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Guidelines to pregnant women: the importance of the shared care in primary health care[a]

Orientações às gestantes no pré-natal: a importância do cuidado compartilhado na atenção primária em saúde

Directrices para las mujeres embarazadas: la importancia de la atención compartida en la atención primaria de salud

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ABSTRACT

Objective: To analyze the association between the adequacy of the guidelines received during prenatal care and the professional who assisted the pregnant woman in most consultations in Primary Health Care. **Method:** 3,111 puerperal women who underwent prenatal care by the Unified Health System in the State of Santa Catarina in 2019 participated, through a questionnaire applied in a hospital environment up to 48 hours postpartum. Association between the main exposure variable and covariates with the outcome according to the professional who carried out the prenatal care was analyzed. **Results:** The most frequent guidelines were the signs of risks during pregnancy (80.3%) and risks of self-medication (76.9%). Prevalences below 50% were observed in the guidelines on adequate breastfeeding management (45.9%) and the possibility of visiting the maternity ward before delivery (38.2%); having received all guidelines at least once during prenatal care was 18.4%. Pregnant women assisted in most consultations by physicians and nurses had a 41,0% greater chance of adequacy in the guidelines compared to those assisted exclusively by physicians. **Conclusions and implications for practice**: The prevalence of guidelines given by health professionals for pregnant women was higher when prenatal care was more shared between nurses and physicians in comparison to the majority of care provided by professionals from only one profession.

Keywords: Prenatal Care; Primary Health Care; Health Promotion; Health Education; Patient Care Team.

RESUMO

Objetivo: Analisar a associação entre a adequação das orientações recebidas durante o pré-natal e o profissional que atendeu a gestante na maioria das consultas na Atenção Primária à Saúde. **Método:** Participaram 3.111 puérperas que realizaram pré-natal pelo Sistema Único de Saúde no Estado de Santa Catarina em 2019, através de questionário aplicado em ambiente hospitalar até 48 horas pós-parto. Analisou-se associação entre a variável de exposição principal e covariáveis, e o desfecho segundo profissional que atendeu no pré-natal. **Resultados:** As orientações mais frequentes foram os sinais de riscos na gestação (80,3%) e riscos de automedicação (76,9%). Observaram-se prevalências abaixo de 50% nas orientações sobre manejo adequado da amamentação (45,9%) e possibilidade de visitar a maternidade antes do parto (38,2%); ter recebido todas as orientações ao menos uma vez durante o pré-natal foi de 18,4%. Gestantes atendidas na maioria das consultas pelos profissionais médico e enfermeiro apresentaram chance 41% maior de adequação às orientações, em comparação com aquelas atendidas exclusivamente por médicos. **Conclusões e implicações para a prática:** A prevalência de orientações dadas pelos profissionais de saúde às gestantes foi mais elevada quando o pré-natal foi mais compartilhado entre enfermeiros e médicos, em comparação ao atendimento majoritário por profissional de apenas uma profissão.

Palavras-chave: Cuidado Pré-Natal; Atenção Primária à Saúde; Promoção da Saúde; Educação em Saúde; Equipe de Assistência ao Paciente.

RESUMEN

Objetivo: analizar la asociación entre la adecuación de las directrices recibidas durante la atención prenatal y el profesional que atendió a la mujer embarazada en la mayoría de las consultas en la Atención Primaria de Salud. **Método:** participaron 3.111 mujeres puérperas que recibieron la atención prenatal a través del Sistema Único de Salud en el Estado de Santa Catarina en 2019, a través de un cuestionario aplicado en un entorno hospitalario hasta 48 horas después del parto. Se analizó la asociación entre la variable de exposición principal y las covariables, y el resultado según el profesional que asistió en la atención prenatal. **Resultados:** las directrices más frecuentes fueron los signos de riesgos en el embarazo (80,3%) y los riesgos de automedicación (76,9%). Se observaron prevalencias inferiores al 50% en las directrices sobre el manejo adecuado de la lactancia materna (45,9%) y la posibilidad de visitar la sala de maternidad antes del parto (38,2%); han recibido todas las directrices al menos una vez durante la atención prenatal fue del 18.4%. Las mujeres embarazadas atendidas en la mayoría de las consultas por profesionales médicos y enfermeras tuvieron un 41% más de posibilidades de adecuarse a las directrices en comparación con las que fueron atendidas exclusivamente por médicos. **Conclusiones e implicaciones para la práctica:** la prevalencia de las directrices otorgadas por los profesionales de la salud a las mujeres embarazadas fue mayor cuando la atención prenatal fue más compartida entre las enfermeras y los médicos en comparación con la mayoría de la atención prestada por profesionales de una sola profesión.

Palabras clave: Atención Prenatal; Atención primaria de salud; Promoción de la Salud; Educación en Salud; Grupo de Atención al Paciente.

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INTRODUCTION

Health actions to qualify attention to women and children are a priority in the design of public policies, and have promoted advances in reducing the mortalities of women and children. Between the last decades of the XX century and the first decades of the 2000s, Brazil achieved significant advances in reducing child mortality, with the value reaching 14.4 deaths of children under five years of age in 2018 for every 1,000 live births.[1] Maternal deaths have also been reduced, but 60 deaths per 100,000 live births in 2015 were insufficient for Brazil to reach the goal of reducing the value to 35 deaths per 100,000 live births, as foreseen in the Millennium Development Goals.[2] Thus, different spheres of government and civil society have been mobilized to think and implement actions through policies and programs aimed at qualifying attention to children and women in the country.

Prenatal follow-up, through preventive actions, seeks to ensure the healthy development of pregnancy and enable the birth of a healthy baby, preserving its health and its mother. Studies have shown that a qualified prenatal is associated with the reduction of negative perinatal outcomes, such as low weight and prematurity, in addition to reducing the chances of obstetric complications, such as eclampsia, gestational diabetes, and maternal deaths.[3,4] However, despite the high prenatal coverage among pregnant women using the Unified Health System (SUS), a study with a national sample reacted in 2011/2012 that analized prenatal appropriate according to recommendations of the Ministry of Health, showed that only 21.6% of women received prenatal follow-up considered appropriate.[5] This finding reinforces that only the high coverage of consultations in prenatal follow-up does not necessarily guarantee the quality of care provided.

All guidance provided by health workers to pregnant women during prenatal follow-up is an important part of this care process.[6] Although relevant, however, national studies have identified failure by health workers to provide guidance on pregnancy, the importance and techniques of breastfeeding, how to prepare for delivery and basic newborn care. Study that evaluated the quality of prenatal care in the basic health in Brazil[7], identified that only 60% of Brazilian pregnant women assisted at SUS received all the guidance recommended during prenatal care in the basic health network in the country.

In this sense, Primary Health Care (PHC) is a strategic space for a low-risk, quality prenatal care. In Brazil, PHC, guided by the National Basic Care Policy (NBCP), highlights that the health team is responsible for the care of pregnant women and children, including disease prevention, health promotion, and treatment of illnesses that occur during the gestational period until the puerperal period and child care. In this scenario, the shared action among health professionals enables different perspectives on prenatal care practices, ensuring comprehensive care and increasing the potential for resolutiveness.[8-10]

However, there are no studies in Brazil analyzing whether there are differences in the quality of prenatal care - particularly in guidance to pregnant women, according to the recommendations of the Ministry of Health - according to the professional category that carried out the care, and whether care by nurses and physicians is associated with better guidance, when compared to that provided by only one professional. Thus, the purpose of this study was to analyze the association between the adequacy of the guidance received during prenatal care and the professional who assisted pregnant woman in most consultations.

METHOD

It is a quantitative, cross-sectional study, carried out among puerperal women living in the State of Santa Catarina. In 2019, the state had 295 municipalities and an estimated population of 7,164,788 thousand inhabitants. Its health care network has 1,947 Family Health Strategy Teams (FHST), distributed in 748 Basic Health Units (BHU) throughout the state; in the hospital care network, it has 1,109 SUS delivery beds in 120 hospitals.[5,6]

The population of this study was composed of puerperal women of any age who had children born in hospitals in Santa Catarina between January and August 2019, and who met the following inclusion criteria: (1) to have lived in Santa Catarina during the entire pregnancy; (2) to have performed all prenatal consultations at SUS in the basic health network or specialized service (high risk prenatal); (3) to have performed the delivery in one of the 31 maternity hospitals that in 2016 had 500 or more births via SUS; (4) to have had a child born alive, stillborn or dead up to 48 hours after delivery, and that were born with more than 500g and at least 22 weeks of gestation.

For sample composition, the following parameters were used: 95% confidence level, 1.6% margin of error, 50,000 population size, and, in order to increase the final sample, expected prevalence of the phenomenon of 50%. The value of 5% was added to the total obtained to contemplate losses and rejections. The number of interviews in each maternity ward was defined in proportion to the number of births it performed in 2016. The total sample of the study was estimated to be 3,665 puerperals to be interviewed in 31 hospitals spread over 30 municipalities in the state.

The data collection took place through the application of a questionnaire composed of 365 questions structured in 11 blocks. The data were collected next to the puerperal woman, in the medical records and also in the pregnant woman's book. The fieldwork was developed by interviewers trained by the research team. The data collection took place in a hospital environment, through face-to-face interviews up to 48 hours after the birth of the baby, with the help of tablets.

The data was stored on the RedCap platform and sent daily from each municipality to the central search server. For data quality control, a random sample of 10% of the interviewees was contacted again by telephone, and a reduced questionnaire was applied to them.[11] All the quality control variables showed good or almost perfect agreement, and six of the eight analyzed variables had Cohen's Kappa greater than 0.680.

The outcome variable was the adequacy of prenatal professional guidance, categorized as "adequate" or "inadequate", being considered adequate when the puerperal has reported having received in at least one moment, during her prenatal period,

the guidance described by the Ministry of Health in the Basic Care Booklet no. 32, on Low Risk Prenatal Care: the importance of exclusive breastfeeding up to six months; how to manage breastfeeding; the importance of performing physical activities during pregnancy; the risks of self-medication and of consuming alcohol and tobacco during pregnancy; the signs of risk that should be observed during the prenatal period; the signs of onset labor; the possibility of escorting during childbirth and after childbirth, and the possibility of having an accompanying person in the maternity ward during the prenatal period.[12]

As the main exposure variable, we used the question: which professional assisted the pregnant woman in most prenatal consultations (nurse, physician or nurse/medical (both): The following adjustment variables were used: a) living with husband or partner (yes/no); b) age in full years (16 to 20; 21 to 24; 25 to 34; 35 or more); c) self-reported skin color (white; black; brown), with yellow and indigenous categories excluded, as they represented only 1% of the sample; d) education (incomplete elementary school; complete elementary school; complete high school; complete higher education); e) number of prenatal consultations (less than or equal to 6; 7 or more); and f) onset of prenatal (less than or equal to 12 weeks of gestation; greater than 12) .

First, the absolute and relative frequencies of the investigated variables were estimated. Then, by means of logistic regression, the odds ratio (OR) were calculated and the associations between the independent variables and the outcome in raw and adjusted models were tested. The variables were included simultaneously in the adjusted analysis, using the stepwise backward procedure. The data analysis was conducted in the Stata software version 14.0 (StataCorp, Texas, USA).

The research has the approval of the Ethics Committee on Research with Human Beings (ECR) of Universidade Federal de Santa Catarina (UFSC), under the opinion number 1.599.464, of 06/20/2016, and followed the ethical precepts, as recommended by Resolution number 466, of December 12, 2012, of the National Health Council.

RESULTS

A total of 3,580 children were interviewed, corresponding to a response rate of 96.7%. Of these, 3,559 performed prenatal; those who had complete information of all the investigated data added 3,111 and formed the population of this study. The sample consisted mostly of women aged 25 to 34 years (46.2%), living with a husband or partner (81.3%), self-reported white skin color (63.7%), and with complete high school or complete higher education (50.7%) (Table 1).

Analyzing prenatal follow-up, it was observed that 48.4% of pregnant women were assisted in the prenatal period by a physician alone, 80.4% had seven or more consultations, and 78.1% had an early onset of prenatal care up to 12 weeks of pregnancy (Table 2).

Regarding the guidance received during prenatal follow-up, when analyzing the entire sample, it was observed that the most common were guidance on the signs of risk in pregnancy (80.3%), on the risks of self-medication without medical guidance during pregnancy (76.9%), on the harmful effects of smoking (75.1%) and alcohol consumption during pregnancy (74.5%), and the chance of having the presence of their partner at birth (64.7%) (Table 2). Prevalences below 50% were observed in the receipt of guidance on adequate management of breastfeeding (45.9%) and on the possibility of visiting the maternity ward before delivery (38.2%). At the end, it was observed that having received all the guidance at least once during the prenatal period was equal to 18.4% (Table 2). professional who assisted pregnant woman in most consultations

For the guidance, those assisted only by medical professionals received less guidance on the possibility of visiting the maternity ward (33.1%) and more on risk signs (77.7%); and those assisted only by the nurse received less guidance on the management of breastfeeding (42.4%) and more on risk signs (80.0%). On the other hand, those assisted by doctors and nurses together received less guidance on the possibility of visiting the maternity ward (43.9%) and more on risk signs (83.3%) (Table 3).

In the raw analysis, it was observed that those who had seven or more prenatal consultations had 1.29 times more chance (p=0.046) of having adequacy of guideline compared to those who had up to six consultations; and those who started prenatal with

Table 1. Description of socioeconomic characteristics of study participants, Santa Catarina, 2019 (n=3,111).

Variable	N	%
Lives with husband/partner		
Yes	2529	81.3
No	582	18.7
Age		
Between 14 and 20 years	471	15.5
Between 21 and 24 years	619	20.4
Between 25 and 34 years	1480	46.2
35 years or over	541	17.9
Skin color		
White	1981	63.7
Dark/black	283	9.1
Brown	847	27.2
Education		
Incomplete elementary school	565	18.2
Complete elementary school	968	31.1
Complete high school	1267	40.7
Complete higher education	311	10.0
Total	3111	100.0

Table 2. Description of prenatal characteristics of study participants, Santa Catarina, 2019 (n=3,111).

Variable	N	%
Professional who assisted in most of the prenatal follow-up		
Physician	1507	48.4
Nurse	355	11.4
Nurse and physician	1249	40.2
No. consultations		
Up to 6	611	19.6
7 or more	2500	80.4
Onset of prenatal		
≤12 weeks	2430	78.1
>12 weeks	681	21.9
Guidance on exclusive breastfeeding 6 months		
Yes	1909	61.5
No	1202	38.5
Guidance on management of breastfeeding		
Yes	1428	45.9
No	1683	54.1
Guided on importance of physical activity during pregnancy		
Yes	1871	60.3
No	1240	39.7
Guided on risks of self-medication		
Yes	2388	76.9
No	723	23.1
Guidance on alcohol consumption		
Yes	2310	74.5
No	801	25.5
Guidance on smoking		
Yes	2331	75.1
No	780	24.9
Guidelines on risks signs		
Yes	2489	80.3
No	622	19.7
Guidance on how labor begins		
Yes	1987	64.0
No	1124	36.0
Guided on the possibility of having the presence of their partners at birth		
Yes	2011	64.7
No	1100	35.3
Guided on the possibility of visiting the maternity ward		
Yes	1222	39.2
No	1889	60.8
Adequacy of guidelines		
Inadequate	2539	81.6
Adequate	572	18.4
Total	3111	100.0

more than 12 weeks had 10.0% less chance of having adequacy of guideline compared to those who started before 12 weeks, although there is no statistical significance in this difference. Furthermore, the marital status indicator showed that those who did not live with a husband or partner were 1.33 times more likely (95% CI 1.19-1.50) to have adequacy of the guidelines, if compared to those who did.

Regarding the variable outcome of main interest, the raw analysis showed that the prevalence of adequacy of prenatal care was 1.34 times higher (p=0.001) among women who reported having been assisted by a physician plus nurse when compared to those assisted only by the physician. There was no difference between majority medical care and majority nurse care only (Table 4).

In the analysis adjusted for adequacy of guidance received during prenatal according to the professional who carried out most consultations, it was observed that those pregnant women assisted in most of the prenatal consultations by medical professionals and also nurses had a 41,0% higher chance of having adequacy of guidance, if compared to those assisted only by the medical professional (Table 5).

DISCUSSION

When analyzing prenatal data in the scope of Primary Health Care in the State of Santa Catarina, it was observed that the prevalence of adequacy of the guidance received during prenatal care was 18.6%, and the guidance received more frequently during follow-up was related to risk signs, risks of self-medication, and risks of smoking. It was also found that performing the follow-up together with the physician and nurse increased the chances of adequacy to the guidelines, when compared with having most of the consultations with only one professional.

Regarding the guidance provided during prenatal care, it is worth highlighting that these are professional practices that do not imply additional financial costs for SUS, but depend on the protagonism and attitudes of professionals. It was observed that when the adequacy of guidance received during prenatal care was analyzed, the majority presented inadequacy. Study on prenatal care in the primary health care in the country [7] presented 39.7% of inadequacy of guidelines based on national Program for Access and Quality Improvement in Primary Care (PMAQ) data, showing that services have not yet been able to reach some groups.

The Ministry of Health reaffirms the importance of health environments being open to fulfilling their role as educators and health promoters. Thus, it is emphasized that during prenatal care, pregnant women and the family should receive fundamental guidance for adequate prenatal care, puerperium and newborn care, among other important topics for health guidance.[12]

Despite the relevance of guidelines during follow-up, this study observed the low prevalence of some guidelines, the most common being on signs of risk in pregnancy, risks of self-medication during pregnancy, risks of smoking during pregnancy, risks of alcohol consumption during pregnancy, and on the possibility of

Table 3. Description of the guidance received by study participants, according to the professional who carried out most prenatal care, Santa Catarina, 2019 (n=3,111).

Variable	Physician n(%)	Nurse n(%)	Physician/nurse n(%)	p value*
Guidance on exclusive breastfeeding 6 months				
Yes	749 (58.8)	187 (60.0)	682 (65.2)	**0.006**
No	527 (41.2)	125 (40.0)	366 (34.8)	
Guidance on breastfeeding management				
Yes	526 (41.1)	133 (42.4)	545 (52.0)	**0.000**
No	750 (58,9)	179 (57.6)	503 (48.0)	
Guided on the importance of physical activity in pregnancy				
Yes	743 (58.3)	176 (56,5)	662 (63.4)	**0.016**
No	533 (41.7)	136 (43.6)	386 (36.6)	
Guided about risks of self-medication				
Yes	957 (75.2)	240 (77.1)	821 (78.6)	0.155
No	317 (24.8)	72 (22.9)	227 (21.4)	
Guidance on alcohol consumption				
Yes	909 (71.4)	232(74.3)	812 (77.7)	**0.003**
No	367 (28.6)	80 (25.7)	236 (22.3)	
Guidance on smoking				
Yes	918 (72.0)	234 (75.1)	819 (78.4)	**0.002**
No	358 (28.0)	78 (24.9)	229 (21.6)	
Guidance on risks signals				
Yes	989 (77.8)	249 (80.0)	871 (83.3)	**0.004**
No	287 (22.2)	623(20.0)	177 (16.7)	
Guidance on starting labor				
Yes	781 (61.3)	197 (63.3)	712 (68.1)	**0.003**
No	495 (38.7)	115 (36.7)	336 (31.9)	
Guided on possibility of having partner in childbirth				
Yes	772 (60.6)	192 (61.7)	728 (69.7)	**0.000**
No	504 (39.4)	120 (38.3)	317 (30.3)	
Guided on possibility of visit to the maternity ward				
Yes	424 (33.1)	139 (44.6)	560 (43.9)	**0.000**
No	852 (66.9)	173 (55.4)	588 (56.1)	
Adequacy of guidelines				
Inadequate	1072 (84.0)	259 (83.0)	825 (78.7)	**0.004**
Adequate	204 (16.0)	53 (17.0)	223 (21.3)	

*Value obtained using chi-square test.

Table 4. Raw analysis of the adequacy of guidance received during prenatal care, according to the professional who carried out most consultations, Santa Catarina, 2019 (n=3.111).

Variable	Adequate	
	OR (IC95%*)	pValue
Professional		
Physician	1.00	
Nurse	0,96(0,2-1,29)	0,798
Nurse and physician	**1.34(1.19-1.60)**	**0.001**
Number of consultation		
Up to 6	1.00	
7 or more	**1.29(1.01-1.67)**	**0.046**
Onset of prenatal		
<= 12 weeks	1,00	
>12 weeks	0.90(0.71-1.15)	0.424
Lives with husband/partner		
Yes	1.00	
No	**13.3 (1.08-1.63)**	**0.006**
Age		
Between 14 and 20 years	1.00	
Between 21 and 24 years	0.96(0.70-1.32)	0.846
Between 25 and 34 years	1.06(0.80-1.39)	0.805
35 years or over	0.94(0.67-1.30)	0.723
Skin color		
White	1.00	
Black /dark	1.16(0.86-1.55)	0.315
Brown	1.01(0.83-1.24)	0.870
Education		
Incomplete elementary school	1.00	
Complete elementary school	0.91(0.69-1.19)	0.471
Complete high school	0.86(0.66-1.12)	0.282
Complete higher school	1.10(0.76-1.57)	0.633

*IC 95%: 95% of confidence interval.

Table 5. Adjusted analysis of the adequacy of guidance received during prenatal care, according to professional who carried out most consultations, Santa Catarina, 2019 (n=3.111).

Variable	Adequate	
	OR (CI95%*)	pValue
Professional		
Physician	1.00	
Nurse	1.5 (0.75-1.47)	0.749
Nurse and Physician	**1.41(1.14-1.75)**	**0.001**

*95% CI: 95% of confidence interval; ** Adjusted by number of consultations, onset of the prenatal, reside husband partner, education, skin color and age.

having a companion at birth. These findings point to the existence of a biologicist view of prenatal care, in which it is even more important to value guidelines of risks as opposed to guidelines of self-care and autonomy. A national study with data from the first cycle of the PMAQ, analyzing the prevalence of guidelines received at prenatal care, observed that the guideline received most was about exclusive breastfeeding (91.0%), followed by guidelines on feeding and weight gain (88.9%) and baby care (85.9%), values different from those found in our study, which shows gaps in prenatal care.[7]

The Ministry of Health defines that in the first prenatal visit, the pregnant woman should be given all the necessary guidance for a healthy pregnancy, in order to facilitate her adherence to the prescribed conducts and interventions, and success in the guidelines is essential for the pregnant woman's adherence to the next prenatal visits.[12] However, a study conducted in Rio de Janeiro showed that risk behaviors, such as drinking alcohol, smoking, and consuming illicit drugs during pregnancy were reported by women in large numbers during prenatal care in public health facilities, reinforcing the importance of such guidelines during prenatal care.[13]

Regarding the guidelines on the management of breastfeeding, it was observed that they were present in only 45.9% of the follow-ups, when they should be reported by all the participants in this study, considering that breastfeeding contributes to strengthening the bond between mother and baby and is very important in the growth and development of the child. In addition, the period of greatest difficulty for breastfeeding occurs in the first weeks after delivery, and ignorance about the management of breastfeeding can cause complications and lead to early weaning.[14]

For the guidance on the possibility of visiting the maternity ward, it was observed that 44.9% of those assisted by a doctor and nurse together received this guidance, while in those assisted only by the doctor the prevalence was only 35.6%. Another study conducted in Vitória-ES, in 2014, showed the importance of guidance and the link between the pregnant woman and the maternity ward, and that this should occur from the onset of prenatal care, facilitating access by pregnant women at the time of delivery or in the event of emergencies.[15] Such guidance arises from the implementation of the Stork Network, and have the purpose of linking the pregnant woman, avoiding peregrination and difficulty of access, in addition to speeding up care.[16]

It was observed a greater proportion of having received such guidance in those women who performed prenatal care together with the two professionals, doctor and nurse. On the other hand, those assisted only by the medical professional presented the lowest proportions of guidelines for visits to the maternity ward, companion during childbirth, signs of risk in pregnancy, risk of smoking, risk of alcohol, risks of self-medication and exclusive breastfeeding until the child is six months old.

It is worth highlighting that the prevalence in this study of seven or more consultations in prenatal follow-up was 80.9%, in which 78.3% started prenatal early before 12 weeks of gestation. Nevertheless, national studies, when assessing prenatal adequacy

according to parameters of the Ministry of Health, have shown that only 68.3% had a prenatal visit considered adequate.[17] These findings point to a national scenario in which most pregnant women have an adequate number of prenatal visits; however, this number of visits does not reflect their quality, and the need to evaluate the guidance received during prenatal care is highlighted as an important criterion in the quality of care provided.

The Ministry of Health[18] has defined, among the essential recommendations for the health care of women and children in the PHC scope, the importance and effectiveness of the care provided by more than one health professional, such as nurses and physicians, in prenatal, perinatal, and puerperium care, adding to the contributions of each profession to a better prenatal care.

In pregnant women assisted only by the professional nurse, a greater proportion of guidance on risk signs in pregnancy, risks of smoking, alcohol and risks of self-medication was observed. According to the Law of Professional Practice of Nursing (Law nº 7.498/1986) and the Ministry of Health, low risk prenatal care can be accompanied by the nurse in the scope of PHC, with the professional being responsible for health education activities to the pregnant woman and the puerperal, providing, from the nursing consultation, the prescription and nursing assistance.[19] As a consequence of that, training in Nursing allows to act in prenatal care, carrying out individual and group educational actions and nursing care as a team member.[20]

In the analyses, it was observed that the adequacy of guidelines remained associated with the professional, being greater in those assisted jointly by the medical professional and nurse. Therefore, it was observed that each professional has his/her own specificities in the care for pregnant women and, through the union of professionals with distinct and complementary knowledge, the benefits are observed in the care for this public, also contributing to the improvement of women's and children's health indicators.

Thus, according to the competencies set forth in the *Booklet of Attention to the Prenatal of Low Risk,* of the Ministry of Health, it is up to medical professionals and nurses to participate as team members in prenatal care, contributing to the promotion of pregnant women's health and improvement in their quality of life, thus playing an educational role.[12]

These findings lead to a reflection about the work process in Primary Care, in which health actions are highlighted in an integrated manner, with continuity of care. In this way, the importance of the medical professional and the nurse as team members in taking care of women and babies according to their specificities is reaffirmed, in the search for the improvement of the assistance provided and in the protagonism of women.

This investigation has limitations that deserve to be highlighted. One of them refers to the memory bias in relation to prenatal information. Puerperal women may have had difficulty in answering some questions related to prenatal care. However, the reminder period is not very long, and pregnancy tends to be a defining moment, which is reflected in good memories of events. In addition, a tested questionnaire was applied to help obtain adequate answers, and interviewers were extensively trained for its best application. The high response rate obtained and the high sample analyzed should also be highlighted.

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

The results of this study showed the existence of gaps regarding guidance offered by health professionals during antenatal care. On the other hand, it was observed that the adequacy of guidance received during prenatal care is greater when there is shared attention between physicians and nurses.

In analyzing the guidelines, it was observed a low prevalence of offering some recommendations, losing important opportunities to sensitize and empower pregnant women to access information that can contribute to a good pregnancy, childbirth and puerperium. Methods and strategies should be defined in order to ensure that the pregnant woman receives all the recommended guidelines and is able to implement them. Thus, the importance of shared care during prenatal care and the promotion of educational actions to clarify all their doubts and insecurities is reinforced, contributing to a low risk pregnancy, both for the woman and the child.

From the objectives of this study, it was possible to know the shared performance of nursing and medical professionals in relation to the guidance provided during prenatal care. It was identified that shared action through a systematized process of care can promote better outcomes in prenatal care, delivery and puerperium. However, it is necessary to continue studies on women's and children's health, seeking strategies for interventions and guidelines to ensure more equitable and resolutive care.

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AUTHOR'S CONTRIBUTIONS

Study design. Acquisition, data analysis and interpretation of results. Writing and critical review of the manuscript. Approval of the final version of the article. Responsibility for all aspects of the content and completeness of the published article. Bruna Leticia Marques. Yaná Tamara Tomasi. Suelen dos Santos Saraiva.

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