THE KNOWLEDGE OF NURSES IN THE PRENATAL CARE CONTEXT

M. Dias Gonçalves¹, I. Sanches Giacometti Kowalski², A. Cristina De Sá³

¹ São Camilo University Center Espírito Santo (BRAZIL)
² São Camilo University Center - São Paulo (BRAZIL)
³ Anhembi-Morumbi University São Paulo (BRAZIL)

Abstract

Aiming to improve low-risk prenatal care, the Brazilian Ministry of Health proposed a reorganization of the care model. The main objective of the program is to increase the quality of the services provided. The priority is the establishment of strategies for permanent education of health professionals developing their basic skills for professional practice. This study aimed to identify the skill profile of nurses regarding the knowledge in low risk prenatal care in the Family Health Strategy of the South of Espírito Santo State. This study is an exploratory, descriptive and cross-sectional research with qualitative approach. The sample included 83 nurses from 23 cities in the selected geographic region. A standardized questionnaire was created for this study. The Bardin technique was used for data analysis. The results indicated the predominance of nurses aged between 24 and 33 years. Most of them had completed the undergraduate nursing course 6 to 10 years ago. As for the work plan, 45% of the sample has a temporary service contract, and 53% followed public tender process. It was shown that 90% of the sample concluded postgraduate courses, with prevalence in the public health area. Knowledge analysis was categorized and sub-categorized: knowledge of the manual (updating and outdating); knowledge of the institutional protocol (knowing, not knowing and importance of protocol); knowledge of integrality in actions (comprehensiveness and little knowledge); knowledge on the classification of risk profile (professional awareness and culture); knowledge of professionals in monitoring and evaluating care (information, registration, prenatal care and immunization). “Knowledge” is considered a fundamental aspect, in the sense of the need for appropriation of knowledge, starting from the training process for instrumentalization of nurses in the development of the necessary skills for their professional practice. The need for greater investments in In-Service Permanent Education was observed in order to improve professional practices in relation to prenatal care, and to improve the quality of health services.

Keywords: Professional skills, prenatal care, permanent education, nurses, Family Health Strategy.

1 INTRODUCTION

Despite advances in health, Brazil has still many challenges to overcome. According to the Ministry of Health (MOH), women’s health is a priority of the government, which is committed to implementing health actions that contribute to women’s human rights and reduce morbidity and mortality from avoidable and preventable causes [1].

For a quality health care to women in the Basic Attention (BA), it is necessary to guarantee and carry out actions during pregnancy and puerperium. According to the MOH, it is up to the health team to welcome pregnant women and provide full assistance, using qualified listening for creation of bond. It is also worth noting that a satisfactory prenatal care requires identifying the real needs of pregnant women, as well as appropriate technical, scientific knowledge and resources to carry out quality actions in the pre-natal ([2], [3]).

Nurses are important in the care process and have the client as their subject, with the duty to participate in the process of evaluation of “doing in Nursing” in order to contribute to the improvement of care provided in health services, including in the Family Health Strategy [4].

The aim of this study was to identify the knowledge of nurses in low-risk prenatal care under the Family Health Strategy (FHS) in the south of the State of Espírito Santo, considering the importance of the skills of nursing professional in the work performed by the FHS units of the State in accordance with the local reality, aiming, in particular, to improve the assistance provided to its citizens.
2 METHODOLOGY

This is an exploratory, descriptive and cross-sectional study with qualitative approach. The sample included 83 nurses from 23 municipalities in the selected geographic region. A semi-structured questionnaire was used with questions based on the proposals of Basic Care Booklet nº 32 of the Ministry of Health, Brazil - Attention to Low-Risk Prenatal Care published in 2012.

The research instrument consisted of open questions about the knowledge needed by nurses to develop low-risk prenatal care: knowledge of the low-risk prenatal manual; knowledge of the institutional protocol; knowledge of integrality in prenatal health actions; knowledge on the classification of risk profile of pregnant woman and knowledge of the profile of pregnant woman assisted in prenatal care.

Data was collected in loco, in the municipalities and in an individualized manner, according to the Opinion nº 496,121 of the Research Ethics Committee of the São Camilo University Center - São Paulo, which approved the study. The analysis of the results was carried out according to Bardin, respecting the steps: pre-analysis; material exploration; treatment of results [5].

3 RESULTS

In the characterization of participants, there was a predominance of nurses aged between 24 and 56 years, and mostly 6 to 10 years elapsed after conclusion of the undergraduate training. According to the sample, 45% of the nurses have a temporary contract, and 53% are public service tenderers. It was verified that 90% of the participants had done postgraduate courses, mostly in the public health area.

We attempted to understand the "knowing" competence of the research participant. During the analysis of this study, the relevance and the idea repetition, according to Bardin, were used as criteria for the selection of categories and subcategories.

3.1 Category ‘Knowledge of the low-risk prenatal manual’

3.1.1 Subcategory ‘Updating’

This subcategory presented the coding of the knowledge of participants in relation to the updated low-risk prenatal care booklet. There was a demonstration of professional commitment to know and follow the recommendations adopted for prenatal care, as follows:

_I am aware of the fact that it contains the essential information for low-risk prenatal care, and, in this way, it can guarantee quality care, resolution and scientific and organized knowledge (P32). I knew the manual within the FHS, I studied it and I started to execute the protocol (P38)._ 

Therefore, they place the manual as a document that needs to be studied. They also report the existence of a municipal protocol that nurses follow to perform prenatal care. By knowing the recommendations of the MOH and of the municipality, the participants demonstrated a professional conduct that can contribute to improve the quality of the health service.

The MOH manual aims to provide guidelines for prenatal care based on more updated evidence, guaranteeing access to a quality literature and guiding professionals about the work process, as well as follow-up of usual risk pregnancy and possible intercurrences [3].

We observed that the participants demonstrated interest in new knowledge, highlighting essential prenatal care points studied during the training offered to the group:

_There was a training course with the nursing team of the municipality that started with our interest. We had contact with issues that are the responsibility of the nurse during low-risk prenatal care, stimulation to adherence, reception, follow-up of routine visits and physical examination (P65)._ 

In the temporal analysis of the training of health professionals, there was an approximation between MOH and the Ministry of Education, facilitating the formation of human resources in the SUS [6]. There was also a greater participation of these professionals in political processes and decisions related to training, outlined in loco regional instances, valuing regionalization and decentralization as national health policy. According to the Ministry of Health, FHS professionals should have a proactive approach towards the health problems of the population [7].
The National Policy on Permanent Health Education of the MOH raises an issue to be considered regarding the education of health professionals, noting that this training process is fundamental and must be planned, designed and executed according to the strategic analysis of the service [8].

3.1.2 Subcategory 'outdating'

This subcategory presents responses from the participants about their knowledge about the manual. In the answers, they recognize the need to update themselves, considering the knowledge they have insufficient. They emphasize in their answers the previous manual knowledge (2006), not the manual current one (2012).

"I am only aware of the 2006 booklet, the end-of-course written paper on Primary Care was about prenatal care at the FHS (P6)."

"Yes, but I have not read it yet (P10)"

We observed those who did not perceive themselves to be out of date. Participants reported that they have used the manual, but they cite the previous MOH manual (2006) as an instrument to guide their practices.

"I have access to the 2006 manual of the Ministry of Health; it is the manual that I study to carry out the monitoring (P3)."

"I use the 2006 low-risk prenatal care manual, which directs care to pregnant woman from the first contact to the puerperium (P67)."

Participants responded on access to knowledge, and, with a critical eye, point out some problems to be discussed within the scope of management, as follows:

"I did not have access (P15)."

"I do not know why I did not get it from the Municipal Health Department (P19)."

The answers highlight the need to make the low-risk prenatal manual of the MOH available in the Health Units. It is worth mentioning that having the initiative to seek knowledge becomes fundamental in the digital age, when information spreads fast.

In the study, we could identify that the participants affirm in their answers to ignore the current low-risk prenatal manual (2012), as follows:

"The 2012 one, no, only the previous manual […] (P30)."

"I do not know the 2012 manual (P78)."

In this result, the participants assume that they do not know the most updated material, thus having an outdated knowledge about prenatal care, which may compromise the quality of care and endanger the life of pregnant women and their babies. Updating is fundamental to the exercise of the profession; the qualification of professionals is still a great challenge to be faced [3].

3.2 Category ‘knowledge of the institutional protocol’

3.2.1 Subcategory ‘knows the institutional protocol’

We sought to identify the knowledge of participants about the protocol of care approved by the institution, as follows:

"The new protocol was only started so that the first consultation is performed by the nurses, it does not exist for subsequent consultations (P22)."

"Consultations interspersed with the doctor; examination and orientation requests (P30)."

In the answers, we noticed that there are municipalities that have the service protocol, but with restrictions regarding nursing consultations. The MOH recommends that nurses, among other activities, be able to perform nursing consultations in usual risk prenatal care according to the local protocol [3].

"It is necessary that the protocols be based on manuals, technical standards, consensuses and other documents made available by the MOH or the State Department of Health, adapting it to the local reality [10]."
They showed to recognize the need for professional autonomy and that the protocol helps them in this matter:

**Nurses can and should provide low-risk prenatal care [...] (P31).**

The nurse must have autonomy to perform prenatal consultation and monitoring of actions (P73).

In the responses, the participants emphasized the professional autonomy necessary to perform prenatal consultations, demonstrating interest in assuming their responsibilities regarding low-risk prenatal care, following the MOH guidelines.

### 3.2.2 Subcategory ‘does not know the protocol’

Participants said not to be aware of the existence of a municipality protocol for prenatal care:

**Despite knowing the protocol of the Ministry of Health, in the municipality where I work, there is no prenatal care protocol (P25).**

The city does not provide this protocol. I follow the protocol of the Ministry of Health (P38).

We observed the opposite relationship between knowing and not doing, showing signs of discontentment. Regarding the protocol of assistance, they emphasize that, the discussion of protocols in municipalities does not occur and, when it occurs, it is not clear and has no active participation of health professionals. They mention the responsibility of the municipality to provide the protocol, which should direct the health service, adapting it to the local reality under its responsibility, and following the SUS guidelines in order to effectively improve the health conditions of the population [10].

### 3.2.3 Subcategory ‘knowledge on the importance of the protocol’

We sought to identify the relevance of a protocol of care approved by the Institution for the professional practice of nurses, emphasizing legal aspect, as follows:

**The protocol is an important reference in the nursing consultation to pregnant women, because it gives support to the professional in relation to the care and practically provides a script for a quality consultation (P50).**

Through the protocol, we can correctly follow the prenatal routine. It serves as a support for the professional and is essential for adequate assistance (P61).

Participants express a positive opinion about the legal support for the professional in the performance of their prenatal activities and refer to the protocol as a standard conduct to patient care and safety.

This can be seen as a facilitating point in the implementation of the document in the municipalities. It is worth remembering that knowing prenatal routines and their importance does not guarantee quality care. It is necessary to develop skills to perform the care with quality and safety.

It is evident that the protocol makes the participants feel more confident, because the protocol is an instrument that supports the activities within the institution where they provide assistance. The establishment of a prenatal care protocol provides safety in the performance of their duties [11].

In the nurses' view, the protocol of the municipality should be considered a security in the exercise of their functions, since it is a normative document, provides support, protects and directs the activities carried out by the professionals in the BA context, specifically in family health [10].

The participants recognize in their responses the service protocol as an instrument capable of strengthening the link between nurses and the staff and between nurses and the pregnant women, as follows:

I think it is very important because the nurse becomes closer to the pregnant women, pity that we do not have protocols (P20).

*It is important, because it establishes a greater bond with the pregnant woman ... exercising an educational and technical role with the nursing consultation (P49).*

When we consider the answers, it is worth emphasizing the importance of having professionals in the municipalities that value the link with pregnant women. Municipal management to concretize the situations was raised by the participants.
Family health teams need to be responsible for pregnant women in their covered area in the coordination of care, even when referred to a specialized service. Greater bond between women and health teams and best service lead to greater chance of early detection a pregnancy, prenatal initiation, orientation and actions of contraceptive counseling [3].

### 3.3 Knowledge on ‘integrity in prenatal health actions’

#### 3.3.1 Subcategory ‘definition of integrity’

We sought to understand what the participants know about integrity in health actions focused on prenatal care, as follows:

*Reception with a holistic approach, guidance and awareness of the team to facilitate the access to the BHU. Provision of care in multiprofessional treatment (P26).*

*Not evaluating only the gestation, but other aspects of pregnant women, such as psychological, social and health factors in general (P33).*

In the answers, a perspective with multiple meanings is observed related to the practice of welcoming pregnant women and evaluating their health conditions and psychosocial values. We also observed that there are participants with a critical view on the effectiveness of health actions in order to guarantee integrity, as follows:

*What depends on the team we manage to do, but integrity is not guaranteed because many actions depend on other sectors (P25).*

*There is still much to do for me to say that I offer integral attention to pregnant women, but today we are concerned with food, prevention of other diseases and prenatal care itself (P74).*

Participants demonstrate a broad view of the concept of integrity and express the need to discuss the issue among health professionals.

In relation to the preparation of health professionals, it is essential to have spaces for debates, seminars and other activities of permanent education in the Health Units to add more knowledge to the health professionals who assist pregnant women [12]. Permanent Education Circles (understood as a space for collective discussion) represent the way to construct integrity in health care, where the actors discuss situations and problems of their daily work life in order to improve the team work process [13].

#### 3.3.2 Subcategory ‘little knowledge’

Participants were able to present their knowledge about integrity when focused on their professional practice:

*I have little idea, not enough (P4).*

*The need to have an adequate unit with equipment that give support for quality service (stretcher, sonar ...) (P73).*

The answers demonstrate little knowledge about integrity and call our attention to reflect on the professional practices of health care and their relationship with the concepts and principles of SUS that must be followed in health care, including in the case of low-risk prenatal care at the FHS.

Health professionals must know the integrity of the attention, since this represents an important mechanism for the quality of health actions. Nurses must also be aware of the diagnosis of the health situation of the population served, to provide all kinds of care that may be necessary and to know the organization of the care networks [14].

### 3.4 Category ‘knowledge on the classification of risk profile of pregnant woman’

#### 3.4.1 Subcategory Professional awareness

We sought to identify the knowledge of participants regarding the importance of risk classification of pregnant women in prenatal care, as follows:

*It is of great importance for the early identification of risk factors (P41).*
From the classification we define which care measures the pregnant women needs during the prenatal care. In high-risk cases, we forward and monitor them to avoid possible complications during delivery and puerperium (P50).

The answers show the early identification of risk signs and the need to forward the pregnant women to reference services when necessary. They demonstrated knowledge that evaluating the risk during pregnancy should be the target of the professionals involved in prenatal care.

This fact is in line with the recommendations of the MOH, which arguments that it is relevant that family health teams within BA be prepared to provide integral and resolutive assistance, contributing to the improvement of prenatal care quality [15].

Regarding the importance of the risk classification of pregnant women, the participants value the follow-up and emphasize the interaction with other professionals, as follows:

Along with the doctor of the team. Because prenatal care is provided by both professionals (P18).

Yes, because even prenatal care is not performed at the FHS, it is necessary to know about all pregnant women and their risks so that the FHS may work with the gynecologist doing the interventions (P32).

The response of (P18) demonstrates effectiv eness in work relationships and values the prenatal care provided by the team. The MOH clarifies that the work is composed of several knowledge types, practices and actions that, if applied to the interdisciplinary relationship, complement each other [16].

They emphasized the need for FHS teams to work in line with reference sectors to give continuity to high-risk prenatal care, thus avoiding service fragmentation, constituting in this case the care networks. The MOH recommends that integral assistance must be provided and that the design of care flow be evident and in accordance with the health region [3].

3.4.2 Subcategory ‘culture’

When answering about their knowledge regarding the risk classification, the participants recognize aspects related to human behavior, as follows:

The adherence of pregnant women is still low because they think they can only do prenatal with the obstetrician. The belief in the biomedical model is still strong (P66).

In our culture, people only accept consultation with the obstetrician (P12).

It was identified that the participants did not perform the risk classification, since the pregnant women do not adhere to the consultation. Another factor evidenced was the choice for specialists, strengthening the view of the biomedical model demonstrated by the population.

According to the MOH Manual of High-Risk Prenatal Care, there are ways in which prenatal care can be facilitated, such as: early prenatal care; home visits; educational groups, among others. These actions increase the chance of strengthening the relationship of pregnant wome with health teams, besides establishing the bond with the pregnant women, families and the community [3].

3.5 Category ‘knowledge of professionals in the monitoring and evaluation of care’

3.5.1 Subcategory ‘information’

We sought to identify the knowledge of participants about the aspect related to the number of pregnant women in their territory, as follows:

We have 28 pregnant women registered in SISPRÉNATAL (P29).

I have 15 pregnant women, two of them at high risk (P49).

Participants answered to be informed about the number of pregnant women under the responsibility of the team, which demonstrates professional involvement.

In terms of information, other participants answered to be unaware of the number of pregnant women in the area of activity of the team to which they belong, as follows:

I do not have the exact number (P58).
I do not remember (P62).

In view of the reports, it was observed that the study includes informed participants and others who acknowledge that they do not have information about the subject studied. It is worth mentioning that the MOH recommends knowing the clients of the area under their responsibility, as well as women of childbearing age and those who wish to become pregnant [3].

3.5.2 Subcategory ‘registration’

We analyzed the responses of participants who are aware of the number of pregnant women registered by the team in the Health Unit, as follows:

*I know all pregnant women registered in the month, because I am the one who makes the registration. When the pregnant woman does not want to do prenatal with the team, an active search is performed (P57).*

*I know them all [...]. Approximately 90% of pregnant women are followed up by the team. Active search, team meetings, pregnant group and baby kit are positive points (P65).*

The answers show that the participants are involved in this process and that the pregnant women’s registration tool favors the first contact, strengthening the bond. Another important finding revealed in the research was the work carried out by the CHA, who assists in the spread of knowledge and in the monitoring of pregnant women by the team. It was highlighted in their answers that pregnant women see as positive the gifts offered in prenatal care, making this aspect one of the positive points of health practices.

In the responses, there were participants who acknowledged that they were not informed about the use of the registration of pregnant women:

*I do not know (P43).*

*I do not know about 70% (P79).*

The answers revealed participants who have involvement and others who are not involved in the prenatal care of the pregnant women in their covered area. These data is reason of concern. It is necessary to understand the real situation of pregnant women in these territories. Considering the FHS as the prime entrance door of pregnant women into the health service, it is the duty of the team to locate these pregnant women as early as possible. The registration represents an opportunity to approach these pregnant women.

The entry point of pregnant women into the health system is the Health Unit, considered a strategic point for the reception and follow-up of prenatal care. The registration of pregnant women, when the pregnancy is confirmed, is advisable, with completion of the electronic file or the SISprenatal card, and the card of the pregnant woman, which is a right of the pregnant women. Regarding the Rights of pregnant women, the MOH recommends that FHS teams know and guide the women on their legal aspects and rights: social; labor relations; abortion; reproductive rights, and on the rights of the father [3].

3.5.3 Subcategory ‘up-to-date prenatal’

We sought to analyze the answers of participants regarding the knowledge of up-to-date pre-natal of pregnant women, as follows:

*The majority of pregnant women start in the first trimester because they ask health agents to send them as soon as they find them. One of the limiting factors is when they start in another Unit (P22).*

*Today, all started prenatal care in the first trimester and do not miss appointments. When necessary, we re-schedule for another day (P56).*

In the responses, they demonstrated a commitment with the follow-up of the pregnant women. They emphasized the decision-making of situations of absence of follow-up of the pregnant woman by the team, as a way of monitoring the situations of the territory, what may compromise the health of the pregnant women.

We observed that there are those who are unaware of the number of pregnant women with up-to-date prenatal care or who do not know to accurately inform on this aspect, as follows:

*I do not know (P13).*
I think 70% of them have their prenatal care on schedule [...] I think they do not do it for carelessness (P20).

The fact that the participants do not know about pregnant women with up-to-date prenatal care may indicate a lack of professional involvement, and may also compromise the monitoring and evaluation of the actions to be taken by the team in low-risk prenatal care.

Initiatives to improve access and quality of BA are important recommendations while working with family health, using the FHS scenario, with an incentive to monitor and evaluate health practices, which is a very important aspect for the health service [17].

Another important issue concerns the judgment made by the professional regarding the pregnant women who are not doing prenatal care. In this case, it is important to consider the study of this cases, which must be carried out by the FHS team, in an effort to know who these pregnant women are; what are they doing; how they live; who is their family; which are their values and beliefs, etc., thus discovering the reason why they are not adhering to prenatal care. This way, a resolution to the case may be possible.

With the objective of knowing the individual and the family and using a professional approach in the context of health care, personal conceptions of beliefs may be deconstructed and prejudices rooted in society may be eliminated, in order to better understand the human being and provide adequate assistance to the individuals [18].

When it comes to prenatal care, we sought information on the performance of active search for pregnant women who are not yet receiving prenatal care, as follows.

Active search is done through home visits of the health agents, who schedule the missing pregnant women. If they continue to be missing, a home visit is done by the team (P67).

We do not always do. We have difficulties to carry out active search due to the structure of the office (lack of car, human resources, etc.) (P66).

The participants showed organization in the work process to make prenatal actions effective, contributing to the quality of care. For effective and quality prenatal care, it is necessary to make sure, among others, the realization of active search of pregnant women who are absent from prenatal care in the continuity of care [3].

According to the MOH, it is the responsibility of municipal management to maintain the functioning of the network of basic health units and stimulate professional training in order to enable intellectual autonomy, "mastery of technical and scientific knowledge, ability to manage time and work space [...] to be aware of the quality and ethical implications of their work. Municipal management needs, therefore, to work in partnership with the teams, responding to the demands that have arisen from the population, in order to provide support and guarantee the necessary resource for better health [19].

3.5.4 Subcategory 'immunization'

We tried to identify if the participants know the pregnant women in their covered area, on the aspect of immunization. They revealed to know the pregnant women with up-to-date vaccine schedule, as follows:

Yes. 100%; because in the follow-up, the vaccine card is requested and, if necessary, it is updated (P34).

We have no difficulty in immunizing pregnant women [P55].

In the responses, the participants express the feeling of empowerment of the situation, which can be seen positively in the sense of commitment and responsibility with their work and their functions.

In other responses, it was observed that the participants acknowledged that they were not informed about this point, justifying as follows:

I do not know, but in our approaches in the FHS, it is a well explained and oriented topic and the FHS provides the vaccination (P32).

No, since the vaccination card is missing for this follow-up (P47).

We identified that there were participants who did not know about the situation of vaccination of pregnant women in their covered area. In an attempt to justify why they were not informed, we perceived a lack of initiative in seeking new information to assist in solving problems.
The MOH recommends the vaccination of pregnant women to provide protection for mothers and also for the babies. Furthermore, the MOH provides material resources for prenatal monitoring and, among other aspects, immunization with the follow-up card; the B sheet for pregnant women; and the registration in the system ([3], [2]).

4 CONCLUSIONS

We considered that "knowing" is a primordial aspect, in the sense of the need for appropriation of knowledge, starting from the training process for instrumentalization of nurses in the development of the necessary skills for their professional practice.

By analyzing the knowledge, it was possible to identify the need for updating based on the recommendations of the Ministry of Health, as a contribution to the improvement of issues involving low-risk prenatal care in the FHS.

It was verified the need for greater investments in In-Service Permanent Education in order to improve professional practices in relation to prenatal care, and to improve the quality of health services.

REFERENCES


