged to reflect on a problem in common with other realities:[17] the need to work and improve communication in the health system, especially in the maternal and child health care network. In this sense, the NPCHC contributes with strategies and actions towards the articulation of primary care services with maternity hospitals and vice versa.[18] It was perceived in this study that the adequate management of Nursing care is related to the support of the team, clinical autonomy and the support provided by the coordination of primary care. It was verified that the existing difficulties included insufficient human resources and material inputs of assistance, as well as the lack of time caused by the overload of activities, the concomitant execution of unit management and assistance. These are elements already found in other studies.[19-21]

A study developed in six primary care units in London showed that the expansion of the functions of primary care nurses contributed to the quality of care. The authors found, as benefits, the expansion of access, comprehensive care by increasing the time of the nursing consultation, the expansion of professional competence, knowledge and professional recognition, and the reduction of care costs.[22]

These results converge with the reality studied in which the following benefits stand out for the users: increased access, promotion of good practices in pregnancy, labor and birth, and maternal empowerment/competence/autonomy. For nurses: it contributes to resoluteness, expansion of clinical practice, and autonomy. For Unified Health System: the strengthening of policies and programs, aiming at the quality of obstetric and neonatal care, with the strengthening of primary care and FHS teams.[23] It is believed that actions on women's sexual and reproductive health in the context of primary care go hand in hand with the availability of prenatal, delivery, and postpartum care, including access to contraceptive methods and women's empowerment.[24]

From this point of view, reproductive planning with informed and conscious choice is an instrument in favor of women's rights.[25] Unwanted pregnancy is a challenge for quality care, besides being a delicate moment for the woman. In this sense, the reception of these situations must be exquisite in order to help women and, when possible, the companions, to build healthy bonds. The importance of prenatal care is understood in the understanding that the social dimensions, the environment and eating habits, employment and income conditions, social vulnerabilities, infectious diseases, among others, bring significant impacts to the health and formation of the fetus.[26]

Nurses, when performing management actions, can also provide preventive and quality care to the mother-child binomial, including preventing low birth weight, being essential that, in PHC, nurses are active in the nursing team with preventive actions that bring benefits to the health of pregnant women and their babies.[27]

However, FHS nurses, in their daily routine, end up validating care activities more than management actions. To get around this, a critical reflection on the practice should be performed

and the managerial action should be renewed.[28] This study showed that it is necessary to expand the understanding, on the part of managers and professionals, that Nursing care management is not linked to a certain position (management, leadership, coordination). Recognizing, in the interviews, the feeling of feeling distanced from women's care because of being in the coordination of the unit is the first step to integrate and consolidate the management of Nursing care as one understands the importance of these spaces where care is being planned and distributed throughout the entire care network. In this way, one must be vigilant so that the professional nurse is not being overloaded with responsibilities that are not linked to the Nursing process, becoming a "troubleshooter" of the service.

It is believed that primary care nurses should be vigilant with regard to Nursing care so that these can be instruments in favor of maternal autonomy and empowerment. The construction of a birth plan can be an important step in this direction, as well as for the woman's protagonism and autonomy. Likewise, it is important to understand that a baby is born in a certain condition of life, society, and different feelings, and knowing this helps to promote a more equitable and quality care. Thus, one must work to situate the woman in her social and family context and provide a support network with the inclusion of the father and family members who are experiencing the pregnancy process.

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

Nursing care management for the quality of prenatal care in PHC means valuing the subjective aspects of care and the singularities of the pregnant woman and her family and promoting singular, multidimensional, continuous, vigilant, systematized, and integrated care based on well-defined and implemented protocols, based on scientific evidence, effective communication in the health care network, considering the social and biopsychological changes experienced by the pregnant woman and her life context, making her the protagonist of the process of pregnancy, delivery, and birth, and involving the participation and support of the family/support network in the care.

Prenatal care should promote a healthy and calm pregnancy and the preparation for a respectful and safe labor, delivery and birth, in line with the physiology of the process of pregnancy, delivery, birth and breastfeeding, making the woman aware of her rights and making her understand what will/can happen to her, which will make her able to make decisions based on informed choice and guided by the principles of autonomy and maternal empowerment.

Primary care nurses are strong allies when actions and efforts need to be implemented in order to break with a biomedical care model focused on tests and drugs. It is believed that the quality of health and nursing actions in prenatal care has the potential to generate positive results for humanity in the long term.

As implications of the findings for the practice, we highlight the need for an adequate number of personnel and the execution of health actions in an integrated manner, in a network, with effective communication between the different levels of care, intensifying the preparation for the physiological birth and the puerperium, including breastfeeding.

The study presents, as a limitation, the fact that it included only nurses as participants. It is suggested the development of new studies related to addressing the conditions of social vulnerability of women of reproductive age, such as teenage pregnancies, unwanted pregnancies, abortion attempts, unemployment and hunger.

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