PRENATAL CARE OF RURAL WOMEN WORKERS IN THE FAMILY HEALTH STRATEGY

A ASSISTÊNCIA PRÉ-NATAL DAS TRABALHADORAS RURAIS NA ESTRATÉGIA SAÚDE DA FAMÍLIA

LA ASISTENCIA PRENATAL DE LAS TRABAJADORAS RURALES EN LA ESTRATEGIA SALUD DE LA FAMILIA

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ABSTRACT

Objective: to know prenatal care developed in the Family Health Strategy. **Method:** this is a descriptive study with a qualitative approach, with the participation of pregnant women, doctors and nurses from rural areas. The data collection was through semi-structured interviews and the analysis through the technique of Content Analysis in the Thematic Analysis modality. **Results:** it was verified that the prenatal consultations are focused on the medical professional, that the health professionals do not approach the environment and the work process of pregnant farmers. The guidelines showed that the process of communication between the professionals and the pregnant woman needs to be improved. **Conclusion:** low-risk prenatal care in the Family Health Strategy in rural areas is focused on the Biomedical model, and few professionals recognize/know the environment and the work processes of pregnant women farmers. **Descriptors:** Rural Workers; Prenatal Care; Family Health Strategy.

RESUMO

Objetivo: conhecer a assistência pré-natal desenvolvida na Estratégia Saúde da Família. **Método:** estudo descritivo, de abordagem qualitativa, com a participação de gestantes, médicos e enfermeiros do meio rural. A coleta de dados foi por meio de entrevistas semiestruturadas e a análise por meio da técnica de Análise de conteúdo na modalidade Análise Temática. **Resultados:** constatou-se que as consultas de pré-natal são centradas no profissional médico, que os profissionais de saúde não abordam o ambiente e o processo de trabalho das gestantes agricultoras e, nas orientações, evidenciou-se que o processo de comunicação entre os profissionais e a gestante precisa ser melhorado. **Conclusão:** a assistência ao pré-natal de baixo risco na Estratégia Saúde da Família no meio rural é focada no modelo Biomédico, sendo que poucos profissionais (re)conhecem o ambiente e os processos de trabalho das gestantes agricultoras. **Descritores:** Trabalhadores Rurais; Cuidado Pré-Natal; Estratégia Saúde da Família.

RESUMEN

Objetivo: conocer la asistencia prenatal desarrollada en la Estrategia Salud de la Familia. **Método:** estudio descriptivo, de enfoque cualitativo, con la participación de gestantes, médicos y enfermeros del área rural. La recolección de datos fue por medio de entrevistas semi-estructuradas y el análisis por medio de la técnica de Análisis de contenido en la modalidad Análisis Temático. **Resultados:** se constató que las consultas de prenatal son centradas en el profesional médico, que los profesionales de salud no enfocan el ambiente y el proceso de trabajo de las gestantes agricultoras. En las orientaciones se evidenció que el proceso de comunicación entre los profesionales y la gestante precisa ser mejorado. **Conclusión:** la asistencia al prenatal de bajo riesgo en la Estrategia Salud de la Familia en el área rural es enfocada en el modelo Biomédico, siendo que pocos profesionales (re) conocen el ambiente y los procesos de trabajo de las gestantes agricultoras. **Descriptores:** Trabajadores Rurales; Atención Prenatal; Estrategia de Salud Familiar.

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INTRODUCTION

Considered as the main entrance door of the patient into the health system, the Basic Health Unit (UBS) should receive and assist the pregnant woman in prenatal care in a comprehensive manner, observing the risk situations she is exposed to ensure the development of gestation, a healthy newborn, and a maternal well-being.¹

The traditional UBSs in Brazil are being structured by the Family Health Strategy (ESF), with the purpose of reorganizing basic health care in the country, surpassing the hospital-center model of curative care. According to Paim et al., The ESF focuses on families and communities, and on integrating health care with health promotion and preventive actions.²

This Strategy is intended to go beyond the biomedical care model. In this new model, the multi-professional team is composed of a physician, nurse, nursing technician or assistant and community health agents (ACS), able to be added a dental surgeon and an oral health technician or assistant.³ The actions of these professionals in their acting territory, at individual and collective levels, must be in accordance with the health needs of pregnant women, considering the criteria of frequency of risk, vulnerability and resilience. Regarding health actions, the team should plan and implement activities including health promotion and protection, disease prevention, diagnosis, treatment and rehabilitation of health, as well as the maintenance of the health of pregnant women through the involvement, responsibility and participation.¹

The common characteristics to certain populations should be recognized as influencing people's living and health conditions. To this end, it is necessary to adopt territorialization processes that contribute to the knowledge of the population's life context, their health problems and needs, and the formulation of a diagnosis as a basis for health surveillance work.⁴

The continuous process of territorialization must permanently contemplate the dynamics, seeing the territory lived as locus to operationalize intersectorality (ies), helping the people who live there, and solving their complex problems.⁵

The National Obstetric and Neonatal Care Policy ensures the right of the pregnant woman to prenatal care. Due to the needs of simple behaviors to solve them of the health professional for the woman during pregnancy,

not requiring the use of high technology, this care can be performed in the basic health unit. However, this Policy does not address the specificities of the work environment of the pregnant women. In this case, attention is drawn to the work process of pregnant women in the rural environment, since the environment in which the productive process is developed can generate exposure to physical, chemical, biological, mechanical and ergonomic risk factors, causing predictable and preventable complications during gestation.

During prenatal care, professionals should consider the specificities of this type of population, the prevalence of common diseases and gestational risks. Therefore, this study is justified by the need to verify if the health professionals of the ESF team adopt a differentiated approach for the rural pregnant women in the prenatal care, since they are exposed to rural work risks.

OBJECTIVE

- To know the prenatal care developed in the Family Health Strategy.

METHOD

This is a descriptive study with a qualitative approach, carried out in the second semester of 2013 in all six Family Health Strategy units (ESF) covering the rural area of a municipality in the west of Santa Catarina, considered as an economic and agroindustrial center. It is also recognized for the export of food products of animal origin, ancestry in the Basic Education Development Indexes (IDEB) and the Gross Domestic Product (GDP), the rate of creation of companies and jobs, exceeding the state and national averages of new jobs in the formal labor market in 2011.⁷

All the doctors (D) and nurses (N) who worked in the rural environment of the municipality under study, totaling four professionals of each study, participated in the study. There were also seven pregnant women (P) rural workers included in the research who fit the criteria of inclusion of the research: more than 18 years old; formal and/or informal rural workers (engaged in rural activity assisting the spouse or family member); in the third trimester of gestation at the time of data collection, and not starting labor before attending the interview; having prenatal in the Health Unit of the territory in which they lived.

The procedure for data collection was the interview, using a script with semi-structured

questions to encompass all the faces of the research object, to facilitate the approach, to guide the interview between the collaborator and the researchers, avoiding the loss of the focus and objectives of the study, as well as to know the perspective of social actors.⁸

Before the attentive listening of doctors, nurses and pregnant women, a pilot test of the interview script was applied with a doctor and an ESF nurse and with a pregnant rural worker in a neighboring municipality by three scholars from the National Center for Scientific and Technological Development (CNPq), academics of the 8th period of the Nursing course, qualified to participate in the study. After the return of the pilot study, the reason hindering the participant to answer the questions was evaluated. In this case, the instrument was reassessed and revised to clarify and understand the issues.⁸

Following the appointment of the interview with the health professionals, it was agreed as a place to carry out the work unit. However, it was not always done on the day and time previously scheduled, due to the demand of patients and the services provided were prioritized. Thus, some interviews needed to be rescheduled.

After having interviewed all the doctors and nurses of the health units, the first contact with pregnant rural workers and the scheduling of the home visit was carried out, so an interview was promoted, through the community health agent of the ESF, facilitating the insertion of researchers in the study environment.

The conversations were recorded by the researchers and transcribed in full by the students who had access to the audio recording. Subsequently, the transcripts were checked by the researchers by listening of the files.

The understanding and interpretation of the data was made through the Thematic Content Analysis, followed by the following steps: pre-analysis consisted in the choice of the questions to be analyzed from the resumption of the research objectives. In this step, the unit of registration was determined, that is, the keyword, phrase or theme inserted in the unit of context of each question analyzed. Then, there was the exploration of the material consisted in reading and re-reading the material. The registration units defined in the previous step were searched from the context units. In the treatment and interpretation of the data, the researchers sought interpretation according to the apprehension and internalization of the

themes that underlie the research and the proposed objectives, ensuring the criteria of reliability and validity.⁸

It is worth mentioning that, in the initial approach process, the study participants were informed about the research objectives, besides ensuring the preservation of their identity and voice. Those who agreed to participate in the study requested the signing of the terms of Free and Informed Consent (TCLE) and Voice Use, according to guidelines and regulatory norms of research involving human beings.⁹

The project of this study was evaluated and approved by the Municipal Health Department of the city and by the Research Ethics Committee, under protocol number 038/2013. The study was funded by the National Council for Scientific and Technological Development (CNPq).

RESULTS

Regarding the profile of the health professionals, a prevalence of females and age between 25 and 55 years old was observed. Most of the participants have more than five years of graduation, specialization in the area of public health. The health professionals said they did not receive specific training to provide assistance to pregnant rural workers. The work time of the professionals in the ESF varied between one and 21 years, and between four months and thirteen years in the ESF that covers the rural area.

Regarding the characteristics of pregnant women, they are between 18 and 38 years old, most of them have completed high school and their relationship with the partner is stable. In the time residing in the rural area, it ranged from five months to eleven years. Their labor activity is focused on poultry farming (collection and preparation for hatching eggs), dairy farming (manual and mechanical milking), animal feeding, shed cleaning (for feeding livestock and animal husbandry) and subsistence farming (planting, gardening/planting and harvesting). Three participants are employed and work on average seven hours a day. The rest work assisting the spouse or relatives in the seven days of the week, and the working time varies according to the function exercised, and it can reach 10 hours a day in dairy farming.

In the obstetric history of the pregnant women who participated in the study, most of them were multigested and the previous deliveries occurred at term, vaginally and by cesarean.

Regarding prenatal care, we will initially present it from the perspective of health professionals. In this case, the analysis of the interviews identified the categories: 1) prenatal care; 2) the preparation to assist pregnant rural workers.

Regarding the category of 'prenatal care', most of the professionals said that they requested the exams included in the city hall protocol such as blood count, VDRL, partial urine, fasting blood glucose, obstetric ultrasound, IgG and IgM toxoplasmosis, anti-HIV, anti-HBs, anti-HBc IgG, HBsAg, blood group and Rh factor and vaginal secretion, according to the following testimonies:

All those [exams] that are in the protocol here of the city hall. (D1).

Let me see it here [in the computer program]. So: blood count, blood typing, syphilis, vaginal secretion, partial urine, IgG and IgM toxoplasmosis, HBsAg, anti-HBc IgG, HIV, glucose, anti-HBs. We also request obstetric ultrasonography. (N2).

Also, extra tests such as thyroid stimulating hormone (TSH) are ordered by most physicians, as well as uroculture, indirect coombs, free T4 and abdomen ultrasound are also required, depending on the situation reported below:

It will depend on the findings in the first protocol, from the first tests. (D1).

Regarding the guidelines provided by health professionals to pregnant women during prenatal consultations, they were advised on technical issues related to the importance of prenatal care and the monthly number of visits, scheduling consultation with the dentist of the health unit, participation in the pregnant group, and which health unit to look for in case of pregnancy problems. Regarding the specific care of the pregnancy, they advise on the relevance of the exams, not self-medicate, the need for obstetric ultrasound, and the importance of vaccines. Regarding the gestational physiological alterations, the professionals guide on the corporal modifications, muscle pain, gastric malaise, bleeding, swelling in the legs, urinary tract infection, among others. About living habits, they talk about avoiding smoking and drinking in pregnancy and doing physical activity, as the following statements:

I guide on the importance of blood tests [...], the medicines that pregnant women can not use during pregnancy, the signs of alarm that they [pregnant] have to face in the case of water bag breaking, an arterial hypertension. (D2).

To avoid smoking and alcoholism; Physical activity. (D1).

I like to explain the need for [obstetric] ultrasonography. (D3).

The signs she has to observe if she [the mother] has bleeding and the care she should look for; in any different situation she should seek the doctor [...]; already invited to the group [of pregnant women]. (N2).

The reason why she [the pregnant woman] goes to the dentist, the reason for the vaccination. (N1).

I'm going to tell you about some changes they may have during pregnancy: muscle pain, a little bit of vomiting and swelling in the legs, so they know what's normal. (D3).

General measures to combat the main symptoms, such as: emesis, dizziness and urinary infection. (D4).

We are giving the lectures of pregnant women, this month we talked about the modifications of the body. (N3).

According to most of the professionals, the health guidelines are directed to the issues raised by the pregnant women during the prenatal visit, evidenced by the following statements:

It depends a lot on what doubts they have, as far as possible what they are asking, I guide. (N1).

We ask them [pregnant women] to say the doubts and depending on what they say, we reinforce the guidelines [...] (D1).

When questioned about the guidelines regarding the prevention of labor injuries of pregnant women, the professionals mentioned that they talk about the use of Personal Protective Equipment (PPE); the abstention of physical effort in the work and exchange of sector; care with the posture to preserve the spine; hygiene and alert to the mechanical risk of an accident at work, as evidenced by the following statements:

Many times, they [pregnant women] have been complaining that they are not able to exercise [labor] their activity, that they feel a lot of pain, then we suggest that they change sectors. Aim to use the protective materials where you need them. They [pregnant women] who harvest grass [herb-mate], avoid climbing the tree. (D1).

On the position at work, never lower yourself without flexing your legs so as not to overload the spine; Avoiding lifting too much weight if working on heavy. (N2).

Take care not to have an accident with animals during work. (N1).

I always advise on hygiene because they [many pregnant women] get milk from the cow, and that is one of the measures to avoid brucellosis. (D4).

Also, when guiding the pregnant woman, one of the professionals admits that she does

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not have much time during the consultation guiding her, trusting that additional guidelines are made in the pregnant group of the health unit, as evidenced in the following speech:

I guide in the consultation, but there is also the group of pregnant women, who [the pregnant women] have more guidelines. Sometimes, there is no time for us here to make all the guidelines, then they are done in the group of pregnant women [...]. (D1).

Regarding the category "the preparation to assist pregnant rural workers", at the end of the interview, the health professional was asked if he feels prepared to assist the pregnant rural worker, noting that none received specific training for rural assistance and most of them said yes. However, according to the professionals' statements, they are little aware of the health demands of the rural area, since, according to them, there is a lack of time to (recognize) know the rural environment and the life dynamics of pregnant women due to high demand in the health unit. Also, there is a lack of a full-time car for professionals to cross rural areas, since access to the vehicle provided by the Health Department is limited to a few days of the week.

A lot [about the pregnant rural worker] I'm learning during clinical practice. (D3).

If there were time to sit down and have a conversation with them [pregnant rural women] to understand a little of the routine I would need much more than 15 minutes, then I would have to have time for that, and a car available. (N2).

After completing the interviews with the health professionals, the interviewed pregnant rural workers to know the prenatal care developed in the ESF of the rural area in their perspective. At this stage, the analysis of the interviews resulted in the category 'prenatal care'. For most pregnant women, prenatal care was started before ninety days of gestation, and they performed more than five consultations until the third trimester of pregnancy, according to the following statements:

I started [prenatal] a month and a little. (P1).

I think I was entering the third [month] already, or two and a little I think I was. (P6).

I think I did about six, seven consultations. (P3).

Although the first consultation was with the nurse, the rest of the prenatal care was centered on the medical consultation, demonstrated in the statements of the following pregnant women:

The doctor who did the other consultations. (P3).

The first time I had the prenatal care was the nurse, then she passed me to the doctor, but she [nurse] asked for the exams. (P6).

It was the nurse, but then I went to the doctor. (P7).

According to the reports of most pregnant women about the physical examination, it was focused on the breasts, abdomen and lower limbs:

She looked only at her belly. (P2).

Just looked at the belly (...) in all the consultations. (P3).

She looked at my breast, my belly, she heard the little baby's heart and told me to take off my stocking and squeezed my leg and foot. (P7).

Regarding the orientations related to the corporal changes, the pregnant women point out that the focus of the speeches of the health professionals was for the breasts and the abdomen. In the physiological aspect, there was relationship of the orientations with the gastric problem.

Change of body and breasts that belly grows; These things she was talking about. (P4).

The first time, even the nurse commented something that would be normal my discomfort, vomiting and nausea. The other [consultations] I went to the doctor, but she did not say anything. (P6).

She [the doctor] said that it would increase the breast, it would be very hungry, that the breast and the vagina would grow darker. (P7).

Regarding the health promotion guidelines, most of the pregnant women stated that they did not receive information about it. Among the guidelines received, they mention the food and physical exercise.

In the food, they [nurse and doctor] told me that I had to eat a lot of iron, [example] beans and meat. (P6).

Do not do too much exercise in early pregnancy until the 3rd and 4th month. (P7).

The pregnant women stated that health professionals did not question them about their environment and work process. This fact may have contributed to the omission of guidance on self-care actions against occupational risk factors during prenatal care, which led to the omission of the work environment factor in the guidelines, as evidenced in the following reports:

He did not ask [doctor] anything. (P4).

At no consultation did he [physician] ask, only in this last one [consultation] he

mentioned my varicose veins, then he asked what I was doing. (P6).

This lack of appreciation of the labor practice of pregnant women by health professionals indicates that the reality of pregnant women's work environment is poorly considered and evaluated, implying the fragility of comprehensive health care for prenatal workers.

DISCUSSION

It was observed that the pre-natal of six workers was started early in the ESF of the rural area, and most of the pregnant women performed the minimum number of six consultations recommended by the Ministry of Health. The MS proposes the onset of prenatal care in the first trimester or 120 days of gestation and the accomplishment of at least six visits as a basic condition for the assistance to pregnant women.¹⁰ Also, the onset of early prenatal care is a conditioning factor for a satisfactory gestational process. It indicates adequacy and impact of the intervention programs that have relation with the assistance to the pregnant woman.¹¹

Regarding the medical and nursing professionals responsible for performing the prenatal visit, most of the pregnant women stated that the doctor was the one who assumed the prenatal care from the second visit, so there is no intercalated follow-up of the professionals - physician and nurse - during prenatal care, as directed by the Brazilian Ministry of Health.¹⁰ Through the nursing consultation, it is possible to know the characteristics and health needs of pregnant women, which helps to orient the guidelines according to the real needs of this group, and being an opportunity to influence the change of the pregnant woman's habit, qualifying prenatal care.¹² Also, low-risk prenatal nurses in the basic health care network are guaranteed by MS and the Professional Exercise Law.¹⁰

In the physical examination performed at the prenatal clinic, it was noticed that the focus of the analysis of health professionals is the breasts, the abdomen and research of edema in the lower limbs. This result is analogous to the other studies carried out in Brazil.¹³⁻⁵ Also in the physical examination, it is necessary to consider at this moment, the integrality proposal, contrasting with the fragmentary and reductionist approach of the people, seeking to holistically approach the subject, considering biopsychosocial.¹⁶

Regarding the prenatal care that health professionals report, it was noticed that the exams requested by professionals are those part of the local prenatal protocol, as directed by MS.¹⁰ However, the health of workers is conditioned also to chemical and biological risk factors, which may be present in specific work processes⁶, evidencing that after a clinical analysis other exams are necessary.

The guidelines given by the doctor and nurse to the pregnant women regarding the number of consultations, non-self-medication, vaccination, physical activity, alcoholism and smoking, participation in the group of pregnant women in the ESF unit, and the importance of the exams and scheduling for consultation with the dentist are similar to the guidelines provided in prenatal care by health professionals from other ESF units, and they have also been found in studies conducted in the states of Rio Grande do Sul.¹⁵⁻¹⁷

Health professionals also advise on the body changes associated with pain, malaise, swelling in the legs and urinary tract infection. A similar situation was observed in the study that investigated the prenatal care provided in the ESF units of a municipality of Mato Grosso.¹⁸

At certain moments of prenatal care, the guidelines made by the doctors or nurses are directed by the questioning of the pregnant woman during the consultation, a situation that attests to the professionals' commitment to provide clarification and guide the pregnant woman based on her doubts.¹⁰ However, this conduct may compromise prenatal quality by considering that the pregnant woman, especially when primigravidae, may be lazy about the physical and physiological changes that occur during the gestational process¹⁹, as well as on gestational complications from occupational risks.²⁰⁻²¹⁻²² Also, the pregnant woman may stop asking the healthcare professional about her doubts about being shy, or feeling embarrassed. There may also be interference in communication due to the power relations that exist in communicative action, which are constituted by the context including: the clothes, the posture, the approach and the environment where the health professional acts.²³

Regarding the guidelines for the prevention of occupational factors, health professionals usually talk about the use of PPE, physical effort at work, care with posture, hygiene and mechanical risk of accidents at work. Regarding this item, it is pointed out that the

professionals admit to knowing only some risks the pregnant women are exposed during the rural work, a situation that can confirm the fragility of the integral health care in the prenatal of the rural workers, since these women develop productive activities that can expose them to harm. According to the National Policy on Integral Health of the Populations of the Field and the Forest, there are physical, chemical, biological, mechanical and ergonomic risk factors in rural work,⁶ requiring occupational guidelines beyond those described by professionals.

In addition, MS indicates the degree and classification of certain behaviors to be adopted or not in the clinical practice of gestational care, which follows a scale from A (highly recommended) to D (not advisable), being the environmental or occupational exposure component of risk classified in grade D.¹⁰ This fact may contribute to the lack of knowledge and/or negligence of health professionals about the approach to occupational risks that the pregnant woman is exposed.

Based on the context of prenatal care provided by health professionals to pregnant women assisted by the ESF in the rural area, presented from the perspective of health professionals, it is noted that professionals' actions are based only on the guidelines recommended by the Ministry of Health for effective assistance and quality prenatal care.¹⁰

It is noteworthy that in the care actions for the prevention of work-related injuries and health promotion of pregnant workers, most interviewees stated that they received no guidance. Regarding the guidelines, there was mention only of diet and exercise. It is noteworthy that during prenatal care the woman should receive information on the following topics: hygiene care, physical activity, nutrition, development of gestation, corporal modifications, symptoms and orientation of frequent complaints, warning signs, preparation for childbirth, care of the newborn, among other¹⁰, in addition to occupational self-care.

Regarding the absence of work-related guidelines, it should be emphasized that this information may not have been provided in a clear and precise manner, causing a lack of communication.²⁴ No message is effective in itself. In the dialogue between the parties, there has to be some sense, otherwise communication becomes one-dimensional, compromising the desired health action.²⁵ In addition, the dialogue between the health professional and the pregnant woman involves

different cultures and expectations, which also may have been harmed by the health professional not having focused on what the Ministry of Public Health and Ecuador's National Health Council denominate as interculturality in health care, a practice to adapt health care to the population's cultural needs, customs and traditions to satisfy a larger number of patients. From this perspective, the most relevant elements are the recognition of one's identity and the horizontal dialogue between the parties in the construction of agreements and the execution of pacts.²⁶

The aforementioned issues may explain why health professionals reported informing pregnant women about prenatal care during their prenatal visit, and pregnant women state that they had received no guidance about it. Regarding the absence of prenatal guidelines for pregnant women related to the context and life dynamics of the rural worker, it is worth noting that, when considering the worker's health issues (in prenatal care), it is necessary to know,, the productive activities carried out within the scope of the work of the health team, the workers through the situational diagnosis of the territory, and, if possible, the causes of illness and death in this group.²⁷

Likewise, an opportune moment to know the context of women's life and to guide them is in the agreement to the group of pregnant women. However, this prenatal care practice was not mentioned by pregnant women. It is worth mentioning that learning within the group of pregnant women is fundamental for the growth of professionals and stimulates the teaching-learning dynamics, informing pregnant women.²⁸

Also, a high level of clinical acumen is required in the performance of diagnoses, the ability to perform the necessary procedures in a context where access to a specialist is difficult, the visits to families, the use of technology to communicate and exchange information with colleagues in distant locations to work as a health professional in the rural context, considering the difficulties and geographical, cultural and socioeconomic barriers of the rural environment.²⁹

Based on the above and on the reports from health professionals and pregnant rural workers, there is a fragility in comprehensive health care for pregnant women in rural areas. Therefore, the actions of prenatal care reveal fragilities that can be minimized by health professionals, and women's health policies need to be debated and re-elaborated to meet locoregional specificities, since,

according to the professionals, the assistance provided to pregnant rural women follow the protocol of the Ministry of Health. However, it was evidenced, through the results of the study, that prenatal consultations are centered on the medical professional, with little participation of nursing.

According to professionals, they approach in their guidelines information that goes beyond physiological changes in the pregnancy process, including, in this case, aspects related to the pregnant woman's work environment, such as the use of PPE and other measures of occupational protection. However, the pregnant women participating in the study reinforce that the assistance received in the ESF during prenatal care is only focused on the medical consultation and the guidelines are specific to the gestational process, and there is no mention in their statements that they were oriented regarding risk factors and exposure in their work environment in rural areas. In this contradiction, there is the questioning about the way in which the communication between the pregnant woman and the health professional has been performed since the pregnant women do not remember to have received guidance regarding the labor care during the prenatal care performed at the ESF. Thus, it is worth reflecting on meaningful dialogue, in which words must make sense, have meaning and practical application in the dynamics of daily life.

Another point to consider is that this information is not provided to all pregnant women and, coincidentally, study participants were not given such care. It is worth mentioning that the professionals mention that they do not receive training on care for pregnant women in rural areas. Also, they assume that they know little about the territory where they operate.

It is necessary to uncover the risks inherent to the rural productive processes to assist the pregnant rural worker, necessarily implying to know the specificities of the work environment in which the pregnant woman is, since she can be harmful to the health of the pregnant woman and/or her child. Thus, the process of territorialization is highlighted as a method that contributes to the (recognition) knowledge of work processes in the rural environment and to the planning of health surveillance actions of this population, positively impacting prenatal care for pregnant women.

Finally, the need to rethink/re-elaborate/implement policies of assistance to the pregnant woman that directs the

professional care to the cultural and labor specificities of the pregnant women is emphasized. Moreover, even without a national policy that addresses these issues, it is important that health professionals seek to fully assist these pregnant women, recognizing more and better the environment and the work process in rural areas.

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