

Prenatal care by nurses in the East Zone of the city of São Paulo - Brazil

ATENÇÃO PRÉ-NATAL POR ENFERMEIROS NA ZONA LESTE DA CIDADE DE SÃO PAULO - BRASIL

ATENCIÓN PRENATAL POR ENFERMEROS EN LA ZONA ESTE DE LA CIUDAD DE SÃO PAULO - BRASIL

Nádia Zanon Narchi¹

ABSTRACT

The objective of this study was to analyze the exercise of competences in prenatal care performed by nurses in the East Zone of the city of São Paulo through the identification of the activities performed by them and their frequency as well as possible difficulties found. This quantitative, descriptive-exploratory study was carried out in 59 health centers, from October 2006 to December 2007, with a sample of 131 nurses. The results showed that nurses did not perform essential competences necessary to obtain a qualified prenatal care due to personal and institutional barriers found in their job. It was concluded that there is a need to review the policies of public health structures in São Paulo to guarantee the implementation of the Unique Health System guidelines regarding the improvement of prenatal care and to provide human and financial resources to reach this purpose.

KEY WORDS

Prenatal care.
Maternal-child nursing.
Clinical competence.
Maternal mortality.
Health Public Policy.

RESUMO

Com o objetivo de analisar o exercício das competências dos enfermeiros para a atenção pré-natal por meio da identificação das atividades que desempenham e sua frequência, bem como dos possíveis obstáculos que encontram, realizou-se estudo quantitativo, descritivo-exploratório, em 59 Unidades Básicas de Saúde da Zona Leste da cidade de São Paulo, de outubro de 2006 a dezembro de 2007. A amostra foi constituída de 131 enfermeiros. Os resultados mostraram que os enfermeiros não exercem as competências essenciais para a atenção qualificada ao pré-natal, devido às barreiras pessoais e institucionais com que se defrontam em seu trabalho. Conclui-se pela necessidade das estruturas públicas de saúde municipais revisarem suas políticas de modo a garantir a implementação das diretrizes do SUS no que se refere à melhoria da atenção à saúde materno-infantil, e à destinação de recursos humanos e financeiros nessa direção.

DESCRIPTORIOS

Cuidado pré-natal.
Enfermagem materno-infantil.
Competência clínica.
Mortalidade materna.
Políticas Públicas de Saúde.

RESUMEN

Con el objetivo de analizar el ejercicio de las competencias de los enfermeros para atención prenatal en la zona este de la ciudad de São Paulo a través de la identificación de las actividades que desempeñan y su frecuencia, así como de los posibles obstáculos que encuentran, se realizó un estudio cuantitativo descriptivo exploratorio en 59 Unidades Básicas de Salud, de octubre de 2006 a diciembre de 2007, en muestra constituida por 131 enfermeros. Los resultados demostraron que los enfermeros no ejercen las competencias esenciales para la atención calificada del prenatal debido a barreras personales e institucionales que enfrentan en su trabajo. Se concluye en que hay una necesidad de que las estructuras públicas de salud de São Paulo revisen sus políticas con el fin de garantizar la implementación de las directivas del Sistema Único de Salud en lo que se refiere al mejoramiento de la atención de la salud materno infantil y a la derivación de recursos humanos y financieros en dicha dirección.

DESCRIPTORES

Atención prenatal.
Enfermería materno-infantil.
Competencia clínica.
Mortalidad materna.
Políticas Públicas de Salud.

¹ Obstetric Nurse. Master Degree in Obstetric and Neonatal Nursing. Professor Doctor of the Obstetrics Course of the School of Arts, Sciences and Humanities of the University of São Paulo. São Paulo, SP, Brazil. nzn@usp.br

INTRODUCTION

Maternal and perinatal morbidity-mortality goes on being a concern in Brazil, so it is necessary not only enhancing qualifications but also increasing the quantity of healthcare providers working in the area.

According to the technical report issued by the Pan American Health Organization⁽¹⁾, qualified assistance refers to the process by which a woman and her baby receive suitable care during the pregnancy/post-childbirth cycle, where care providers should be given conditions to ease their performance at the various levels of the healthcare system, in addition to behaving and having knowledge and skills to make their midwifery practice safe, thus decreasing maternal mortality, i.e., to be competent enough to handle both normal pregnancy, childbirth and normal post-childbirth and risky situations and complications of women or newborns.

That report⁽¹⁾ adds that in order to keep their skills updated and offer assistance able to meet women's needs, healthcare providers also need to have access to essential equipment and drugs and to an operating referral and return system, and to be a part of an education and healthcare system able to stimulate critical thinking and clinical competence and to develop effective personal and communication skills.

Specifically about non-physicians, the International Confederation of Midwives (ICM)⁽²⁾ has defined the skills required to exercise basic midwifery, i.e., the knowledge and skills required from midwives to render qualified assistance to women in all reproductive cycle's phases.

When setting those competences the ICM, together with the World Health Organization (WHO) and the International Federation of Gynecology and Obstetrics⁽²⁻³⁾ have also defined how midwives, nurses or nurse-midwives should provide effective care based on the best and more updated evidence to provide supervision, care and assistance to women during pregnancy, childbirth and post-childbirth, and also to the family and communication, prenatal education and preparation for parenthood by clearly privileging gynecology, reproduction planning and assistance to the child.

As to prenatal assistance, a significant part of the Brazilian municipalities still do not specifically recruit nurses, whether specialized in midwifery or not, despite the finding⁽⁴⁻⁶⁾ that they can contribute to increase the services' coverage and quality once they are fully qualified to participate in the process of promoting and monitoring pregnant women's health.

Therefore, despite being qualified, non-physicians not always find legal and regulatory support enabling them to

perform their role in full and to contribute to improve the assistance rendered to maternal and perinatal health.

Under this perspective, once nurses have attitudes, knowledge and skills to exercise their profession, the object of this study is outlining the exercise of those competences when rendering prenatal assistance, which is justifiable considering the inexpressive number of studies in the area and the subsidies it can provide to the construction of Public Polices able to ensure the implementation of the Brazilian Healthcare System's guidelines referring to more valuation and inclusion of non-physicians in mother-child assistance and consequent promotion of safe motherhood.

OBJECTIVES

The objective of this research was to analyze the exercise of competences in the prenatal assistance provided by nurses in public healthcare services in the East Region of the city of São Paulo by identifying the activities they do and their frequency, as well as possible obstacles or difficulties found in their work.

METHOD

A descriptive and exploratory study with a qualitative approach conducted in 59 primary healthcare units in the East Region of the city with a population of 204 nurses rendering prenatal services in 2006, when the fields were defined and data collected.

For convenience purposes, the sample consisted of 131 subjects, equivalent to 64% of the population, with the participation of the nurses of all the primary healthcare units selected.

Data were collected from October 2006 to December 2007, and a questionnaire was used containing the following items:

- Questions related to nurses' characteristics such as age, education, the time they had worked in prenatal assistance, composition of the team to which they belonged and other places where they worked;
- List of the 85 prenatal assistance-related activities followed by an ordinal scale with the following frequency attributes: *never, seldom, frequently, always*, where the subjects could check the activities they did in prenatal assistance and their frequency;
- *Space* to inform in writing professional or institutional occurrences, facts or events interfering with or faced as obstacle to their work in said assistance.

To prepare the questionnaire, besides the personal experience of the researcher, documents related to midwifery competences, safe motherhood and usual midwifery prac-

...the International Confederation of Midwives (ICM) has defined the skills required to exercise basic midwifery...

tices were used, in addition to those recommended by scientific evidence^(2-3,5-9).

In order to validate the questionnaire and make it precise, four experienced experts evaluated it and a pretest was also conducted with six nurses who did not participate in the study.

The questionnaire was mailed to 204 nurses attached to an introduction letter, two copies of a consent form and a stamped envelope addressed to the researcher. A list with the names of the nurses working in prenatal assistance in the East Region was furnished by the Regional Healthcare Coordination, which also helped the author sensitize the subjects.

Out of the total of questionnaires mailed, 131 were returned properly completed and the data were reviewed by means of descriptive statistics. Furthermore, the items participants classified as obstacles to their work were ranked by similarity.

The project was approved by the Ethics Committee on Research of the Prefecture of São Paulo, Opinion No. 0188/CEP/SMS/2006 and all subjects were informed about the relevance of the research and they could choose to join the research according to a Free and Informed Consent Form.

RESULTS AND DISCUSSION

As shown in Table 1, the characteristics of the 131 nurses showed that most of them were young, from 23 to 32 years old (38%), the arithmetic means being older, 42.8 years old; they had graduated in Nursing ten years earlier or less (66%) and had worked in prenatal care for eight years or less (90%).

Regarding education, sixteen subjects (13%) informed that besides their bachelor's degree they also had other qualifications, seven in Public Health, five in Midwifery and four in the Medical-Surgical area, a modality of complementary education that no longer exists in Brazil and which does not correspond to a post-graduation degree.

As to specialization, 74% of the subjects informed having attended at least one course, the most usual being the Public or Collective Healthcare course (27%) followed by the Family Healthcare Program (12%), Midwifery (10%) and Hospital Administration (8%).

Only 34% of the nurses informed having attended updating or long-lasting courses in the last five years, and the most usual courses were Gynecologic Cancer Prevention (11%) and those related to specific qualification in the Family Healthcare Program (11%).

Table 1 - Characteristics of the nurses providing prenatal care in the East Region - São Paulo - 2007

Characteristics	N	%
Age range		
23 to 27	20	15
28 to 32	30	23
33 to 37	15	11
38 to 42	22	17
43 to 47	17	13
48 to 52	15	11
53 to 57	7	5
58 or more	3	3
Did not answer	2	2
Total	131	100
Had graduated in nursing		
5 years earlier or less	41	31
Between 6 and 10 years earlier	46	35
Between 11 and 15 years earlier	14	10
Between 16 and 20 years earlier	15	11
Between 21 and 25 years earlier	9	7
Between 26 and 30 years earlier	3	3
More than 30 years earlier	2	2
Did not answer	1	1
Total	131	100
How long have you worked in prenatal assistance		
Less than 1 year	4	3
Between 1 and 4 years	61	46
Between 5 and 8 years	54	41
Between 9 and 12 years	8	6
13 years or more	3	3
Did not answer	1	1
Total	131	100

Most subjects (75%) belonged to the Family Healthcare Program's teams and provided assistance in consultations alternated with doctors of their team, of other teams or obstetric doctors of Primary Healthcare Units or units to which pregnant women at obstetric risk had been referred for childbirth. As to the characteristics of the Family Healthcare Program's team to which they belonged, 83% informed its minimum composition, i.e., a nurse, a doctor, two nursing assistants and four to six community healthcare agents. Finally, 88% reported that they did not work at other places and the rest informed they had activities unrelated to primary healthcare, such as at hospitals or other places.

In the item of the questionnaire where subjects should inform the activities composing prenatal assistance, nurses reported that they *always* or *frequently* did most (76%) of the 85 tasks listed, with a frequency equal to or higher than 75%. Some of the other activities, which are more significant because of their importance and respective frequency, are shown in Table 2.

Table 2 - Nurses' activities less often than 75% in prenatal assistance in the East Region - São Paulo - 2008

Activities	Frequency	
	N	%
Triage and follow-up of all pregnant women in the Primary Healthcare Unit's area of coverage	69	53
Assessment, registration and follow-up of pregnant women's nutritional status through their bodily mass index	68	52
Full physical-gynecological examination of pregnant women in the first visit	80	61
Inspection of the external genitals of pregnant women in all visits	80	61
Follow-up in the post-childbirth period to check health conditions untreated during pregnancy	95	72
Educational activities in groups of women in the post-childbirth period or mothers	71	54
Home visits for educational purposes with life partners and/or members of the family of pregnant women	83	63
Use of therapeutic protocols to treat infections in pregnant women and/or life partners	40	31
Pre-conceptive evaluation of women/couples in the community	57	44

The coverage of prenatal care refers to the monitoring of pregnant women in the area covered by the Primary Healthcare Units. It would be excellent if services and healthcare providers, in addition to mapping women in childbearing age in the territory, had the proper means to record and follow up all pregnant women, even those who were not given prenatal assistance at a public healthcare institution, in order to follow up the process and the outcome indicators of maternal and perinatal care as established in various Brazilian and international programs designed to promote safe motherhood^(3,5,7,9-10).

As to evaluating, recording and monitoring the weight gained by pregnant women through the bodily mass index (IMC), it is worth highlighting that at the time data were collected this was not a piece of information included in the perinatal chart used by the primary healthcare network in the city of São Paulo, despite its having been recommended in technical manuals and literature since 2004⁽⁸⁻⁹⁾.

As to physical-gynecological examination, it is worth noticing that this is essential during prenatal visits to detect interurrences and inform pregnant women about changes caused by pregnancy that go unnoticed by women,

such as, for instance, those associated to physiological leucorrhea during pregnancy with genital infection⁽¹³⁾.

As to educational activities with mothers and post-childbirth follow-up related to health conditions untreated during pregnancy, what usually happens is the return of the woman to the health service just for vaccination and to monitor the newborn and not to take care of herself or to receive care, which mirrors the frequent lack of articulation among primary healthcare actions aimed at promoting women's health after childbirth, as highlighted by several authors who have analyzed the operational difficulties of the Brazilian Healthcare System to organize the care recommended by the Program of Humane Prenatal and Childbirth (PHPN)^(4,11,14).

Visiting homes for educational purposes related to life partners and/or family members is a highly important activity to detect and/or prevent problems affecting the evolution of the pregnancy, which is not always possible during prenatal visits. About this, integration between healthcare services and families in the territory or in the area of coverage of a Primary Healthcare Units leads healthcare providers to get familiar with the social, economic and demographic context of the population and it encourages them to understand the health-disease process in order to promote feasible interventional proposals targeting on improving health conditions and, consequently, quality of life.

The pre-conceptive evaluation of women and/or couples in the community should be part of the roll of activities because it identifies risk factors or diseases that may change the normal evolution of a future pregnancy and helps preventing maternal and perinatal morbidity-mortality. According to the technical manual for qualified and humane assistance to prenatal and post-childbirth⁽⁹⁾, such activity should be an item in the programs for reproduction planning and prevention of STDs within the context of a free and informed choice.

It should be emphasized that besides checking the ordinal scale of frequency nurses do the activities, many of them made comments in writing, such as: they had never performed a gynecological palpation or did not know how to do it; only doctors are allowed to inspect pregnant women's external genitals; cardiopulmonary auscultation in pregnant women is only done if there are complaints; only doctors can give puerperal consultation; Family Healthcare Program's nurses act as doctors' assistants; the Brazilian Healthcare System does not pay an ultrasound test when it is requested by a nurse.

It is important to highlight that the participation of non-physicians in prenatal care has brought significant advances to its quality. From this perspective, studies⁽¹⁵⁻¹⁷⁾ point out that without the nurses the care would probably be restricted to individual consultations based on complaints and conducts, simple obstetric examinations and ordering and interpreting tests, a biomedical model where women can

barely express their feelings and aspects related to their family and the context of their lives, health and work are not considered.

That is why there should be true articulation between the Program of Humane Care and Childbirth and the Family Healthcare Program, once this program should secure a more comprehensive and integrated care⁽¹⁴⁾. Therefore, it is not quite understandable within a context that involves mostly the Family Healthcare Program, as approached in this study, that nurses feel or behave as assistants when they actually help providing better care, particularly by promoting safety and supporting women during pregnancy and after childbirth.

The notes made by the subjects in the questionnaire evidence a number of problems arising from both lack of knowledge of fundamental aspects of suitable assistance to women during pregnancy and childbirth and lack of acknowledgement and respect for their work, which they describe as obstacles to providing care. In this regard, it should be emphasized that only 29% of the nurses did not report obstacles to their work in prenatal assistance. The remaining 71% listed 200 types of difficulties, whose categorization is shown in Table 3.

Table 3 - Categorization of difficulties indicated by the nurses in prenatal assistance - São Paulo - 2008

Categories	Difficulties	
	N	%
Making assistance available	84	42
Referral and return system	58	29
Professional relationship	24	12
Working process	20	10
Socio-economic and cultural conditions of the population	14	7

In the category making assistance available, nurses reported difficulties in providing assistance to pregnant women and after childbirth due to personal problems or institutional issues related to insufficient material resources and unsuitable physical facilities. In that category were included obstacles resulting from: institutional obstacles to request tests and prescribe drugs; Primary Healthcare Units' limited working hours; lack of material and/or equipment, such as sonar and scale; unsuitable or insufficient physical space for individual assistance or group activities; productivity requirements, i.e. at least three consultations should be performed per hour; inadequate printed materials, pregnancy card and/or perinatal chart without graphs allowing following up the uterus' height and pregnant women's weight; specific nursing protocols in primary healthcare; shortage of contraceptives in the Primary Healthcare Units; the personnel or other nurses' lack of knowledge, qualification or training to provide prenatal assistance.

The prohibition of requesting tests and prescribing drugs set forth in May 2007 by the Municipal Department for the Health of São Paulo in force at the time data were collected resulted from a temporary restraining order imposed by the Federal Council of Medicine to Administrative Rule 648/2006 dealing with the Brazilian Policy of Primary Healthcare (PNAB).

For this reason, after an agreement with the organizations representing the Medicine and Nursing areas, Administrative Rule GM No. 1625/2007 was published in the Brazilian official press on July 11th, 2007, which has changed the attributions of healthcare providers in the Family Healthcare Program's teams disposed in the Brazilian Policy of Primary Healthcare. As a result, Administrative Rule MS No. 648/2006, Attachment I, item 2, defines the functions of Primary Healthcare nurses as follows:

To provide full assistance to people and families in the Family Healthcare Unit, and where applicable or required, at home and/or other community centers; to provide nursing consultations, to request complementary tests and prescribe drugs, the legal dispositions applicable to the profession being observed and according to the protocols and other technical standards established by the Ministry of the Health, state and municipal administrators and those of the Federal District.

Therefore, and pursuant to the dispositions in the Law of Professional Nursing, both requesting tests and prescribing drugs as established in public health programs remain legal in Brazil. Additionally, the women healthcare protocol in force in the city of São Paulo guides the assistance to be provided and enables nurses to have a conduct in the most varied situations, in prenatal assistance among them.

However, as already pointed out, nurses' activities exceed biomedical assistance; their main activity should focus on setting a supporting and understanding relationship enabling discussions on fundamental aspects of women's health⁽¹⁵⁻¹⁷⁾, i.e., building a relationship of trust aimed at providing the necessary health education during pregnancy and after childbirth. The quality of care is closely related to these aspects, despite being less appreciated by the population because they are not aware of them and by many nurses because they associate professional qualification to autonomy to prescribe drugs and order tests, for example.

Another obstacle described is the productivity required by the Municipal Department for the Health of São Paulo, i.e., healthcare providers working in primary healthcare units have to do a minimum number of procedures per month. The Family Healthcare Program's nurses are instructed by the Primary Healthcare Coordination and by the Family Healthcare Program of the municipality of São Paulo to provide two scheduled consultations plus one, if any, per working hour, totaling 32 scheduled consultations plus 16, if any, per month. These numbers, which at first sight may seem suitable, should be reviewed, i.e., it is crucial to discuss the way a consultation is scheduled and how nurses and the management council see the matter.

According to 19% of the subjects, this is one of the reasons preventing nurses from working the prenatal period. Nurses who due to their qualifications are able to render longer assistances once at each consultation they should discuss with women and their respective partners essential subjects to promote mother and child's health and the health of the family and even of the community.

It is also necessary to discuss the matter of professional qualification considering the reports of lack of preparation or knowledge to provide assistance, which demands specific midwifery skills and knowledge, an unusual area of specialization in the qualification of non-physicians in this study. Within such a context, by taking into account the comments and descriptions made by the subjects in the questionnaire, their continuous education is deemed important, particularly for those who assess this need because they are not familiar with the specificities of midwifery care, not always properly contemplated in nursing graduation courses⁽¹⁷⁾.

It is worth noticing that nurses report the Primary Healthcare Units' unsuitable infrastructure. According to the Brazilian Policy of Primary Healthcare⁽¹⁰⁾ and the manual of humane prenatal and post-childbirth assistance⁽⁹⁾, to be able to provide assistance in a more organized way it is essential to ensure that a healthcare unit works full time, which would demand a higher number of professionals; guaranty of minimum equipment and instruments, such as sonar, scale, gynecological beds, among others; availability of drugs and contraceptives for women and their partners; suitable number of professionals qualified to follow up pregnant women according to full-assistance principles and by taking into account their family and social context; adequate physical facilities to assist pregnant women and their family, in addition to areas for educational activities in groups; laboratorial support for all routine prenatal tests; and recording, processing and data analysis tools, such as pregnant women's card and perinatal chart.

So, the limited hours of a Primary Healthcare Unit, inadequate physical area, insufficient number of professionals, among others, are requirements to be discussed and improved by the administrators in charge of primary healthcare in the East Region of São Paulo.

As to printed materials, their objective is to systematize the follow-up offered to pregnant women and, as such, they should meet the Brazilian and international requirements for prenatal control⁽⁶⁻⁹⁾. However, adequate and updated tools are not enough; healthcare providers should be able to use and value them, which unfortunately does not happen considering some papers evidencing this problem⁽¹¹⁻¹³⁾. It is crucial to stress that when information about the pregnancy period is not available to those providing healthcare to pregnant women and at childbirth, fragilities may occur in the actions that can increase maternal and perinatal morbidity-mortality indexes.

The category concerning the referral and return system includes childbirth, tests, contraception and specialized

medical care. Here, subjects highlighted a lack of beds and guaranty of delivery at the unit to which women at obstetric risk have been referred; lack of places for sterilization of the couple after childbirth; lack of units for referral of women at obstetric risk; women's complaints about hospitals and units to which they have been referred; inexistence of return to the primary healthcare unit; non operating or slowly operating laboratories; limitations to the number of tests, particularly obstetric ultrasound; lack of guaranty that a pregnant woman will visit the hospital to which she has been referred before childbirth.

All the aspects related to the absence of a structured and organized referral and return system in the East Region lead us to believe that the Brazilian Healthcare System is not able to effectively guarantee the continuity of the assistance at all levels inside the healthcare system, particularly in a city as large as São Paulo.

About that there is still a lot to be done to meet the set of proposals of the Brazilian Policy of Primary Healthcare related to offering prenatal, childbirth and post-childbirth assistance to all pregnant women; a dignified and quality childbirth and post-childbirth; a previous visit to the place where they will give birth; guaranty of the presence of a companion at childbirth and access to specialized medical services to monitor gestational risks together with primary healthcare actions⁽¹⁰⁾. Based on the scenario described, gaps and inequalities still exist in the East Region once nurses described an unsuitable interaction among primary healthcare, ambulatory ward and hospital services to assist prenatal, childbirth and post-childbirth in the region.

The category of professional relationship refers exclusively to difficulties reported by the nurses in assisting women together with physicians. Subjects expressly described facts or events of a personal or professional nature related to disrespect or prohibitions made to their work. Besides, nurses mentioned a number of medical assistance problems which devaluate and/or make nursing instructions difficult and even lead pregnant women away from the UBS.

The difficult relationship between physicians and non-physicians shows the need of a change in healthcare paradigms in Brazil, particularly mercantilist and biomedical ones, which highlights and values interventionism and medical consultations against preventive and educational healthcare aspects, which are particularly visible in a nurse's work⁽⁵⁻⁶⁾.

As already mentioned, in order to enable actual improvements in the assistance it is necessary to increase not only the quantity, but mostly to enhance the qualifications of the professionals who provide pregnancy and post-childbirth care. They should master skills and have enough knowledge to make their practice safe and capable of promoting safe motherhood, besides relying upon conditions able to ease their work at several levels in the healthcare system^(3,7).

In the category of working process in primary healthcare, reports on nurses' workload were included as a result

of the scarcity of human resources in the Primary Healthcare Units and excess of assistance and administrative tasks. In this area participants reported lack of professionals in the Family Healthcare Program's teams, particularly physicians; shortage of community healthcare agents; excessive number of consultations in the agendas; excessive administrative tasks, and finally their own lack of motivation or that of their colleagues to work in primary healthcare due to its precarious situation.

As described herein, considering the inexistence of the conditions mentioned to provide assistance to women during the pregnancy-puerperal cycle, nurses are probably not able to realize the importance of their role in decreasing maternal and perinatal morbidity-mortality.

In the last category, called the population's social, economic and cultural status, fortunately just a few nurses reported obstacles to provide care to the population as a result of their own precarious situation, i.e., difficulties arising from the population that do not participate in the assistance as they should, or which do not demand improvements.

Although subjects reported working hard for women during prenatal assistance, in view of the foregoing, they are not able to put into practice said assistance in full because there is no integration among the team members towards a common objective and as a result of lack of communication between the Primary Healthcare Units and the remaining services. Such aspects added to professional devaluation, the precarious situation of the system and lack of commitment of some people, hinder proper assistance.

According to the scenario described, it is questionable how nurses can be qualified and put into practice essential competences to provide prenatal assistance if they cannot perform their role in full, if they do not see themselves as capable of changing the assistance scenario where they work, if they do not feel respected by other healthcare providers, if they do not have an effective operating referral and return system, among other aspects.

Many of the issues pointed out here were also described in a research conducted in another Brazilian city⁽¹⁷⁾, according to which the nurses described difficulties in providing prenatal care because they failed to master "knowing how to learn", "knowing how to do", "knowing how to live together" and "knowing how to be", which are components that articulate personal knowledge and capacities with the attitudes that determine professional competence.

Under this perspective, we have to emphasize that exercising essential competences is not limited to the ambit of their applicability; it demands deep knowledge and mainly an exercise on reflection through which subjects mobilize a set of values, knowledge and skills in favor of the situations, which mainly demands strengthening professional identity through qualification and particularly the commitment to changing the healthcare reality⁽¹⁶⁻¹⁸⁾.

FINAL CONSIDERATIONS

In spite of the limitations imposed by failing to assess professional knowledge, attitudes and skills, identifying actions and mainly obstacles has allowed us to visualize the scenario in the prenatal assistance in the East Region, mainly because nurses were willing to do it.

Therefore, by characterizing the subjects, the activities they reported to do and the difficulties they described, it has been possible to conclude that the East Region's nurses face obstacles to put into practice or exercise essential competences to render prenatal assistance due to personal and/or institutional barriers they face in their daily work in primary healthcare.

It seems to be clear that changing this scenario requires that the public healthcare structures in São Paulo, particularly those in the city, have their policies reviewed in order to guarantee the implementation of already existing programs and the Brazilian Healthcare System's guidelines concerning both the improvement in maternal-child assistance and destination of human and financial resources in that direction, which will surely lead to better results in maternal and perinatal assistance.

To meet pregnant women's needs in a safer way in any situation it is crucial to invest in primary healthcare and it is essential to interfere, above all, in how the relationship and bond among the Primary Healthcare Units, hospitals and services in the East Region occur, known as one of the most important obstacles to prevent damages to mother and child's health.

It is also necessary to value nurses' contributions to promote safe motherhood. Once qualified prenatal assistance requires specific knowledge and skills, both of obstetric physiopathology and the social, cultural aspects of this phase in a woman's life, nurses need to value their work, to seek better qualification and especially a partnership with women and their families during the pregnancy-childbirth cycle.

We expect that the product of this research provides subsidies to actions aimed at improving the quality of the care rendered and also includes a higher number of non-physicians in primary healthcare, which will surely contribute to improving its quality. Within this scenario it is important to highlight that due to the way prenatal care and the Family Healthcare Program are operated in the city of São Paulo, there seems to be room for more qualified professionals, particularly nurse-midwives and midwives, as duly proven by scientific evidence pointing at interventions able to help preventing maternal mortality during pregnancy and post-childbirth^(3,5-8,17). These duly qualified professionals will be able to contribute to improve the quality of the care provided and the necessary evolution of the biomedical and interventionist assistance model also in force in primary healthcare.

REFERENCES

1. Organización Panamericana de la Salud (OPAS). Consulta Técnica Regional: Atención Calificada del Parto en América Latina y el Caribe [CD ROM]. Santa Cruz de la Sierra; 2003.
 2. International Confederation of Midwives. Competencies [text on the Internet]. New York: ICM; 2002. [cited 2007 Nov 16]. Available from: http://www.internationalmidwives.org/Portals/5/Documentation/Essential%20Compenglish_2002-JF_2007%20FINAL.pdf
 3. World Health Organization (WHO). International Confederation of Midwives. International Federation of Gynecology and Obstetrics. Department of Reproductive Health and Research. Making Pregnancy Safer: the critical role of the skilled attendant. Geneva; 2004.
 4. Costa AM, Guilhem D, Walter MIMT. Atendimento a gestantes no Sistema Único de Saúde. *Rev Saúde Pública*. 2005;39(5):768-74.
 5. Calderon IMP, Cecatti JG, Vega CEP. Intervenções benéficas no pré-natal para prevenção da mortalidade materna. *Rev Bras Ginecol Obstet*. 2006;28(5):310-5.
 6. Di Mario S. What is effectiveness of antenatal care? [text on the Internet]. WHO Regional Office for Europe; 2005. [cited 2005 Dec 28]. Available from: <http://www.euro.who.int/Document/E87997.pdf>
 7. World Health Organization (WHO). Safe motherhood needs assessment. Geneva; 2001.
 8. Organización Panamericana de la Salud (OPAS). Lineamientos y directrices de enfermería para la mejoría de La calidad de la atención prenatal en embarazos de bajo riesgo en América Latina y el Caribe. Washington; 2004.
 9. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Área Técnica de Saúde da Mulher. Pré-natal e puerpério: assistência qualificada e humanizada. Brasília; 2005.
 10. Brasil. Ministério da Saúde. Secretaria de Políticas de Saúde. Programa de humanização do pré-natal e nascimento. Brasília; 2000.
 11. Barbos MA. Avaliação da assistência pré-natal de baixo risco no município de Francisco Morato [dissertação]. Guarulhos: Universidade Guarulhos; 2006.
 12. Narchi NZ, Fernandes RAQ, Viana KA. Records of anti-tetanic immunization in documents of mothers: a descriptive study. *Online Braz J Nurs* [serial on the Internet]. 2006 [cited 2007 dez 15];5(2):[about 5 p]. Available from: <http://www.uff.br/objnursing/index.php/nursing/article/view/374/86>
 13. Narchi NZ, Kurdejak A. Occurrence and recording of genitourinary tract infections during pregnancy. *Online Braz J Nurs* [serial on the Internet]. 2008 [cited 2008 Dec 15];7(2):[about 5 p]. Available from: <http://www.uff.br/objnursing/index.php/nursing/article/view/j.1676-4285.2008.1490/350>
 14. Serruya SJ, Lago TDG, Cecatti JG. O panorama da atenção pré-natal no Brasil e o Programa de Humanização do Pré-Natal e Nascimento. *Rev Bras Saúde Matern Infant*. 2004;4(3): 269-79.
 15. United Nations Population Found. Maternal Mortality Update 2006. Expectation and delivery: investing in midwives and others with midwifery skills. New York; 2007.
 16. Bonadio IC. "Ser tratada como gente": a vivência de mulheres atendidas no serviço de pré-natal de uma instituição filantrópica. *Rev Esc Enferm USP*. 1998;32(1):9-15.
 17. Dotto LMG, Moulin NM, Mamede MV. Prenatal care: difficulties experienced by nurses. *Rev Lat Am Enferm*. 2006;14(5):682-8.
- Ramos MN. A pedagogia das competências: autonomia ou adaptação? 2ª ed. São Paulo: Cortez; 2002.

Project funded by São Paulo Research Foundation.