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PRENATAL NURSING CONSULTATION: NARRATIVES OF PREGNANT WOMEN AND NURSES

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ABSTRACT

Objective: analyze the prenatal nursing consultation from the perspectives of pregnant women and nurses.
Method: qualitative and descriptive study, involving 20 pregnant women and four nurses, at a primary health care service located in the city of São Luís/Maranhão (Brazil). The data were collected through semistructured interviews, participant observation and a focus group and analyzed based on the premises of thematic analysis.
Results: the pregnant women expressed their satisfaction with the physical examination, highlighting that the welcoming. Complaints were made on the nurses' technical competence, specifically regarding counseling on urinary tract infection. Some facilities were highlighted after the implementation of the *Estratégia Rede Cegonha*, mainly in the scheduling of appointments. The following difficulties were mentioned: lack of some prescribed drugs and long terms for carrying out and receiving preventive examinations.
Conclusion: the pregnant women assessed the nursing consultation as very good, but they tend to attribute the logistic difficulties at the Health Center (lack of inputs) and even the forwarding to the medical professional (prescription of drugs to obtain outside the Health Center) to the nurses. Based on the research, relevant points could be identified that can influence positive criticism against the nursing consultation, as it constitutes more than half of clinical prenatal care in Brazil and can also change the conditions sensitive to hospitalization in primary care.

DESCRIPTORS: Pregnancy. Nurse. Prenatal Care. Office nursing. User embracement. Nursing. Pregnant women.

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CONSULTA DE ENFERMAGEM NO PRÉ-NATAL: NARRATIVAS DE GESTANTES E ENFERMEIRAS

RESUMO

Objetivo: analisar a consulta de enfermagem no pré-natal, a partir da perspectiva de gestantes e enfermeiras.
Método: estudo qualitativo e descritivo, realizado junto a 20 gestantes e quatro enfermeiras, em uma unidade básica de saúde localizada no município de São Luís/Maranhão (Brasil). Os dados foram coletados por meio de entrevistas semiestruturadas, observação participante e de um grupo focal e analisados a partir dos pressupostos da análise temática.
Resultados: as gestantes expressaram satisfação com o exame físico, destacando o acolhimento. Houve queixas quanto à competência técnica das enfermeiras especificamente em aconselhamento de infecção urinária. Algumas facilidades foram destacadas após implantação da Estratégia Rede Cegonha, principalmente no agendamento de consultas. Como dificuldades, foram relatadas: falta de alguns medicamentos prescritos e prazos longos para realizar e receber exames de natureza preventiva.
Conclusão: as gestantes avaliam como muito boa a consulta de enfermagem, entretanto, tendem a imputar às enfermeiras, e à consulta de enfermagem, as dificuldades de logística do Centro de Saúde (falta de insumos) e mesmo o encaminhamento ao profissional médico (prescrição de medicamentos para obtenção externa ao Centro de Saúde). A pesquisa permitiu identificar pontos relevantes que podem influenciar uma crítica positiva sobre a consulta de enfermagem, já que ela constitui mais da metade do atendimento clínico do pré-natal de baixo risco no nosso país e também tem potência para alterar as condições sensíveis à internação na atenção primária.

DESCRITORES: Gestação. Enfermeira. Pré-natal. Consulta de Enfermagem. Acolhimento. Enfermagem. Gestantes.

CONSULTA DE ENFERMERÍA EN LA PRENATAL: NARRATIVAS DE MUJERES EMBARAZADAS Y ENFERMERAS

RESUMEN

Objetivo: analizar la consulta de enfermería en el prenatal, desde la perspectiva de mujeres embarazadas y enfermeras.
Método: estudio cualitativo, descriptivo, realizado junto a 20 mujeres embarazadas y cuatro enfermeras, en una unidad básica de salud localizada en el municipio de São Luís/Maranhão (Brasil). Los datos fueron recolectados por medio de entrevistas semiestructuradas, observación participante y de un grupo focal, analizados a partir de los supuestos del análisis temático.
Resultados: las mujeres embarazada expresaron satisfacción con el examen físico, destacando la acogida. Ha habido quejas sobre la competencia técnica de las enfermeras específicamente en el asesoramiento de la infección urinaria. Algunas facilidades fueron destacadas después de la implantación de la *Estratégia Rede Cegonha*, principalmente en la programación de consultas. Como dificultades, se han reportado: falta de algunos medicamentos prescritos y plazos largos para realizar y recibir exámenes de naturaleza preventiva.
Conclusión: las mujeres embarazada evalúan como muy buena la consulta de enfermería, sin embargo, tienden a imputar a las enfermeras, ya la consulta de enfermería, las dificultades de logística del Centro de Salud (falta de insumos) e incluso el encaminamiento al profesional médico (prescripción de médico) medicamentos para obtención externa al Centro de Salud). La investigación permitió identificar puntos relevantes que pueden influenciar una crítica positiva sobre la consulta de enfermería, ya que constituye más de la mitad de la atención clínica del prenatal de bajo riesgo en nuestro país y también tiene potencia para alterar las condiciones sensibles a la internación en la población la atención primaria.

DESCRIPTORES: Gestación. Enfermera. Prenatal. Consulta de enfermería. Acogimiento. Enfermería. Mujeres embarazadas.

INTRODUCTION

The progressive expansion of the organization process of Primary Care services in Brazilian cities points to the qualification of health professionals as a challenge, especially with regard to the care process, access to exams and results in a timely manner, as well as the integration of Primary Care with the network focused on maternal and child care.[1]

The focus of women's health care in Primary Health Care, understood as the gateway of the health services, is prenatal monitoring. Prenatal care consists of care, behavior, and procedures for the health of the pregnant woman and the fetus; with the purpose of detecting, curing or controlling diseases early, avoiding complications during pregnancy and childbirth. It thus proposes to guarantee quality maternal and fetal health and consequently reduce the maternal and fetal morbidity and mortality rates.[2]

The nurse is one of the essential professionals to perform this prenatal care, because he is qualified to act with health promotion and disease prevention strategies and use humanization in the care provided.[3] To this end, he elaborates the nursing care plan in the prenatal consultation, according to the needs identified and prioritized, establishing the interventions, guidelines and referring to other services, also promoting the interdisciplinarity of actions, especially involving dentistry, medicine, nutrition, and psychology.[4]

According to Decree 94.406/87, which regulates Law 7.498, dated June 25, 1986, and regulates the practice of Nursing, it is the sole practice of the nurse, among others, to execute the nursing consultation and its prescription of care; and, as members of the health team, to prescribe drugs previously established in public health programs and as part of the routine approved by the health institution, as well as to provide nursing care to the pregnant, parturient, postpartum women and infants.[5]

Prenatal care is an appropriate moment to develop educational actions, using dialogue, bonding, and listening to pregnant women and their companions as tools. This work strategy permits an approximation between professionals and pregnant women, strengthening the knowledge and the clarification of doubts. The professionals who assist this population need to constantly evaluate this strategy in order to control the effectiveness of the guidelines as the quality of the service provided is an important factor.[6]

In Brazil, prenatal care, despite the good coverage and importance of the Family Health Strategy (Estratégia Saúde da Família - ESF) teams in this coverage, needs to be reviewed, as there is low compliance with the official program standards. Although the ESF presents potential advantages in prenatal care in relation to other health models, one cannot think that only the bureaucratic passage of the pregnant woman through the service can promote the quality of care, and it is necessary to offer conditions that permit the early capture and reception of the pregnant women, aiming, above all, for adherence to prenatal care.[7–8]

In view of these arguments, we ask ourselves: what do pregnant women say about the nursing care received during prenatal consultations? How do they feel during all the stages of prenatal care? What do pregnant women report that may compromise prenatal care? How do the nurses define welcoming? How do they analyze the logistic difficulty in the Basic Health units (BHU) and intra-professional relations?

It should be emphasized that listening to the protagonists directly involved in prenatal care, pregnant women and nurses, could enable strategies to strengthen health care for this population group and to qualify the actions of promotion, prevention and early identification of diseases and timely intervention, particularly aiming to reduce maternal and infant morbidity and mortality. Based on these questions, the study aimed to analyze the nursing consultation in prenatal care based on

the narratives of pregnant women and the nursing team. It is inferred that these questions surround this consultation and, although indirectly, have an impact on the pregnant women's evaluation of this activity.

METHOD

This is a qualitative, exploratory and descriptive study, involving pregnant women receiving prenatal care at a BHU in the city of São Luís (Maranhão/Brazil), from October 2015 to September 2016. Twenty pregnant women attended by nurses, of any gestational age and in any age group, and four nurses linked to the BHU where the study was undertaken participated. The following inclusion criteria were determined for the interviews: pregnant women who were in prenatal care after more than two nursing consultations; and for the focus group, the nurses who provided prenatal care to pregnant women. The following exclusion criteria were determined: pregnant women who did not have the cognitive capacity to express themselves; and for the focus group, nurses who were away from activities during the research period (leave and vacation). The number of participants was defined by the representativeness rule (heterogeneous universe given the different characteristics of the participants and, at the same time, homogeneous, due to the research phenomenon); and the relevance rule (the content of the interviews was appropriate as a source of information to achieve the research goal).

The following data were collected: a) participant observation, focusing on the routine of the sectors, appointment making, screening, dressing, vaccine, pharmacy, and informal conversations among professionals and with the directors, schedules, and agendas. Thirty-five hours of participant observation were recorded during the morning and afternoon shifts; b) semi-structured interview, with open questions, about the nursing consultation in prenatal care. The interviews were carried out at the pregnant women's homes, after a first contact with the Community Health Agent (CHS), through which the pregnant woman authorized our visit. We consider that this procedure would enhance their freedom to answer the questions; c) focus group to formulate more precise questions, give focus to the research, be sufficiently provocative to permit an enthusiastic and participatory debate and promote conditions to further deepen it.[9]

The participants in the focus group were all the nurses who worked in the study setting. The focus group was guided by open questions built during the data analysis based on the interviews with the pregnant women in the second stage of the thematic analysis. Therefore, they were the product of the hypotheses and analytical inferences, among which we highlight the definition of welcoming, the logistics and management of the primary care service, and the relationships between medical professionals and nurses. The nurses participating in the focus group were granted these conditions in order to permit freedom of expression.

The focus group took four hours and was held in one of the offices of the primary health care service after arranging the space. The chairs were arranged in a circle, with a table in the center and an electronic device on top to record the interview. Four nurses participated in the focus group. The proposed discussion followed a roadmap with three broad questions, namely: the primary care service (logistics and internal relations), the reception and the technical competence of the nurse for the consultation. Data analysis occurred after the transcription of the semi-structured interviews, enriched with the records of the participant observation and the focus group. Content analysis followed the thematic analysis modality.[10]

The data analysis was executed in three stages (pre-analysis, exploration of the material and treatment and interpretation of the results). The pre-analysis consisted of the exhaustive reading of the data obtained in the interviews and in the focal group and defined as the corpus of analysis. In the second stage, the material was explored, aiming to obtain cores of meaning and to understand the

discourse. In this phase, the analytical work was aimed at finding meaningful words and expressions based on the organization and reduction of the content of a speech, so as to describe the characteristics evidenced in the research participants' discourse. This process is named categorization. The treatment and interpretation of the results was the third stage of the analysis, in which two themes or analytical categories were constructed by combining the cores of meaning.

For the identification of the pregnant women, the letter G was used, accompanied by numbers from 1 to 20 and, for the nurses, the letter E, numbered from 1 to 4.

RESULTS

Analytic categories

The empirical data pointed out two contexts and two categories: the nursing consultation according to the pregnant woman, which is the objective of this research, and the logistic determinants, which indirectly impact the health care for pregnant women in the BHU.

In the analysis of the first context, five subcategories were constructed: The welcoming of the nurse; The problem-solving ability of the consultation; The physical examination; The guidelines on health and satisfaction with the consultation.

In the reception, the pregnant women feel welcome when the nurses are cheerful, talk with them, speaks slowly and is in no hurry to finish the consultation and when the consultation takes time.

> *So, for me, the welcoming would be this: I informing and serving as a bond for her.* (E3)

> *Always happy! She asks how we are ... she asks everything, she says everything, I like her attendance, she asks me if I'm okay, what I feel and what I've felt, she talks a lot with us.* (G3)

> *She is thoughtful, not in a hurry ... she asks everything, everything I asked or said, was clarified.* (G5)

Nurses who do not smile, do not inquire, show that they are stressed and in a hurry, are evaluated as offering bad welcoming.

> *The first one had no smile at all ... she was very stressed.* (G6)

"The problem-solving ability of the nursing consultation" has limitations determined by the specific duties of the nurse practitioner and the need for prenatal medical evaluations.

> *I got this bacterial infection... she forwarded me to the doctor.* (G8)

But we also find insufficient clinical-obstetric knowledge.

> *It was referring to the urinary tract infection, which I asked her if it was transmitted to the baby and she did not even answer me.* (G6)

In some statements, the pregnant women's dissatisfaction was observed when they are forwarded to the medical consultation.

> *I think only she could solve it, but she's forwarding... I do not know, I did not ask why either.* (G19)

> *The problem is that you always have to keep on seeing the doctor because there are drugs she cannot prescribe, it has to be with a doctor's prescription, so that's annoying, you see? The boring part is this, that the nurse cannot prescribe that drug.* (G14)

It should be noted that most of the pregnant women interviewed characterize the nursing consultation as able to solve problems.

I like her care... I feel so safe that I'm not seeing another nurse. (G7)

The pregnant women value "the physical examination" performed by the nurses, especially when listening to the Fetal Heartbeat (FHB), and the concrete understanding that the baby is alive and well.

She examines the belly, talks, talks about how the baby's heart is ... explains things. (G8)

It was noticed that pregnant women experience difficulties to discuss their emotional or subjective problems, referring them to the sphere of private life that should not be discussed during the nursing consultation.

No, because I never told her that she was having trouble. (G3) *For me, like, she's just taking care of my little baby, my health, so my problems, she will not solve anything at all.* (G15)

"In the health guidelines", the care of the mother and the baby, food, and medication was emphasized, revealed as useful, practical and careful information.

She tells me to feed more than three times a day, says what I have to eat. She advises on the type of bra suitable for us to wear, she talks a lot. (G1)

She explains that I have to take medicine, says what we have to eat and what we cannot. (G4)

The pregnant women report "Satisfaction with the nursing consultation", when the nurse asks questions, doubts and is thoughtful. *Yes, she asked a lot of questions, asked if it is my first pregnancy, if I have a stable life, if the pregnancy was planned, asked a lot of questions. I have no complaints.* (G1)

Attends well, listens, hears, explains that I should be satisfied when I leave, that I understood, and I am understanding the consultations, I am getting it right. (G8)

I keep thinking, in my consultations with my obstetrician I kept thinking, I always talk to my sister ... and she said that in the consultations she took part in she felt more welcome than with the doctor, so I think we make the difference, it's not because I'm nurse, in welcoming. (E3)

The pregnant women demonstrated satisfaction regarding how long the nurse stays with them in the consultation, and they understand that the nursing consultation is distinguished.

I think it's enough. In the first consultations, she takes time, asks a lot of questions. (G1)

It's time-consuming. She even keeps "like this" listening to us, with her hand on her chin, then she'll explain. (G8)

In this context, the pregnant women also reported satisfaction with the consultation, when they were well treated, stressing that treating well means passing on information, being passionate about what they do, verifying that the baby and the mother are in good health.

The person knows how to separate this professional part from the personal part, and we see that the professional is there because he likes it (G16).

It's to instruct, to check if everything is right, if the baby is well, if the mother is well, for me that is to treat well. (G18)

In the analysis of the second context, the indirect determinants of the quality of the nursing consultation were found, revealing two subcategories: The facilities for prenatal follow-up and The difficulties experienced in prenatal care, with the primary care service as a gateway and place where the nursing consultation takes place.

In the pregnant women's discourse, they unanimously agree on three factors regarding the "facilities for prenatal follow-up".

The ease in scheduling appointments.

The first appointment is easy, then the nurse will reschedule, which helps a lot, so we do not need to keep coming. (G12)

Now after you get pregnant, it's better because we can get everything soon, easier ... now pregnant, I'm leaving here, with the nurse, the best thing in the world, because it's already scheduled. (G14)

The access to the laboratory tests was another facility in the participants' reports, due to the existence of a laboratory affiliated with the BHU, in which they get priority, both in collecting material and in receiving the results.

The reality changed last year ... you request the exams, stamp with the service's stamp and indicate the Cedro laboratory, ask her to take the pregnant woman's file, plus the SUS card and tell her that it is assured. (E2)

The exams were very good in this sense, so we do not keep on going from one place to another, not all exams are done, but the few they do there, it's is already good (P12).

The existence of vaccines is another positive point, and this availability seems to be a constant in the BHU, with only brief intervals of vaccination that is lacking.

All vaccines, always available... none was ever missing. (G11)

I got it! There was a period that it was lacking, but they justified that it was the Ministry of Health that took time to get the vaccines, but I took all of them. (G18)

"In the difficulties", the issue of referral and counter-referral was highlighted, which seems to be one of the main problems causing distress and concern.

We are insecure, anxious about not knowing where the baby will be born, there isn't that security, because it's done at the service, and at the time of this matter between the service and the maternity, there is not that connection... at the time of going to the maternity, then you arrive, it is full, there is no bed, then you're already forwarded to another (G18).

Concerning the need to buy the prescribed medication, which should be dispensed by the BHU.

A lot comes through the management, they do not send folic acid, ferrous sulfate, never came again, I'm not going to guarantee that. (E1)

Medication also I always buy on my own, because as I told you in the beginning, there is never folic acid and acetaminophen. (G16)

Undergoing and getting the results of ultrasound examinations and cancer prevention were also mentioned as difficulties.

There are facilities for the preventive exam, but it takes two to three months, you end up losing this patient. (E2)

Nowadays, the faithful clients undergo the preventive exam, the client who like to undergo the test with you, have confidence, know that it will take time, but trust you. (E1)

It was private ... always private, I was not even aware that I could do the ultrasound by the Rede Cegonha (Stork Network). I did it in the private system because it takes so long. There

is the facility to undergo the test, you schedule, you do the exam soon, but the waiting time is very long, two to three months on average to receive it, I think that's long. (G12)

They have a different concept, they imagine that if they pay it will be better because it is not a long examination. She goes there and it gets ready with a week, she goes there with the documents, we inform the pregnant woman's file and the Public Health System card and her ID card, she explains that it is through the Stork Network, but there are two exams we asked for, which were not done, which are rubella and anti-abs, these are not in the agreement. (E4)

There is an interesting aspect in the pregnant women's discourse, which refers to the fact that the medical professionals do not schedule the subsequent consultation with the nurse so that the pregnant woman is forced to resort to the appointment marking sector for this appointment, which in principle would be simple to put in practice.

It was a boring situation because the nurse made the appointment for the doctor and did not reschedule for me to see her again. (g12)

We have the responsibility to make the doctor's appointment and he does not do that for us ... I do not think it's my job, as a nurse, to make a doctor's appointment ... but I'm going there and I make it, and the patient's right is guaranteed. (E3)

There is dissatisfaction among the pregnant women regarding the delay to start attending as the professionals are late for work at the BHU.

What I notice is that nobody comes in early. We arrive on time, eight o' clock, and I also notice that the archive sector sometimes takes time because they are going to take the files of the doctors who will arrive later. (E1)

Because it's eight hours to get downtown (G9).

Last time, I spent more than two hours waiting. The appointment was set at seven hours and thirty minutes, and she arrived at ten o'clock in the morning. (G7)

In the welcoming, which is first performed by the reception, at this primary care service, the pregnant women's dissatisfaction was surveyed, with complaints about "bad mood and impoliteness of the attendants".

They do the work correctly, but they're all grumpy, we gotta know how to talk to them ... I have never liked how they attend there at the door. (G14)

DISCUSSION

Nursing consultation according to the pregnant woman

Nursing welcoming

The quality of care was marked by relationships of interaction, bonding, trust, listening ability, horizontal and therapeutic relationships between nurses and pregnant women. Attitudes that collaborate towards prenatal care, as they express the professionals' respect for the pregnant women.

In a study about nurses working in prenatal care, the availability for dialogue, listening, and clarification was also highlighted.[11] In this sense, another research shows that the welcoming the nurses offer expresses positive characteristics, such as receiving well, instructing, and asking questions.[12] As a result of these attitudes, the nursing consultations are characterized as good and welcoming.

Regarding trends in prenatal care in Brazilian nursing, the importance of welcoming and bonding was highlighted.[13] Welcoming is an ethical posture that involves listening to the patient's complaints, recognizing her as a protagonist in the health and illness process, with responsibility for solving them and for the activation of knowledge-sharing networks.[14]

During the participant observation, it was noticed that the nurse, when calling the pregnant woman for the care, received her with a smile. In the context of women's health, the nurse plays an important role in the humanization of care, as the pregnancy process and the postpartum period are permeated by feelings of fear and insecurity.[15] For the participants in the focus group, welcoming is when the nurse is thoughtful, bonds with the pregnant woman, when there is an approximation, and when the nurse corresponds to her expectations. Therefore, welcoming can be understood as part of the work reorganization process, and as a necessary posture/practice for health professionals, guaranteeing access, problem-solving ability and bonding in the health service.[16]

Problem-solving ability in the consultation

Some pregnant women considered that the problem-solving ability of the nursing consultation was limited, as they interpreted the referral of the nurse to the medical professional as the nurse having little knowledge. This condition occurs when the pregnant woman needs drug therapy, especially involving antibiotics. From the viewpoint of the pregnant woman, this movement, although attending to professional specifics and the demands of the program, is experienced as meaningless, "one professional forwards to the other". The pregnant woman does not understand these different professional skills and experiences them as professional incompetence and as the inability to solve their problems.

The nurses at the Health Center reported that, in some cases, they forward the pregnant women to the medical professional as, even though they have the institutional knowledge and authorization to prescribe the necessary antibiotic, sometimes it is not available at the pharmacy and, to obtain medication outside the BHU, a medical prescription is required.

Physical examination

The nurses execute the physical examination well, and the information passed on is able to reassure the pregnant woman. In a study about the quality of the prenatal care process, it was described that pregnant women attending the Family Health Units are more often physically examined, emphasizing the importance of the Family Health Strategy as a care organization model.[17] According to the pregnant women's statements, however, the nurses were not concerned with investigating the pregnant women's mental health status as one of the axes of the nursing consultation, mainly their mood, which is relevant during the pregnancy and postpartum, when it could strongly impact the availability to take care of oneself and care for the infant. There still seems to be a long way to go in integrating mental health into basic care though. Some psychological disorders during pregnancy, such as stress and anxiety, show an association with low birth weight, which is considered to be a factor influencing the health of the baby and the pregnant woman.[18] Therefore, considering new perspectives for care relationships in prenatal care should be prioritized over the biomedical model so that a new care model can be effectively achieved.[6]

Health guidelines

Health guidelines are the content the pregnant women evaluate and appreciate the most. In a study in Obstetrics, the importance of the pregnant women receiving dietary advice and the monitoring of their gestational weight gain were highlighted.[19] Another research highlights the pregnant women's

valuation of the guidelines they receive from the professionals during consultations, especially those related to food, rest, physical exercise, weight control, medication, among others, which corroborate the statements of this study.[11]

Satisfaction with the consultation

The nurse's attitudes of technical knowledge and interest favor the bond with the pregnant woman. In a study on prenatal care, satisfaction with the nursing consultation was evident in 84.3% of the participants, pointing out that most of the pregnant women rated the care received by the nurse during prenatal consultations as good.[20]

According to verbal information from a BHU employee, during the participant observation, the pregnant women say that they do not like nurses who attend very fast and do not examine them, and this is confirmed when they resort to the appointment making sector, requesting a new appointment with another nurse, and scheduling a previous appointment. The pregnant women inform when scheduling the preventive examination, the name of the nurse with whom they wish to consult. When they perceive the nurse's attention and interest in the pregnancy, the pregnant women feel confidence and security in this professional, and this will be the reason to proceed with the prenatal follow-up and to follow the guidelines the nurse prescribed. Thus, the quality of the information and the nurse's interest are protective factors for compliance with prenatal consultations. This factor is evaluated in a study carried out in the state of Paraná (Brazil) on admissions sensitive to primary health care, and points out that, during pregnancy, an inappropriate clinical consultation presents 2.40 times the chance of hospitalization for a sensitive condition, and consultations adjusted according to the gestational age were associated with a 2.16-fold risk of hospitalization due to a Primary Care Sensitive Condition.[7]

Health Center, logistics and indirect impact on the nursing consultation and health care of pregnant women

The facilities

After the implementation of the Stork Network Strategy (Estratégia Rede Cegonha - ERC), the scheduling of first-time consultations for pregnant women became a priority. The nurse herself became responsible for scheduling subsequent appointments, without the need to resort to the appointment-making sector, mainly due to the existence of queues. This increases the length of the pregnant woman's stay in the BHU, compromising her domestic activities, besides the time needed to travel between the health service and her home.

By reducing the waiting time of pregnant women to have their needs met, whether involving appointments or care, this action reveals a welcoming environment, with easy access, and the nursing consultation is experienced as a protection factor for the pregnant woman. The result of another study corroborates this research, as most users also considered the humanized care and the easy access to the consultation as the positive elements of the care, representing motivating factors for prenatal compliance, which is one of the major objectives of ERC.[21]

Routine prenatal exams are requested during the first visit, whose purpose is to investigate, prevent and treat diseases such as diabetes, toxoplasmosis, rubella, cytomegalovirus, herpes, syphilis; human immunodeficiency virus (HIV), Chagas disease, hepatitis B, hepatitis C, maternal phenylketonuria and urinary diseases.[4] The ease of undergoing exams is a source of security and tranquility for the pregnant women, as they do not only save money, but their health condition is monitored in due time, differently from the stage before the implementation of the ERC, when they got the test result after peregrination and at the end of the pregnancy, according to the focus group.

The difficulties

Even with conceptual priority, to guarantee the delivery bed, the question of referral and counter-referral is not yet a reality in the service studied, so that pregnancy and postpartum are still weakly connected. The results of a study emphasize that 16.2% of the women reported peregrination, being more frequent in women living in the Northeast.[22] In this context, it is emphasized that one of the objectives of the ERC is to establish a link between the pregnant woman and the maternity hospital of reference.[23] In another research, the precariousness of the health system, which considerably restricts the access to the services offered, can be considered as obstetric violence.[24]

The lack of drugs prescribed by the nurse (acetaminophen, folic acid, ferrous sulfate, cephalexin, among others) in the BHU basic pharmacy negatively affected the quality of the consultation, generating anxiety in the pregnant woman and the non-resolution of her health and prevention problems.

Most patients are unaware that the ultrasound exam can and should be performed by Public Health System (Sistema Único de Saúde – SUS), and that they are entitled to get it through the ERC. Some pregnant women, even knowing that this test can be done by the SUS, decide to perform it in the private network, given the continuing difficulty to schedule and to receive the result. There is a reference service for the ERC to get the ultrasound examination, but there is a three-month delay to receive the result, according to the focus group. In the study on prenatal care, the discomfort caused by the fact that they had to pay the ultrasound to obtain an immediate result was also highlighted.[21] In a study on prenatal care, these findings were confirmed, because the pregnant women reported delayed delivery of the exams and also to schedule others.[25]

The preventive examination of cancer registers a contradiction in the SUS. Although it can be scheduled and performed, there is a delay of three months to receive the result, rendering the preventive nature of the treatment unfeasible. Many pregnant women seek the result of the preventive exam, but it will take a minimum of two months to be accessible. The participants in the focus group confirmed that the result of the preventive examination takes about three months to be ready, which negatively affects the pregnant women and the treatments that are necessary for the first pregnancy term. In this context, the professionals of this ERC felt uneasy, caused by something that relates neither to the logistics nor the technique of care for pregnant women, but to interprofessional relationships. The nurses are dissatisfied with the pregnant women's return from the medical consultation as these professionals do not schedule a return appointment to another health team member, causing the pregnant woman to resort to the scheduling sector. In the focus group, however, the nurses reported that this problem was already being resolved.

The implementation of the ERC, entailed improvements for the quality of the services offered to the pregnant woman, mainly with regard to the scheduling of nursing consultations. It was observed that the care begins after eight hours and thirty minutes, although the BHS informs that attendance starts at 8.00 a.m. This issue produces an accumulation of many minutes of unease, especially for the last minutes of the day.

The importance of assiduousness and the punctuality of the nurse as a professional commitment are highlighted.[21] The problem related to the waiting time for care was also evident in the literature, when the pregnant women mentioned it as one of the main factors hindering the prenatal care.[26]

Little readiness to answer the pregnant women's questions was observed, with delayed responses, without looking up from the paper and without signs of courtesy, such as "good morning" when arriving at the service. Furthermore, it was observed that some employees started working without greeting the pregnant women, without greeting. In some cases, courtesy, when it was available, was directed only to co-workers. The importance of welcoming is highlighted, from the arrival to the reception to the exit from the office, being important, although of indirect impact, for satisfactory prenatal care.[21]

This study has the limitation of having investigated a single health service in a state capital in the Northeast with low coverage of the Family Health Strategy. Most of the interviewees came from popular classes and these classes make up the predominant profile of prenatal care in SUS. The analysis of the data obtained can guide a discussion with the nurses of the health service in order to respond to the criticism and improve the nursing consultation; together with technical staff, to discuss interpersonal relationships and cordiality at work. Finally, as a recommendation to guarantee high-quality teaching in the education of generalist nurses, to understand the importance of the quality of primary health care professionals who should solve 80% of the health demands of the population they attend.

CONCLUSION

The study allowed us to identify relevant points that may influence positive criticism on the nursing consultation, as it constitutes more than half of the low-risk prenatal clinical care in Brazil and also has the power to change the conditions sensitive to hospitalization in primary care, where the greatest risks of hospitalization are among women and, among them, pregnant women.

The aspects of welcoming raised questions about the bonding, interaction, horizontal relations, and therapeutic relationships, including professional competence with problem-solving ability. The physical examination performed by the nurses was observed as a strong point. The nursing consultation presented a positive evaluation, mainly when the pregnant women perceived the interest of the nurse professional, the availability of time and the technical knowledge. The pregnant women experienced the easy scheduling of nursing consultations, the permanent availability of vaccines and the performance of laboratory tests as a quality of care.

The pregnant women interpret the forwarding to physicians as a limitation of the technical knowledge of the nurse. It is observed that the separation between the mental and the physical remains and that the pregnant women consider that talking about their mental state means talking about something very intimate and personal. Similarly, the nursing team does not perform the mental examination, not even simplified, to detect the main prevalences of mood swings, not taking into account the impact of these changes on the physical condition of pregnancy and its consequences in the postpartum, especially for the mother's emotional availability to take care of the baby in the most frequent cases of postpartum depression.

The access difficulties to basic medication and the obligation to have the resources to purchase this medication were highlighted. Another negative factor was the three-month delay to obtain the results of the cancer preventive exams and the ultrasound examination, which negatively affects the preventive function of these exams, the identification of damages and injuries, and/or alterations. Failure to comply with schedules and lack of cordiality on the part of the employees generated malaise and could undermine the assessment of prenatal care quality.

REFERENCES

1. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Guia prático do agente comunitário de saúde. Brasília, DF: Ministério da Saúde; 2012.
2. Domingues RMSM, Viellas EF, Dias MAB, Torres JA, Theme-Filha MM, Gama SGN, *et al.* Adequacy of prenatal care according to maternal characteristics in Brazil. Rev Panam Salud Publica [Internet]. 2015 [cited 2018 Feb 23]; 37 (3):140-7. Available from: https://www.scielosp.org/article/rpsp/2015.v37n3/140-147/pt/
3. Suhre PB, Costa AEK, Pissaia LF, Oreschi C. Systematization of nursing assistance: perceptions from pregnant women monitored at a basic health unit. Rev Ciênc Saúde [Internet]. 2017 [cited

2018 Feb 23]; 5(1):20-31. Available from: http://www.revistaeletronica.unicruz.edu.br/index.php/enfermagem/article/viewFile/5488/1054

4. Ministério da Saúde (BR). Departamento de Informática do Sistema Único de Saúde. Sisprenatal. Brasília (DF): Ministério da Saúde; 2015 [cited 2016 Dec 15]. Available from: http://datasus.saude.gov.br/sistemas-e-aplicativos/epidemiologicos/sisprenatal

5. Brasil. Decreto no. 94.406, de 8 de junho de 1987: regulamenta a Lei nº 7.498, de 25 de junho de 1986, que dispõe sobre o exercício da enfermagem, e dá outras providências. Diário Oficial da República Federativa do Brasil, Brasília, 9 de junho de 1987.

6. Pohlmann FC, Kerber NPC, Pelzer MT, Dominguez CC, Minasi JM, Carvalho VF. Prenatal care model in the far south of Brazil. Texto Contexto Enferm [Internet]. 2016 [cited 2018 Feb 23]; 25(1): e3680013. Available from: http://dx.doi.org/10.1590/0104-0707201600003680013

7. Pitilin EB, Pelloso SM. Primary care sensitive admissions in pregnant women: associated factors based on the prenatal care process. Texto Contexto Enferm [Internet]. 2017 [cited 2018 Feb 23]; 26(2):e06060015. Available from: http://dx.doi.org/10.1590/0104-07072017006060015

8. Gaíva MAM, Palmeira EWM, Mufato LF. Women's perception of prenatal and delivery care in cases of neonatal death. Esc Anna Nery [Internet]. 2017 [cited 2018 Feb 23]; 21(4):e20170018. Available from: https://doi.org/10.1590/2177-9465-ean-2017-0018

9. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 14th ed. São Paulo, SP: Hucitec; 2014.

10. Minayo MCS. Pesquisa social: teoria, método e criatividade. 29th ed. Petrópolis, RJ: Vozes; 2010.

11. 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 [cited 2016 Nov 10]; 7(5):4354-63. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/download/4355/6376

12. Aguiar RS, Aguiar N, Costa MA, Araújo MAB. Perception of women about the nurse's reception in prenatal care. Cogitare Enferm [Internet]. 2013 [cited 2016 Dec 10]; 18(4):756-60. Available from: http://revistas.ufpr.br/cogitare/article/view/34933

13. Stumm KE, Santos CC, Ressel LB. Tends of studies about prenatal care in nursing in Brazil. Rev Enferm UFSM [Internet]. 2012 [cited 2016 Nov 10]; 2(1):7165-73. Available from: http://cascavel.ufsm.br/revistas/ojs2.2.2/index.php/reufsm/article/view/3060/3143

14. Ministério da Saúde (BR). Política Nacional de Humanização. Brasília, DF: Ministério da Saúde; 2010.

15. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Política Nacional de Atenção Integral à Saúde da Mulher: princípios e diretrizes. Brasília, DF: Ministério da Saúde; 2011.

16. Ferreira GM. Acolhimento: um processo em construção. [monografia] Belo Horizonte, MG: Universidade Federal de Minas Gerais; 2009. [citado 2016 Nov 15], Available from http://www.nescon.medicina.ufmg.br/biblioteca/imagem/2258.pdf.

17. Anversa ETR, Bastos GAN, Bastos LAN, Nunes LN, Pizzol TSD. Qualidade do processo da assistência pré-natal: unidades básicas de saúde e unidades de Estratégias Saúde da família em município do sul do Brasil. Cad Saúde Pública [Internet]. 2010 [citado 2016 Nov 10]; 28(4):789-800. Available from: http://www.scielo.br/pdf/csp/v28n4/18.pdf

18. Araújo DMR, Vilarim MM, Sabroza AR, Nardi AE. Depressão no período gestacional e baixo peso ao nascer: uma revisão sistemática da literatura. Cad Saúde Pública [Internet]. 2010; [citado 2016 Nov 10];26(2):219-27. Available from: https://doi.org/10.1590/S0102-311X2010000200002

19. Rezende Filho J, Monteiro CAB. Obstetrícia fundamental. 12th ed. Rio de Janeiro: Guanabara Koogan; 2011.

20. Costa CSC, Vila VSC, Rodrigues FM, Martins CA, Pinho LMO. Characteristics of prenatal care in the Basic Health Network. Rev Eletr de Enferm [Internet]; 2013 [cited 2016 Nov 10];15 (2):516-22. Available from: https://dx.doi.org/10.1590/S0104-11692006000500007

21. Guerreiro EM, Rodrigues DP, Silveira MAM, Lucena NBF. Prenatal care in basic health care under the eyes of pregnant women and nurses. Rev Min Enferm [Internet]. 2012 [cited 2016 Nov 16]; 16(3):315-23. Available from: http://reme.org.br/article/details/533

22. Domingues RMSM, Hartz ZMA, Dias MAB, Leal MC. Evaluation ofthe adequacy of prenatal care in the SUS network in the city of Rio de Janeiro, Brazil. Cad Public Health [Internet]. 2012 [cited 2016 Nov 10]; 28(3):425-37. Available from: https://www.arca.fiocruz.br/handle/icict/9417

23. Ministério da Saúde (BR). Portaria nº 1.459, de 24 de junho de 2011. Institui, no âmbito do Sistema Único de Saúde – a Rede Cegonha. 2011 [cited 2016 Nov 15]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt1459_24_06_2011.html

24. Rodrigues DP, Alves VH, Penna LHG, Pereira AV, Branco MBLR, Silva LA. The pilgrimage in the reproductive period: a violence in the obstetric field. Esc Anna Nery [Internet]. 2015; [cited 2016 Nov 10]; 19(4):614-20. Available from: https://doi.org/10.5935/1414-8145.20150082

25. Pereira KGP, Abreu RMSX, Leite ES, Sousa AKA, Farias MCAD. Attention to women's health in prenatal care. REBES [Internet]. 2015 [cited 2016 Nov 20]; 5(4):1-8. Available from: http://www.gvaa.com.br/revista/index.php/REBES/article/view/3662/3314

26. Silva ZN, Andrade B, Bosi MLM. Access and shelter in prenatal care in the light of pregnant women's experiences in Primary Care Health Debate [Internet]. 2014 [cited 2016 Nov 25]; 38(103):805-16. Available from: http://www.scielo.br/pdf/sdeb/v38n103/0103-1104-sdeb-38-103-0805.pdf

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There is no conflict of interest.

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