Original Article

Quality of nursing appointments in routine prenatal care*

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ABSTRACT

The objective of this study has been to evaluate the quality of nursing appointments in routine prenatal care. This is a descriptive study, conducted in Redenção, Ceará, Brazil, based on the non-participant observation of five nurses, each in three prenatal appointments, amounting to fifteen observations, subsidized by a check-list form with variables recommended by the Ministry of Health in the strategy of the Quality Care Program (PROQUALI). The results show that the care was considered satisfactory for the issue of reception and partially satisfactory for anamnesis, health guidelines, and physical examination. Thus, prenatal care has been classified as partially satisfactory, since activities essential to the promotion of an uneventful gestation were not performed. This brings the need for investments in human resources development and greater monitoring of the quality of the care by managers.

Descriptors: Prenatal Care; Evaluation; Nursing.

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INTRODUCTION

Access to routine prenatal care is given primarily in Primary Health Care, whose multiprofessional care contributes to more favorable maternal and perinatal outcomes, since it allows the early detection and treatment of pathologies, as well as the control of vulnerability factors related to the pregnant woman and the fetus from the monitoring of health conditions[1].

In order to ensure quality prenatal access, a number of strategies were instituted in Brazil, such as the Family Health Strategy (FHS), the Prenatal and Birth Humanization Program (PHPN) and, more recently, the Stork Network, which aim to reduce the rates of maternal, perinatal,

and neonatal morbidity and mortality[2-3]. In this sense, the Ministry of Health (MH) advocates several criteria for the care of the pregnant woman during her follow-up, which must be followed by all the professionals who treat pregnant women, aiming to guarantee integral and quality care, thus reducing risks to the mother and child[3].

However, even with improvements in access to prenatal care, data show that maternal and infant mortality rates are still worrying, especially those related to obstetric causes[4]. This reality shows an alarming problem and therefore requires immediate and effective intervention.

Based on the need to evaluate the quality of the health services offered to the population, the Quality Assistance Program (PROQUALI) was developed, which is a tool for the evaluation, monitoring, and training of FHS teams consisting of Performance Improvement Instruments (IMD), which are protocols of the service structure and actions provided by the teams, allowing the improvement of the care provided by several professionals[1,5-7].

Among the prenatal care professionals, we can mention the nurse, who performs his or her duties according to Law 7,498/86, in a multiprofessional team and meets the assumptions of the Ministry of Health, considered as essential for qualified prenatal care[8]. Thus, these professionals need to be constantly evaluated in relation to their work actions and stimulated to carry out safe health interventions and actions to promote the health of their population.

Based on the assumption that routine prenatal care appointment is part of the professional competence of the nurse in FHS and that the early diagnosis of health problems and their adequate treatment can reduce maternal and neonatal mortality, the objective of this study was to evaluate the quality of nursing appointments in routine prenatal care.

METHODS

This is an evaluative-descriptive research with a quantitative approach, conducted between January 2014 and March 2015, with five FHS nurses of a municipality in the countryside of the State of Ceará, Brazil, which has approximately 26,415 inhabitants and 11 Basic Health Units (BHU), located in the urban and rural areas of the city of Redenção, Ceará, Brazil.

To carry out this study, we investigated five BHU (four located in the urban area and one in the rural area). The remainder was excluded because of the refusal of two nurses to participate in the study, three could not be reached by the researchers because of difficulties in the access, and one nurse responsible for the unit could not be reached.

Data collection was carried out by three researchers who, during two meetings, participated in a training, in which the discussion of the instrument was carried out and each activity that would be evaluated was commented.

Data collection was carried out with the nurse on the days of prenatal appointments, which occur three times a month in each BHU on average, depending on the demand of pregnant women, from the non-

participant observation of the procedures performed by nurses during care related to the quality criteria recommended by the MH.

To support the study, a structured instrument developed by PROQUALI was used, which encompasses the basic activities that nurses must perform during the appointment, based on the guidelines of the MH. The data were recorded on the instrument obeying a classification consisting of YES (Y), when the activity was performed, NO (N) when it was not performed, and NOT APPLICABLE (NA) for procedures and conducts that should be performed only in different gestational periods.

In order to obtain reliable results, and avoid false evaluations, we observed three appointments for each nurse. The records of the observations were grouped according to the topics: characterization of the reception, anamnesis, physical examination, and guidance provided to the pregnant woman.

The data obtained were entered in the Excel software. Each item was evaluated individually and classified according to the performance index of the required item. The simple percentage of each item was calculated and when an item was performed in up to 49.9% of the observations it was considered as unsatisfactory (U), when it was performed from 50.0 to 69.9% of the time, it was partially satisfactory (PS), and when it was performed more than 70% of the time, it was satisfactory (S). In general, the activities present in the quality prenatal care were evaluated according to the procedures recommended by PROQUALI, and then a general calculation of all the activities performed by the nurse was carried out. The items classified as NA were taken from the table because there would be no way to characterize whether the activities were carried out satisfactorily or unsatisfactorily, when necessary.

This study was carried out according to resolution No. 466 of December 12, 2012, approved by the Research Ethics Committee of the *Universidade da Integração internacional da Lusofonia Afro-Brasileira* (UNILAB) under CAAE protocol number: 32387314.7.000. All participating nurses signed the Informed Consent (IC).

RESULTS

We verified that in all appointments the nurses cordially received the users, kept the office door closed, avoided the circulation of third parties at the time of the appointment, listened attentively to the pregnant women, and used the appropriate language for the population treated (Table 1).

Table 1: Quality of the reception of the nursing appointment in routine prenatal care, 2015. Redenção, CE, Brazil, 2014-2015.

Activity	Yes		No		Total		Evaluation
	n	%	n	%	n	%	
Cordially receives the user	15	100	0	0	15	100	S
Introduces themselves	13	86.7	2	13.3	15	100	S
Ensures confidentiality	12	80	3	20	15	100	S
Keeps the door closed	15	100	0	0	15	100	S
Persons do not circulate in the appointment	15	100	0	0	15	100	S
Listens carefully	15	100	0	0	15	100	S
Uses proper language	15	100	0	0	15	100	S

In two appointments, presentation was not performed, since the users knew the professionals who provided the care. The guarantee of confidentiality was also adequate, although there were cases in which it was not emphasized. Thus, we can note that the reception was carried out satisfactorily.

The updating of the clinical history of the pregnant woman and the stimulus for asking questions were satisfactorily performed (Table 2).

Table 2: Quality of the anamnesis of the nursing appointment in routine prenatal care, 2015. Redenção, CE, Brazil, 2014-2015.

Activity	Yes		No		Total		Evaluation
	n	%	n	%	n	%	
Performs/updates clinical history	15	100	0	0	15	100	S
Stimulates the user to ask questions	14	93.3	1	6.7	15	100	S
Identifies needs/concerns	5	33.3	10	66.7	15	100	U
Identifies risk behavior for STI/AIDS	3	20	13	80	15	100	U

In few visits the professionals identified the needs and concerns of the pregnant women, clarified doubts, and identified the risk behavior for STI/AIDS from questions related to the use of condoms and number of partners. This identification of needs may have permeated the thinking of nurses during the appointment, but they were not emphasized or even mentioned, so the item was considered as unsatisfactory.

Regarding the quality of the physical examination, we found that Gestational Age and expected date of birth were calculated, revised, and recorded in the perinatal record and in the pregnant woman's card in all appointments (Table 3).

Other indexes that were also satisfactory but not fully performed during the appointments were weight, height, and blood pressure measurement.

We verified that the professionals placed the pregnant women in the supine position, explained about the physical examination, evaluated fundal height, verified the fetal heart rate, and sent them to a service of greater complexity in most of the appointments that needed such procedures. In some appointments, there was no need for abdominal examination, since the pregnancies were less than 12 weeks.

The nurses performed pre/post HIV testing counseling in only 40% of the appointments, and the nutritional condition of the pregnant woman was verified using the normogram in 20% of the visits. Of the 80% of the appointments in which hand hygiene was necessary for physical examination, only 13.3% were performed. There was a complaint of cardiopulmonary discomfort in 40% of cases; however, cardiopulmonary auscultation was performed in only half of them.

There was a low index of verification of edema in both lower limbs and face. Oncotic cytology was need in 26.7% of the appointments, being performed in 50% of the ones that required it. The evaluation of fetal presentation, performed in the third trimester, was necessary in 46.7% of the cases; however, it was performed only in 28.6% of those who needed it. The index of appointments in which the professionals covered the patient with a bed sheet during physical examination was also low. Breast examination was performed in only one appointment.

Table 3: Quality of the physical examination of the nursing appointment in routine prenatal care, 2015. Redenção, CE, Brazil, 2014-2015.

Activity	Yes / NA		No		Total		Evaluation
	n	%	n	%	n	%	
Calculates/revises GA	15	100	0	0	15	100	S
Calculates/revises EDB	15	100	0	0	15	100	S
Verifies/evaluates NC	3	20	12	80	15	100	U
Places the pregnant women in SP	8 / 3	66.7	4	33.3	12	100	PS
Covers the pregnant woman with sheet	2 / 3	16.7	10	83.3	12	100	U
Explains the procedure to the pregnant woman	8 / 3	66.7	4	33.3	12	100	PS
Washes their hands before the exam	2 / 3	16.7	10	83.3	12	100	U
Evaluates weight/height	14	93.3	1	6.7	15	100	S
Verifies/evaluates BP	12	80	3	20	15	100	S
Checks axillary temperature	0 / 6	0	9	100	9	100	U
Inspects skin/mucous membranes	0	0	15	100	15	100	U
Perform CP auscultation	3 / 9	50	3	50	6	100	PS
Examines LM	6	40	9	60	15	100	U
Looks for edema	5	33.3	10	66.7	15	100	U
Perform breasts examination	1	6.7	14	93.3	15	100	U
Verifies FH	8 / 3	66.7	4	33.3	12	100	PS
Evaluates fetal growth	8 / 3	66.7	4	33.3	12	100	PS
Performs FHR auscultation	8 / 6	88.9	1	11.1	9	100	S
Identifies situation/presentation	2 / 8	28.6	5	71.4	7	100	U
Performs gynecological-obstetrical examination	0 / 6	0	9	100	9	100	U
Washes their hands after the exam	2 / 2	13.3	11	73.7	13	100	U
Records the data	15	100	0	0	15	100	S

GA: gestational age; EDB: expected date of birth; NC: nutritional condition; SP: supine position; BP: blood pressure; CP: cardiopulmonary; LM: lower members; FH: fundal height; FHR: fetal heart rate.

No appointment performed: inspection of the skin and mucous membranes, gynecological-obstetric examination in search of alterations of the cervix or STI in the pregnant women, or verification of the axillary temperature.

The data in Table 4 show a partially satisfactory index of guidance for the importance of VDRL and anti-HIV testing, as well as the investigation of the concerns of the women about prenatal care and childbirth.

Table 4: Quality of the guidance of the nursing appointment in routine prenatal care, 2015. Redenção, CE, Brazil, 2014-2015.

Guidance	Yes / NA		No		Total		Evaluation
	n	%	n	%	n	%	
Importance of VDRL/Anti-HIV	5 / 6	55.6	4	44.4	9	100	PS
Prenatal/childbirth concerns	5 / 3	41.7	7	58.3	12	100	U
Pregnancy, delivery, and postnatal	6	40	9	60	15	100	U
Risk behavior/STI	0 / 3	0	12	100	12	100	U
Available services	7 / 1	50	7	50	14	100	PS
Breastfeeding	3 / 1	21.4	11	78.6	14	100	U
Scheduling of return visit	15	100	0	0	15	100	S
Importance of the return	9	60	6	40	15	100	PS

In none of the appointments did the professionals advise on risk behavior and STI prevention, and in 20% of them this action was not necessary, since the nurse reported having advised them in a previous appointment.

In 93.7% of the cases, the pregnant women needed to go to other services in the unit, but referrals

were made in only 46% of the appointments. Regarding breastfeeding, the index of guidance was unsatisfactory. In such a care, such guidance was not necessary at the moment because it is the first appointment, when more important information such as the importance of the diet, supplementation of iron and folic acid, among other information pertinent to the beginning of gestation is more important.

In all appointments, the nurses scheduled the return, and their importance was emphasized in 60% of them.

From these data, it was evidenced that of the 41 activities evaluated 39% were satisfactory, 19.5% were partially unsatisfactory, and 41.5% were unsatisfactory.

Thus, in general, prenatal care has an index of 58.5%, being then classified as partially satisfactory according to the PROQUALI criteria, based on PHPN, because although it is a strategy that does not require complex technologies, some of the activities, although simple, but essential for the promotion of a pregnancy without complications, were not performed or were performed in low indexes.

DISCUSSION

The evaluation of the conduct of nurses during routine appointments with pregnant women showed that many activities were not performed in their completeness.

In this study, except for reception, which obtained a satisfactory evaluation in all the items researched, anamnesis, physical examination, and guidance presented approximately half of unsatisfactory evaluations regarding the variables analyzed.

Satisfactory percentages of satisfaction (46%) were also observed in another study[5], which has considered the number of appointments, procedures, tests performed, and guidance, and it has presented satisfactory indexes lower than this study. Prenatal care has been evaluated in other studies with 70%[9], 82%[10], and 95%[11] of inadequacy, based on the criteria established by the MH in PHPN.

During the evaluation, reception was satisfactory. This activity implies accountability for the formation of a bond from the reception of the user, with qualified listening and vulnerability assessment, among other care services [12]. In the case of pregnant women, this is even stronger and valued, since it is a moment when they are more fragile and emotional.

Regarding anamnesis, we can verify the importance of investing time and effort in asking pertinent questions to the women's health. It is necessary to investigate clinically important aspects, not being rigid and allowing the individualized and widely debated clinical analysis. It is not enough to have access to prenatal care, it is necessary that responsible professionals use clinical knowledge to intervene in adverse situations[13]. In a study about essential skills in prenatal care, an anamnesis approach of the clinical history of the pregnant women was performed; however, this rate decreases in subsequent appointments [14].

The physical examination constitutes important techniques for the detection of changes, contributing to the improvement of prenatal care[15]. The analysis of the physical examinations carried out in the investigated reality revealed that the calculations of gestational age and the expected date of birth were the

most performed actions, but other important points of the physical examination, such as skin and mucosal examination, were not performed.

The results identified differ from a study that analyzed the quality of the physical examination during the first prenatal visit in Campina Grande, Brazil, with 75 pregnant women, showing high rates of skin and mucosal examination (96.6%); however, blood pressure was verified in only 36.6% of the cases[16]. In both studies, there was a low occurrence of breast examination, evidencing the relevance of the professionals in performing this examination, diagnosing early changes that bring losses during breastfeeding.

In a similar study, it has been observed that clinical breast examination and pelvic examination, which depend on the greater proximity between the pregnant woman and professional, were also not performed in most of the follow-ups [17]. Therefore, we can note the importance of the bond for a quality examination. In relation to pelvic examination, many professionals prefer not to perform any type of uterine exam for fear of stimulating it in a negative way. In order to improve the physical examination in pregnant women, it is up to nurses to keep themselves constantly updated and to use protocols for physical examination, in addition to the supervision of health managers.

The calculation of gestational age and the measurement of fundal height, weight, and maternal blood pressure were constantly performed[11], which can be compared to this study. However, this information is minimal to examine the health condition of pregnant women, which leads to the conclusion that physical examinations are not totally satisfactory in this municipality, so that many women and their unborn children may be at risk and not know this information.

As for serology, specifically, data from a study conducted in Vitória, Brazil, from March 2010 to February 2011, show that more than 20% of the pregnant women did not perform serology for syphilis and approximately 30% did not undergo HIV testing[11]. In the place where this research was carried out, the difficulty is often not in the request or performance of laboratory tests, but in the receipt of the results, which is often time consuming, hindering the caring process.

Pre-test HIV counseling allows for an increase in the performance rate, since women will accept it better, as this concerns them, as evidenced in a study[18] that listed the main concerns of the women about the examination, among them the fear of discovering HIV, of judgments, and of verifying the partner's infidelity. The nurse should invest time and effort in sensitizing pregnant women to take the exam and even invite the partner to take it as well, offering pertinent information in a judgment-free way, explaining its importance for early diagnosis for an adequate care for the pregnant women and the baby.

The obstetric physical examination performed in the investigated BHU was partially satisfactory. In an analysis performed with 500 prenatal cards, the low quality of public services was identified for these exams[6]. Because of its importance for the detection of fetal changes, obstetrical physical examination should be performed in all appointments, as long as the gestational age is adequate. For it to be done properly, it is necessary to create protocols that help the professional in the correct execution and registration of activities.

Measurement of blood pressure, weight gain, and auscultation of the fetal heart beat were satisfactory. These behaviors have also been highlighted in another study that has evaluated the prenatal appointment[5], highlighting that the history of chronic hypertension or the development of pre-eclampsia and low maternal weight are related to low weight birth[11]. Satisfactory measures should be recognized and encouraged with professionals in order to ensure that they continue to be carried out satisfactorily.

However, we can observe that the measurement of fundal height was partially satisfactory and the gynecological examination was unsatisfactory in this study. They are mechanisms that identify changes in the production of amniotic fluid/fetal growth and the gynecological diseases that they can cause, among other disorders, abortion, and premature delivery[2-3]. This failure may lead to poor evaluation of fetal growth, as well as a lack of diagnosis of gynecological infections that may interfere with the progress of pregnancy. It is necessary to sensitize and demystify these measures, emphasizing that the examination should be carried out routinely.

Regarding the prescription of medications when necessary, the evaluation was satisfactory, in agreement with a study that has demonstrated a 94% to 96% percentage of prescriptions[10].

The registration of the data on perinatal cards or records was satisfactory, which can express the quality of the data produced to generate fundamental information, which is different from a research carried out with cards of pregnant women in a city of Espírito Santo, Brazil, where the registration was considered as poor[17].

Health education generates a bond between the professional and the user, culminating in the promotion of self-care and well-being of pregnant women, since this is a public that lacks information because of the changes related to this phase. The low frequency of prenatal guidance was verified throughout the country by a study with 23,940 pregnant women, in which 60% received guidance on breastfeeding and only 41.1% receive guidance about signs and labor[19].

In this study, we observed that the guidance on breastfeeding presented a low index with a lower percentage than that observed in a study that has found 67% of guidance on this subject[11]. Although there have been opportunities to clarify doubts, there is a need for guidance on the most pertinent issues during pregnancy.

Other studies show a variation between 20% and 22% of pregnant women who participate in groups of pregnant women or who receive guidance during pregnancy[5,10]. It has also been verified that nurses, when working with groups, feel a need to articulate with other professionals, providing support for integral care[20].

It is important to answer doubts and minimize the anxiety of the couple. Information on diet, gestational changes, fetal movement, among others, help identify risk situations and guide educational measures that should be emphasized during prenatal care[12]. Therefore, we suggest that nurses should count on the support of a multiprofessional team to carry out educational activities.

CONCLUSION

This study allowed us to know the characteristics of routine prenatal care offered by the municipality, which, despite showing potential, also showed weaknesses that require intervention. Prenatal care was classified as partially satisfactory according to the PROQUALI criteria, based on the PHPN, and new training and updates for Primary Health Care nurses are required.

A potential evidenced in this work was the reception offered to pregnant women, an activity that contributes to the formation of a bond between professional and user, since it is the starting point for the search for a pregnancy without complications, from the communication, confidentiality, and disposition of nurses.

On the other hand, some procedures that are not performed during the care tend to impair the quality of care, such as physical examination, which needs to be improved, since it may reveal findings that have a direct impact on the health of the mother and child.

In addition, nurses also need to focus on the guidance offered to pregnant women, since they assist in maternal self-care. In the case of this study, the guidance may be more apprehended because of the bond already established in the reception. Professionals need to be trained and updated for both activities; it is also important to follow the Ministry of Health standards for adequate prenatal care and more investment in health promotion.

As limitations, it is worth noting that we could not collect data from all the BHU of the municipality, in addition to having limited the evaluation to only subsequent appointments, so that further studies are needed that include more BHU, including neighboring municipalities, and that evaluate the first prenatal appointment.

Therefore, we expect that this study will contribute to advances in prenatal care, from their dissemination in BHU and also in managerial centers, as evaluations are powerful tools to guide the improvement of the quality of health care.

REFERENCES

1. Domingues RMSM, Hartz ZMA, Dias MAB, Leal MC. Avaliação da adequação da assistência pré-natal na rede SUS do Município do Rio de Janeiro, Brasil. Cad Saude Publica [Internet]. 2012 [cited 2017 sep 06];28(3):425-37. Available from: http://dx.doi.org/10.1590/S0102-311X2012000300003.

2. Ministério da Saúde, Secretaria Executiva. Programa Humanização do Parto: humanização no pré-natal e nascimento [Internet]. Brasília: Ministério da Saúde; 2012 [cited 2017 sep 06]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/parto.pdf.

3. Portaria nº 650, de 5 de outubro de 2011 (BR) [Internet]. Dispõe sobre os planos de ação regional e municipal da Rede Cegonha. Diário Oficial da União. 06 out. 2011 [cited 2017 sep 06]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/sas/2011/prt0650_05_10_2011.html.

4. Governo do Estado do Ceará, Secretaria da Saúde. Informe Epidemiológico Mortalidade Materna [Internet]. 09 jun. 2015 [cited 2017 sep 06]. Available from: http://www.saude.ce.gov.br/index.php/boletins?download=1355%3Ainforme-mortalidade-materna.

5. Anversa ETR, Bastos GAN, Nunes LN, Dal Pizzol TS. Qualidade do processo da assistência pré-natal: unidades básicas de saúde e unidades de Estratégia Saúde da Família em município no Sul do Brasil. Cad Saude Publica [Internet]. 2012 [cited 2017 sep 06];28(4):789-800. Available from: http://dx.doi.org/10.1590/S0102-311X2012000400018.

6. Paris GF, Pelloso SM, Martins PM. Qualidade da assistência pré-natal nos serviços públicos e privados. Rev Bras Ginecol Obs [Internet]. 2013 [cited 2017 sep 06];35(10):447-52. Available from: http://dx.doi.org/10.1590/S0100-72032013001000004.
7. Governo do Estado do Ceará, Secretaria da Saúde. Metodologia de melhoria da qualidade da atenção à saúde: instrumento de melhoria do desempenho. 2ª ed. Fortaleza: SESA-CE; 2005.
8. Rodrigues EM, Nascimento RG, Araújo A. Protocolo na assistência pré-natal: ações, facilidades e dificuldades dos enfermeiros da Estratégia de Saúde da Família. Rev Esc Enferm USP [Internet]. 2011 [cited 2017 sep 06];45(5):1041-7. Available from: http://dx.doi.org/10.1590/S0080-62342011000500002.
9. Coutinho T, Monteiro MFG, Sayd JD, Teixeira MTB, Coutinho CM, Coutinho LM. Monitoramento do processo de assistência pré-natal entre as usuárias do Sistema Único de Saúde em município do Sudeste brasileiro. Rev Bras Ginecol Obs [Internet]. 2010 [cited 2017 sep 06];32(11):563-9. Available from: http://dx.doi.org/10.1590/S0100-72032010001100008.
10. Maia MG, Santos JLS, Bezerra MLR, Santos Neto M, Santos LH, Santos FS. Indicador de qualidade da assistência pré-natal em uma maternidade pública. Journal of Management & Primary Health Care [Internet]. 2014 [cited 2017 sep 06];5(1):40-7. Available from: http://www.jmphc.com.br/saude-publica/index.php/jmphc/article/view/195.
11. Polgliane RBS, Leal MC, Amorim MHC, Zandonade E, Santos Neto ET. Adequação do processo de assistência pré-natal segundo critérios do Programa de Humanização do Pré-natal e Nascimento e da Organização Mundial de Saúde. Cien Saude Colet [Internet]. 2014 [cited 2017 sep 06];19(7):1999-2010. Available from: http://dx.doi.org/10.1590/1413-81232014197.08622013.
12. Ministério da Saúde. Atenção ao pré-natal de baixo risco. Cadernos de Atenção Básica, 32 [Internet] Brasília: Ministério da Saúde; 2012. [cited 2017 sep 06]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/cadernos_atencao_basica_32_prenatal.pdf.
13. Zanini RR, Moraes AB, Giugliani ERJ, Riboldi J. Determinantes contextuais da mortalidade neonatal no Rio Grande do Sul por dois modelos de análise. Rev Saude Publica [Internet]. 2011 [cited 2017 sep 06];45(1):79-89. Available from: http://dx.doi.org/10.1590/S0034-89102011000100009.
14. Duarte SJH, Almeida EP. O papel do enfermeiro do programa saúde da família no atendimento pré-natal. Revista de enfermagem do Centro-Oeste Mineiro [Internet]. 2014 [cited 2017 sep 06];4(1):1029-35. Available from: http://www.seer.ufsj.edu.br/index.php/recom/article/view/137.
15. Freitas LV, Teles LMR, Lima TM, Vieira NFC, Barbosa RCM, Pinheiro AKB et al. Exame físico no pré-natal: construção e validação de hipermídia educativa para a Enfermagem. Acta Paul Enferm [Internet]. 2012 [cited 2017 sep 06];25(4):581-8. Available from: http://dx.doi.org/10.1590/S0103-21002012000400016.
16. Lima LFC, Davim RMB, Silva RAR, Costa DARS, Mendonça AEO. Importância do exame físico da gestante na consulta do enfermeiro. Revista de enfermagem UFPE on line [Internet]. 2014 [cited 2017 sep 06];8(6):1502-9. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/4531.
17. Santos Neto ET, Oliveira AE, Zandonade E, Gama SGN, Leal MC. O que os cartões de pré-natal das gestantes revelam sobre a assistência nos serviços do SUS da Região Metropolitana da Grande Vitória, Espírito Santo, Brasil? Cad Saude Publica [Internet]. 2012 [cited 2017 sep 06];28(9):1650-62. Available from: http://dx.doi.org/10.1590/S0102-311X2012000900005.
18. Rothpletz-Puglia P, Storm D, Burr C, Samuels D. Routine Prenatal HIV Testing: Women's Concerns and Their Strategies for Addressing Concerns. Matern Child Health J [Internet]. 2012 [cited 2017 sep 06];16(2):464-9. Available from: http://dx.doi.org/10.1007/s10995-011-0754-4.
19. Viellas EF, Domingues RMSM, Dias MAB, Gama SGN, Theme Filha MM, Costa JV et al. Assistência pré-natal no Brasil. Cad Saude Publica [Internet]. 2014 [cited 2017 sep 06];30(Suppl 1):S85-100. Available from: http://dx.doi.org/10.1590/0102-311X00126013.
20. Gubert FA, Santos ACL, Aragão KA, Pereira DCR, Vieira NFC, Pinheiro PNC. Tecnologias educativas no contexto escolar: estratégia de educação em saúde em escola pública de Fortaleza-CE. Rev. Eletr. Enf. [Internet]. 2009 [cited 2017 sep 06];11(1):165-72. Available from: https://doi.org/10.5216/ree.v11.46914.