CHARACTERISTICS OF THE PRE-NATAL PHASE IN THE PERSPECTIVE OF WOMEN SERVED IN PRIMARY HEALTH CARE UNITS

CARACTERÍSTICAS DO PRÉ-NATAL NA PERSPECTIVA DE MULHERES ATENDIDAS EM UNIDADES DE ATENÇÃO PRIMÁRIA À SAÚDE

CARACTERÍSTICAS DEL PRE-NATAL EN LA PERSPECTIVA DE MUJERES ATENDIDAS EN UNIDADES DE ATENCIÓN PRIMARIA A LA SALUD

Leidiane Ferreira Santos¹, Sayonara Serafim de Brito², Cintia Flôres Mutti³, Nayane de Sousa Silva Santos⁴, Danielle Rosa Evangelista⁵, Leonora Rezende Pacheco⁶

ABSTRACT

Objective: to describe the characteristics of prenatal care from the perspective of the users of the service in Primary Health Care Units. **Method:** a qualitative, descriptive, exploratory study involving 17 women hospitalized in a public maternity hospital. The data production took place through semi-structured interviews, and the statements were submitted to the Content Analysis technique. **Results:** the analysis of the testimonies resulted in the proposition of the categories "Inadequate care for pregnant women attended to Primary Health Care Units" and "Construction of a link between the health team and pregnant women attending the Primary Health Care Units". **Conclusion:** although, there are many public policies in Brazil that guarantee the minimum number of consultations and humanized care, women realize that, this is not always the case in practice. There are flaws in the provision and implementation of services to pregnant women. **Descriptors:** Delivery of Health Care; Primary Health Care; Prenatal Care; Pregnant Women.

RESUMO

Objetivo: descrever as características da assistência pré-natal na perspectiva das usuárias do serviço em Unidades de Atenção Primária à Saúde. **Método:** estudo qualitativo, descritivo, exploratório, em que participaram 17 mulheres internadas em uma maternidade pública. A produção de dados aconteceu por meio de entrevistas do tipo semiestruturada e os depoimentos foram submetidos à técnica de Análise de Conteúdo. **Resultados:** a análise dos depoimentos resultou na proposição das categorias "Assistência inadequada às gestantes atendidas nas Unidades de Atenção Primária à saúde" e "Construção de vínculo entre equipe de saúde e gestantes atendidas nas Unidades de Atenção Primária à Saúde". **Conclusão:** apesar de, no Brasil, existirem inúmeras políticas públicas que garantam à gestante o mínimo de consultas e atendimento humanizado, as mulheres percebem que, na prática, isso nem sempre acontece. Há falhas na oferta e implementação de serviços às gestantes. **Descritores:** Assistência à Saúde; Atenção Primária à Saúde; Cuidado Pré-Natal; Gestante.

RESUMEN

Objetivo: describir las características de la asistencia prenatal en la perspectiva de las usuarias del servicio en Unidades de Atención Primaria a la Salud. **Método:** estudio cualitativo, descriptivo, exploratorio, en el que participaron 17 mujeres internadas en una maternidad pública. La producción de datos se produjo por medio de entrevistas del tipo semiestructurada, y los testimonios fueron sometidos a la técnica de Análisis de Contenido. **Resultados:** el análisis de los testimonios resultó en la proposición de las categorías "Asistencia inadecuada a las gestantes atendidas en las Unidades de Atención Primaria a la salud" y "Construcción de vínculo entre equipo de salud y gestantes atendidas en las Unidades de Atención Primaria a la Salud". **Conclusión:** a pesar de, que en Brasil, existan innumerables políticas públicas que garanticen a la gestante el mínimo de consultas y atención humanizada, las mujeres perciben que, en la práctica, eso ni siempre sucede. Hay fallas en la oferta e implementación de servicios a las gestantes. **Descriptores:** Prestación de Atención de Salud; Atención Primaria de Salud; Atención Prenatal; Mujeres Embarazadas.

^{1,5,6}PhD Professors, Nursing Graduation, Federal University of Tocantins / UFT. Palmas (TO), Brazil. -mails: leidienesantos@uft.edu.br ORCID iD: <https://orcid.org/0000-0002-2969-6203>; daniellerosa@mail.uft.edu.br ORCID iD: <https://orcid.org/0000-0001-6171-3627>; leonorapacheco@mail.uft.edu.br; ORCID iD: <http://orcid.org/0000-0001-6048-3911>; ²Nurse, Nursing Course of the Federal University of Tocantins / UFT. Palmas (TO), Brazil. E-mail: sayonarasbrito@gmail.com; ORCID iD: <http://orcid.org/0000-0002-0919-5209>; ^{3,4}Master Professor, Graduation in Nursing, Federal University of Tocantins / UFT. Palmas (TO), Brazil. E-mail: cfmutti@hotmail.com; ORCID iD: <http://orcid.org/0000-0003-0437-2568>; nayanesantos@mail.uft.edu.br ORCID iD: <http://orcid.org/0000-0002-1668-5505>

INTRODUCTION

During the gestational period, the woman requires specialized and quality assistance, with a view to the adequate development of pregnancy, uncomplicated childbirth and the birth of a healthy child.¹

In Brazil, according to recommendations of the Ministry of Health,² at least six prenatal consultations during pregnancy are required, which can be performed in health units or during home visits, interspersed between doctor and nurse. The care schedule should be programmed according to the gestational periods that determine the highest maternal and perinatal risk. Until the twenty-eighth week of gestation, the consultations must be monthly, from the twenty-eighth to the thirty-sixth, fortnightly, and from the thirty-sixth to the forty-first, weekly. It is also important to start the consultation schedule early, preferably, in the first trimester of pregnancy.

It is worth noting that the adequate number of prenatal consultations corroborates a better chance of contemplating preventive care and of promoting maternal and child health, favoring quality care.³ However, research has shown a lack of care for pregnant women, such as difficulties access to the health service and inadequate number of consultations.⁴⁻⁶

It can be seen that the provision of qualified care to pregnant women is still a major challenge for health systems in several countries.^{3,7} In Brazil, although prenatal care reaches practically universal coverage, inequalities remain in access to adequate care, with the potential to reverse unfavorable perinatal indicators. There is a greater proportion of inadequate assistance in adolescent women, black, with lower education, belonging to lower economic classes, multiparous, without partner, without paid work and residing in the North and Northeast regions of the country.⁴

Data reveal a worrying reality. In 2006, the number of maternal deaths reported in Brazil was 1623 cases, reaching 1872, in 2009. As of 2010, these figures decreased to 1465, in 2014⁸. Although there is a significant drop, the number of maternal deaths is still alarming and shows losses in the care given to pregnant women in the country.⁵

Worldwide, it is possible to identify a significant reduction in the maternal mortality rate. However, pregnant women continue to die from preventable causes, especially due to the lack of specialized and timely care.^{5,7} Inadequate assistance during prenatal and

childbirth contributes significantly to precarious maternal and child health indicators.⁹⁻¹⁰

It is suggested that in order to improve health care during the gestational period, it is necessary to start prenatal care in the first weeks of gestation, especially, in pregnant women at higher reproductive risk. Integration of the services provided through the establishment of an inter-service assistance network is also needed.⁶

The importance of the use of light technologies in the intersubjective relations processed in care is also highlighted, assuming a prominent role in the reorientation of the health care model. In this perspective, access to prenatal care should not be limited to the reception of the pregnant woman at the door of the health services, but should include reception and listening and communication skills. The health professional must seek to understand the many meanings of gestation for the woman and the family, so that their action is based on the humanization of care.¹¹

Thus, the interest in carrying out this research arose from the experiences of the authors in practical activities of the Nursing course of the Federal University of Tocantins, where home visits are made to newborns, puerperal women and families. During the visits, it was noticed that, commonly, the number of prenatal consultations was lower than that recommended by the Ministry of Health, and many women reported dissatisfaction with the assistance to pregnant women in the municipality. Faced with this reality, the following question made the researchers anxious to carry out this research: During prenatal care, quality assistance is offered to the woman, so as to empower her for gestation, delivery and puerperium?

The perception of the woman regarding prenatal care corroborates identifying deficiencies in the care of pregnant women and their families. Thus, it is believed that the results of this research can contribute to improve the knowledge of health professionals regarding the demands of pregnant women and, therefore, qualify and humanize the assistance given to women, corroborating to make the same subject active in the process of gestation, parturition and child care.

Quality prenatal care is an important health indicator of the municipalities and constitutes a fundamental action in the reduction of maternal and perinatal morbidity and mortality.¹² In this scenario, the objective was:

- To describe the characteristics of prenatal care from the perspective of women users of the Primary Health Care Unit service.

METHOD

A descriptive, exploratory, qualitative study, carried out with women hospitalized in a public maternity hospital located in the city of Palmas, Tocantins, Brazil, who received prenatal care in Primary Health Care Units, located in the said Municipality. In total, there are thirty-three Family Health Units installed in the urban perimeter and eight in the rural area, and all offer low-risk prenatal care.

For the production of data, semi-structured interviews were used in the months of September to December 2014. In the identification of symbolic patterns, categories of reality analysis and world views of the universe investigated, the data collection work was completed.

In total, seventeen women were interviewed who met the following inclusion criteria: being admitted to the maternity hospital at the time of data collection for postpartum low-risk pregnancies, and being eighteen years of age or older. Those who did not have prenatal care in Primary Care Units located in the municipality of Palmas were excluded.

The interviews took place in maternity units and were recorded on digital media, after which the participants' consent was obtained. The following questions guided the interviews: Tell me about prenatal care you received at the Basic Health Unit; If any, please tell me about positive and negative aspects of prenatal care received at the Basic Health Unit.

Subsequently, the statements were transcribed by the researchers and analyzed according to the assumptions of Bardin,¹³ which includes the pre-analysis stages (exploration of the material, through exhaustive and comprehensible reading, seeking to systematize initial ideas), material exploration (aggregation of ideas already systematized in units that allow a description of the content) and of the treatment of the obtained results and interpretation (elaboration of texts according to the analysis of the contents, formation of the categories and contextualization of the same with the theoretical reference of the study).

For the analysis of the statements, the following assumptions were adopted by the Ministry of Health, Brazil, specifically the Basic Attention Note: low risk prenatal care,

which presents aspects related to the organization of the work process, the health service and planning; guidelines for follow-up of habitual risk pregnancies and their possible interurrences; guidelines for health promotion and delivery assistance, and legal issues related to gestation, childbirth / birth and the puerperium.²

For the presentation of the results, the interviewees were represented by the letter "N" and alphanumeric system (N1, N2 etc.), in order to preserve the identity of the participants, as well as to avoid exposure and constraint.

This research was approved by the Committee of Ethics in Research with Human Beings of the Federal University of Tocantins, with protocol 038/2014. All the participants were oriented in relation to the objectives of this study and only those who signed the Free and Informed Consent Term were interviewed.

RESULTS

Most of the interviewees were married, had completed high school and developed some paid activity. The age range ranged from 18 to 40 years, with a family income of one to three minimum wages.

The analysis of the statements of the women who took part in this research made it possible to propose the categories "Inadequate care for pregnant women attended to Primary Health Care Units" and "Building a link between health staff and pregnant women attending the Primary Health Care Units" which contributed to understand the experiences they experienced during the gestational period, and how the activities implemented by health professionals can have positive or negative repercussions in these experiences.

♦ Inadequate assistance to pregnant women attending the Primary Health Care Units

Lack of health professionals to care for pregnant women

It is noted that many times pregnant women face realities far below the practices recommended by the national guidelines for attention to pregnant women, as indicated by the following statements:

It was good, only from the seventh month to this time that I did not go to the clinic, because I had no doctors, I was missing. (N1)
With the doctor I consulted very little, only a couple of times. My visits to this pregnancy were few. (N3)

The point is that there was no vacancy, as the demand was very large, the demand for

vacancies was very large, for pregnant women. (N8)

Through the lines it is possible to perceive that prenatal care is characterized by a lack of health professionals, a reduced number of consultations and a delay in care. These aspects evidenced the poor quality and the need to rethink the network of care for pregnant women in the country.

♦ Attention to the pregnant woman centered on the biological model of health care

In this study, it was noticed that many health professionals do not demonstrate efforts to interact and establish effective and affective communication with pregnant women during prenatal care, dealing with them in an impersonal and purely technical way, as evidenced by the following statements:

I was only directed at the health of the babies and to do the exams. I think every prenatal is like that, that's all. [...] I was just going to "show" the results of my exams, only when I had something altered that [health professional] directed more. (N4)

She [the health professional] asked me to lie down, look at my belly, tell me how many weeks I was, [...] look at the baby's heart and look at my exams. (N10)

The nurse would always ask me if I was losing fluids if I had ever fallen at home a few times. I was wondering what my symptoms were during my pregnancy. That was it. (N17)

The speeches suggest that prenatal care is marked by impersonality and lack of acceptance of women, in which health professionals assume biological behaviors directed exclusively at the health of the child, neglecting the psychosocial needs of the woman.

♦ Ineffective communication between health professionals and pregnant women

It was identified that, in some situations, there were failures in communication between professionals and pregnant women, corroborating dissatisfaction regarding the care received in the health units:

[...] I was dissatisfied. Because every time I went with the nurse, she would make the appointment and on the day I went to see her, she would tell me that the schedule had changed. (N8)

It was also identified that pregnant women present information needs that are not always met during prenatal care:

I just did not like it very much because the doctor did not know how to explain the results of the tests right to me. (N12)

In the speeches, it was possible to note a lack of organization in the provision of care for pregnant women, as well as difficulties in establishing effective communication between professionals and these women. These aspects may make it difficult to establish a sense of belonging to the health unit.

♦ Construction of a link between the health team and pregnant women attended at the Units of Primary Health Care

♦ Humanized care, focused on the biopsychosocial demands of pregnant women

In this research, it was noticed that some health professionals practice attentive listening, demonstrate respect for the needs of pregnant women and treat them with empathy. It is perceived that these practices contribute to the woman feeling welcomed by the health team and to the construction of the sense of belonging in relation to the health unit.

[...] people are treated with a lot of affection from them [health professionals], I was often heard by the nurse about personal problems, the nurse stopped to listen to me. (N5)

It was great, as I said. I got along very well with the doctor, she talked about everything with me. It was all very gratifying for me. (N15)

In the speeches, it was noticed actions of reception and effective communication and affective, and that the same collaborate so that the woman empowers of the gestational process and does not feel objectified. A welcoming posture, of the health professional, makes it perceived respected, valued and welcomed.

♦ Effective communication as an instrument of care for pregnant women

The effective communication collaborated so that the woman, during the gestational period, felt welcomed in the health service, connoting a qualified and humanized assistance, by the health professionals:

I was very fond of coming to appointments, she took care of me too well. Everything I asked, she could answer. (N4)

They [health professionals] always left me quite comfortable to talk and clear my doubts. (N7)

Sometimes I did not even ask him anything [healer] and he would talk, he would take away my doubts without my asking. (N11)

Through the speeches, it is possible to establish a dialogical environment for pregnant women, and that this action contributes significantly to the well-being of women and to the building of a link between professionals and pregnant women.

DISCUSSION

Despite the fact that, in Brazil, there are public policies that envisage quality prenatal care, with at least six consultations and attendance by specialized professionals,² in this study it was identified that pregnant women experience insufficient number of assistance, which contributes to making it fragmented and inadequate.

It should be noted that problems related to the long waiting time for care, the fact that they have to reach the health unit very early, well before the opening hours of the service, to guarantee the consultation, the lack of health professionals and the noncompliance of the operating hours are the main factors that make quality prenatal care difficult.¹¹

The scientific literature shows that the physical structure and the poor management of the service also contribute to the lack of reception of the pregnant woman in prenatal care and, according to women assisted in basic health units, this situation is commonly experienced by these clients. In this perspective, it is necessary to improve the physical area of these spaces, increase the number of physicians specializing in obstetrics and make it easier and quicker to schedule consultations.¹⁴

It is highlighted that difficulties in accessing services, non-compliance with working hours and lack of health professionals compromise prenatal care and threaten the right of pregnant women to health.¹¹

In general, there is evidence of problems in the adequacy of prenatal care in several regions of the country.^{9,15-6} These findings may explain the persistence of unfavorable perinatal outcomes, despite the increase in prenatal coverage in Brazil.⁴

In this study, the pregnant women reported an insufficient number of prenatal visits. A similar situation was described in a survey of 1640 mothers, although, 1580 (96.3%) received care during the gestational period, there were 304 cases in which it was considered inadequate. For example, 292 women had fewer than six prenatal consultations.¹⁷

Faced with obstacles to accessibility and availability of services, there is a need to reorient the model of prenatal care in the

country, through unified and integrated health networks, offering quality services, physical space and adequate equipment. Effective strategies must be put in place to ensure that women are guaranteed the rightful and quality accompaniment.¹⁸

It is important to note that the lack of quality of care for pregnant women, as well as harming maternal and fetal health and well-being, still corroborates distress and fear and may compromise maternal well-being and women's emotional health.¹⁸ In the context of comprehensive care for pregnant women, it is suggested that prenatal care be organized in order to meet the real needs of this population, allowing it to express its concerns and anxieties, guaranteeing resolution and enabling the creation of a link between pregnant women and health teams.²

In this study, some women indicated health care directed specifically to the biological demands related to the gestation process. However, these women feel welcomed and more assured when health professionals demonstrate empathy, perform qualified listening and provided effective guidelines, as well as knowledge related to gestation, self-care and childbirth, as well as interventions directed to their psychosocial needs.¹⁹ Prioritizing guidelines on risk signals strengthens the biomedical character of prenatal care.⁶

It is known that the gestation period is characterized as a time when mothers experience various psychological, social and physical changes.²⁰ Thus, the anxiety generated by these transformations should not be disregarded by health professionals. A qualified and attentive listening can open spaces for the anxieties to be named, made explicit, transforming into words the feelings that seem so confused.²

It is necessary to implement strategies that corroborate the link and reception of the pregnant women to the health services, increasing not only the number, but also the quality of the consultations.¹⁴ To do this, it is important to understand the other in a holistic way and to recognize that people do not only present biological character, but are configured in existential beings endowed with values, cultural identity and feelings.²¹

In this scenario, effective communication, sensitivity and capacity for perception are basic conditions for health knowledge to be made available to women and the family, the main actors in gestation and childbirth. Humanizing professional attitudes are indispensable, which include initiatives such as presenting oneself, calling the users by

name, providing information about conduct and procedures that should be performed, listening and valuing what is said by the people, guaranteeing the privacy and confidentiality of information, to encourage the presence of the companion, among other similar conducts.²

In this study, some women mentioned attitudes, from health professionals, that suggest welcoming and humanized care. Reception, health education activities and humanized care favor the construction of a dialogical relationship between professionals and users, presenting themselves as fundamental devices for quality care and to consolidate the integrality of women's health care in the health units.¹¹

Health actions aimed at fostering and building the pregnant woman's family relationship with health professionals, as well as women's awareness about the need to assume autonomy of their health in the gestational process, can contribute to better adherence to pre-natal¹⁴ and, consequently, favor better maternal-infant prognosis. In this sense, it is understood that prenatal consultations should allow time for clinical exams. However, it is also essential to have moments for dialogue, subjective listening and guidance, in order to create an atmosphere of empathy, trust and complicity between the team and the pregnant woman.²

Dialogic communication depends on the attitude assumed by the professional. It is emphasized that the valorization of culture, subjectivity and the construction of an authentic interpersonal relationship favor human and holistic care, with quality and resolution.²¹⁻²²

From this perspective, it is essential, in prenatal care, the periodic training of health professionals so that they can truly receive the pregnant women and address the doubts related to the birth of the child, in order to reduce the anxiety and insecurity of women and their family.¹⁶

Thus, the health care process should take advantage of light technologies such as qualified listening and empathy, so that the professional feels responsible for therapeutic plans that are effectively directed to the real needs of the individuals assisted²¹ and contribute to qualify care in the country, corroborating better indicators of maternal and child health.⁶

CONCLUSION

The results of this study indicate that women perceive, positive aspects in the

assistance received during prenatal care, such as building a link between health teams and pregnant women, communication as an instrument of care and listening practices. These actions contributed to the humanization of care for the pregnant woman, however, negative aspects were also identified, represented by the lack of health professionals in the Primary Care Units, care centered on the biologicist model, and failures in the distribution and implementation of services.

It is concluded that, although in Brazil, there are innumerable public policies that guarantee to the pregnant women the minimum of consultations and humanized care, this is not the reality experienced by many women. It is noted that old demands still persist, such as the lack of specialized health professionals and difficulties in accessing health services. In this sense, effective actions are necessary to provide pregnant women with quality care in a timely manner, in order to corroborate better practices of care and reduction of maternal and perinatal mortality rates.

REFERENCES

1. Martins MFSV. O programa de assistência pré-natal nos Cuidados de Saúde Primários em Portugal - uma reflexão. Rev Bras Enferm [Internet]. 2014 [cited 2017 Jan 07];67(6):1008-12. Available from: <http://www.scielo.br/pdf/reben/v67n6/0034-7167-reben-67-06-1008.pdf>
2. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Atenção Básica [Internet]. Caderno de Atenção Básica: atenção ao pré-natal de baixo risco: Ministério da Saúde; 2012 [cited 2017 Jan 07]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/cadernos_atencao_basica_32_prenatal.pdf
3. Joshi C, Torvaldsen S, Hodgson R, Hayen A. Factors associated with the use and quality of antenatal care in Nepal: a population-based study using the demographic and health survey data. Pregnancy Childbirth. 2014;14(94):01-11
4. Dominges RMSM, Viellas EF, Dias MAB, Torres JA, Theme-Filhall MM, Gama SGN, et al. Adequação da assistência pré-natal segundo as características maternas no Brasil. Rev Panam Salud Publica [Internet]. 2015 [cited 2017 Jan 07];37(3):140-7. Available from: <http://www.scielosp.org/pdf/rpsp/v37n3/v37n3a03.pdf>

5. Pacagnella RC, Parpinelli MA, Sousa MH, Haddad SM, Costa ML, Souza JP, et al. Delays in receiving obstetric care and poor maternal outcomes: results from a national multicentre cross sectional study. *Pregnancy Childbirth*. 2014;14(159):01-15.
6. Viellas EF, Domingues RMSM, Dias MAB, Gama SGN, Theme Filha MM, Costa JV, et al. Prenatal care in Brazil. *Cad. Saúde Pública* [Internet]. 2014 [cited 2017 Jan 07]; 30(Suppl 1):01-15. Available from: http://www.scielo.br/pdf/csp/v30s1/en_0102-311X-csp-30-s1-0085.pdf
7. World Health Organization (Geneva) Trends in Maternal Mortality: 1990 to 2008 - Estimates developed by WHO, UNICEF, UNFPA and The World Bank. Geneva (Suíça): World Health Organization; 2010 [cited 2017 Jan 07]. Available from: http://apps.who.int/iris/bitstream/10665/44423/1/9789241500265_eng.pdf
8. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Atenção Básica [Internet]. Painel de Monitoramento da Mortalidade Materna [série on-line]: Ministério da Saúde; 2015 [cited 2017 Jan 07]. Available from: <http://svs.aids.gov.br/dashboard/mortalidade/materna.show.mtw>
9. Leal MC, Theme-Filha MM, Moura EC, Cecatti JG, Santos LMP. Atenção ao pré-natal e parto em mulheres usuárias do sistema público de saúde residentes na Amazônia Legal e no Nordeste, Brasil 2010. *Rev Bras Saúde Matern Infant* [Internet]. 2015 [cited 2017 Jan 07]; 15(1):91-104. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1519-38292015000100091
10. Lansky S, Friche AAL, Silva AAM, Campos D, Bittencourt DAS, Carvalho ML, et al. Pesquisa Nascer no Brasil: perfil da mortalidade neonatal e avaliação da assistência à gestante e ao recém-nascido. *Cad. Saúde Pública* [Internet]. 2014 [cited 2017 Jan 07]; 30(Suppl 1):01-15. Available from: <http://www.scielo.br/pdf/csp/v30s1/0102-311X-csp-30-s1-0192.pdf>
11. Silva MZN, Andrade AB, Bosi MLM. Acesso e acolhimento no cuidado pré-natal à luz de experiências de gestantes na Atenção Básica. *Saúde Debate* [Internet]. 2014 [cited 2017 Jan 07]; 38(103):805-16. Available from: <http://www.scielo.br/pdf/sdeb/v38n103/0103-1104-sdeb-38-103-0805.pdf>
12. Valente MMQP, Freitas N Q, Áfio ACE, Sousa CSP, Evangelista DR, Moura ERF. Assistência pré-natal: um olhar sobre a qualidade. *Rev Rene* [Internet]. 2013 [cited 2017 Jan 07];14(2):280-9. Available from: <http://www.revistarene.ufc.br/revista/index.php/revista/article/view/177>
13. Bardin L. *Análise de conteúdo*. Lisboa: Edições 70; 2010.
14. Costa CSC, Vila VSC, Rodrigues FM, Martins CA, Pinho LMO. Características do atendimento pré-natal na Rede Básica de Saúde. *Rev Eletr Enf* [Internet]. 2013 [cited 2017 Jan 07]; 15(2):516-22. Available from: https://www.fen.ufg.br/fen_revista/v15/n2/pdf/v15n2a26.pdf
15. Melo EC, Oliveira RR, Mathias TAF. Factors associated with the quality of prenatal care: an approach to premature birth. *Rev Esc Enferm USP* [Internet]. 2015 [cited 2017 Jan 07]; 49(4):540-9. Available from: <http://www.scielo.br/pdf/reeusp/v49n4/0080-6234-reeusp-49-04-0540.pdf>
16. Handell IBS, Cruz MM, Santos MA. Avaliação da assistência pré-natal em unidades selecionadas de Saúde da Família de município do Centro-Oeste brasileiro, 2008-2009. *Epidemiol Serv Saúde* [Internet]. 2014 [cited 2017 Jan 07];23(1):101-10. Available from: <http://www.scielo.br/pdf/ress/v23n1/2237-9622-ress-23-01-00101.pdf>
17. Dias-da-Costa JS, Cesar JÁ, Haag CB, Watte G, Vicenzi K, Schaefer R. Inadequação do pré-natal em áreas pobres no Nordeste do Brasil: prevalência e alguns fatores associados. *Rev Bras Saúde Matern* [Internet]. 2013 [cited 2017 Jan 07];13(2):101-9. Available from: <http://www.scielo.br/pdf/rbsmi/v13n2/a03v13n2.pdf>
18. Silva LA, Alves VH, Rodrigues DP, Padoin SMM, Branco MBLR, Souza RMP. The quality of an integrated network: accessibility and coverage in prenatal care. *J res: fundam care Online* [Internet]. 2015 [cited 2017 Jan 07];7(2):2298-2309. Available from: http://www.seer.unirio.br/index.php/cuidadofundamental/article/view/3744/pdf_1536
19. Moura MAV, E-Silva GF, Santos C, Araújo-Silva VM. La calidad de asistencia de enfermería em el período prenatal desde la perspectiva de la mujer embarazada. *Aquichán* [Internet]. 2014 [cited 2017 Jan 07];14(2):196-206. Available from: <http://aquichan.unisabana.edu.co/index.php/aquichan/article/view/2486/pdf>
20. Tehrani SG, Bazzazian S, Nayeri ND. Pregnancy experiences of first time fathers in Iran: a qualitative interview study. *Iran Red Crescent Med J* [Internet]. 2015 [cited 2017 Jan 07];17(2):1-5. Available from:

Santos LF, Brito SS de, Mutti CF et al.

Characteristics of the pre-natal phase in the...

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4376989/pdf/ircmj-17-02-12271.pdf>

21. Santos LF, Oliveira LMAC, Munari DB, Barbosa MA, Peixoto MKAV, Nogueira ALG. When the communication is harmful in the encounter between health professional and family of hospitalized child [Internet]. Enfermería Global [cited 2017 Jan 07];2015;1(37):2216-26. Available from: http://scielo.isciii.es/pdf/eg/v14n37/en_docencia4.pdf

22. Muñoz-Henríquez M, Pardo-Torres MP. Significado de las prácticas de cuidado cultural en gestantes adolescentes de Barranquilla. Aquichan [Internet]. 2016;16(1):43-55. Available from: <http://www.scielo.org.co/pdf/aqui/v16n1/v16n1a06.pdf>

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Corresponding Address

Leidiane Ferreira Santos
Departamento de Enfermagem
Universidade Federal do Tocantins/UFT
Av. NS 15, ALCNO 14, Laboratório IV, sala 02,
109 Norte
CEP: 77001-090 – Palmas (TO), Brazil