

Abordagem de necessidades de saúde pelo enfermeiro na consulta pré-natal

Approaching health needs by nurse in prenatal consultation

Enfoque de las necesidades de salud por la enfermera en consultas prenatales

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ABSTRACT

Objective: The study's aim has been to distinguish the health needs prioritized by the nursing professional during the prenatal consultations and then to characterize their specificity and coverage. **Methods:** It is descriptive research with quantitative approach, which was carried out in four units of *Estratégia Saúde da Família* (Family Health Strategy), in *Cuiabá-MT*, through participative observation of 50 pregnant women during their consultations, reviewing 79 nursing records and performing the content analysis of thematic type. **Results:** During consultations, the nurses prioritize the coverage of physic-obstetric needs. Eventually, the nurses elicit social and psycho-emotional aspects, but they do not approach them as a need to be fulfilled. Nonetheless, during the consultation, the pregnant women express certain needs, such as social, psycho-emotional state, information, and access to technology and family participation in the consultation. Despite the mobilizing potential related to the need mentioned previously, they are not able to modify what they are giving attention over the consultation period. **Conclusion:** It is necessary to improving most of the work processes in basic attention. It is also relevant focus on upgrading the nurses' actions and their formal education, aiming to cover indeed the overall needs during the prenatal consultations.

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RESUMO

Objetivo: Distinguir as necessidades de saúde priorizadas pelo enfermeiro na consulta pré-natal, e caracterizar a especificidade e abrangência das mesmas. **Método:** Pesquisa descritiva, qualitativa, realizada em quatro unidades da Estratégia Saúde da Família de Cuiabá-MT, mediante observação participante de 50 consultas de gestantes, análise de 79 registros de enfermagem e análise de conteúdo do tipo temática. **Resultados:** Nas consultas, os enfermeiros privilegiam a abordagem de necessidades físico-obstétricas. Eventualmente levantam aspectos sociais e psicoemocionais, mas não os abordam como necessidades a serem satisfeitas. Entretanto, as gestantes expressam necessidades sociais, psicoemocionais, de informação, de acesso a tecnologias e de participação familiar na consulta. Apesar do potencial mobilizador destas últimas necessidades, elas não chegam a modificar o que recebe atenção na consulta. **Conclusão:** É preciso investir na melhoria dos processos de trabalho da atenção básica, na ampliação de suas ações, e na formação e educação dos enfermeiros, tendo em perspectiva a abordagem de necessidades abrangentes no pré-natal.

Descritores: Cuidado Pré-Natal, Necessidades e Demandas de Serviços de Saúde, Estratégia Saúde da Família, Enfermagem.

RESUMEN

Objetivo: Diferenciar las necesidades de salud priorizadas por el enfermero en la consulta pre-natal, y caracterizar la particularidad y amplitud de las mismas. **Método:** Investigación descriptiva, cualitativa, realizada en cuatro unidades de la Estrategia Salud da Família en la ciudad de Cuiabá-MT, mediante observación participante de 50 consultas de gestantes, el análisis de 79 registros de enfermería y el análisis de contenido del tipo temático. **Resultados:** En las consultas, los enfermeros favorecen el enfoque de necesidades físico-obstétricas. Eventualmente, plantean aspectos sociales y psicoemocionales, pero no los abordan como necesidades a ser satisfechas. Sin embargo, las gestantes expresan necesidades sociales, psicoemocionales, de información, de acceso a tecnologías y de participación familiar en la consulta. A pesar del potencial movilizador de estas últimas necesidades, ellas no llegan a modificar lo que recibe atención en la consulta. **Conclusión:** Es necesario invertir en la mejora de los procesos de trabajo de la atención básica, en la ampliación de sus acciones, y en la educación y capacitación de los enfermeros, teniendo en cuenta el enfoque en las necesidades globales en el prenatal.

Descritores: Atención Prenatal, Necesidades y Demandas de Servicios de Salud, Estrategia de Salud Familiar, Enfermería.

INTRODUCTION

Pregnancy triggers innumerable organic transformations, such as psycho-emotional, and sociocultural ones in women's lives, and their health situation is linked to elements of these various orders. Thus, due to the reproductive event, the woman presents comprehensive health needs, which must be objects of prenatal care, through the health team.

The comprehensive needs approach, which derives from the social, intersubjective and physical substances of the reproductive event and the interweaving between them, is an integrated perspective in Brazilian health policies directed to the female group. It is consistent with the precept of integrality

that guides the various practices of the *Sistema Único de Saúde (SUS)* [Unified Health System] and the intended renewal of health care through the Family Health Strategy.

Health needs relate to what is lacking, what appears to be a problem to be cured, to the human potential to be developed, the supply or modification of which is considered important for the conservation of human life and for its healthy development. As well as the health needs are the very ways of satisfying themselves, which are socially built.¹

From this understanding, it appears that reproductive health needs encompass situations, processes and things considered important to the beneficial experience of reproduction, and to the preservation of the health of those involved. Therefore, they refer to organic aspects, to the individual-social dialectic and to a field of citizenship rights. It includes health and social services whose actions and resources promote or maintain reproductive health.²

The nursing prenatal consultation is one of these actions, configured in itself as a necessity, and through it, the transformation of various needs related to the reproductive event, according to social, cultural, institutional, technical, scientific, and professional limits, including the historical and legal limits of the nurses' performance.

Studies on prenatal care carried out in several Brazilian settings suggest or suggest that, in medical and/or nursing consultations, reproductive health needs have generally been approached from an exclusive biological perspective and that it is necessary to expand encompassing socio-cultural and psycho-emotional aspects.

As an example, stands out a recent study,³ carried out in a hospital in *Vitória, Espírito Santo*, in which one of the objectives was to identify the most frequent nursing diagnoses in prenatal care. In this study, the findings allow to infer the priority given to the organic needs, since the diagnoses were focused on physical aspects and related behaviors, such as: poor food intake, low fluid intake, risk for hypertension, risk for hyperglycemia, legs edema, pelvic pain and increased urinary elimination.

Although the studies show the strong brand of the biomedical model in prenatal professional practices, including nurses, the debate on the reproductive health needs addressed in the care of pregnant women has been very general. In other words, the researches do not take them as a specific object of study, they do not dwell on their specification and on the explanation of how they are included and excluded from care actions, and generally do not depart from a theoretical perspective assumed around about what and what they are indeed, as well as the reasons that explain the limits of their approach.

However, it is not denied that the national debate on the subject has given rich contributions to the recognition of the scope of reproductive health needs, especially when addressing them from reproductive experiences and perceptions of women and men. In this sense, we have studies that focus on the postnatal period,⁴⁻⁵ or on specific

health situations, such as increased gestational risk⁶ and abortion in adolescence.⁷

These studies confirm the experience and the perception of several biological needs related to reproduction, and other factors to be considered for health care, such as: misinformation, fears, worries, insecurities, anxiety; tasks overloading, disorganization of daily life and family conflicts; affective-conjugal need, child welfare, exchange of affection with the child, and promotion of their safety; in addition to financial shortages, the lack of broad support from health services and other social services, among others.⁴⁻⁷

Another publication⁸ arises from two studies with fathers and mothers after the birth of the first child, whose objectives were, respectively: to identify feelings, difficulties in family adjustment and strategies used in relation to the new roles; and also identifying the risk and protection factors present in the situation. The study seeks to recognize health needs for a program to support parenting, evidencing as a result the experience and manifestation of aspects such as: ambivalent feelings, changes in family roles and sexuality of the couple, difficulties in interpreting the baby crying, and their sensorial capacities and needs, reduced parental involvement in the care of the latter, need to strengthen the social support network, among others.

In the recent international literature, a study identifies “unsatisfied” or “unmet” needs for health services, but caters to family planning.⁹ Others address health needs concerning the preconception period,¹⁰⁻¹¹ the postpartum period¹² and among different groups of pregnant women.¹³ There is also evaluation research on reproductive health care services, which discuss the linkage of women to prenatal care,¹⁴ their needs related to the reproductive event, considering the proposed prenatal care model,¹⁵ and such as expectations they have and satisfaction with care received.¹⁶

Although all of these studies offer important elements for the improvement of current prenatal care practices, it is still necessary to invest in research that seeks to denature the established and prioritized social ways of attending in the nursing profession, thus highlighting and debating what stands out and prioritizes such as reproductive health needs in prenatal care and how this happens.

In this direction, this study aims to distinguish the health needs prioritized by the nurse in the prenatal consultation, and to characterize the scope and specificity of the same. The subject is debated and contributes greatly to the critical role of nurses in prenatal care and the construction of integrality of reproductive health care.

METHODS

It is descriptive research with quantitative approach, which was carried out in four units of *Estratégia Saúde da Família* (Family Health Strategy), in *Cuiabá-MT*, one from the Eastern Administrative Region and three from the South Administrative Region, chosen from the following criteria: urban unit in operation for at least one year; having physician and nurse in activity during data collection; absence of students conducting the consultation at this stage; nursing consultation integrating prenatal care; and the minimum of 20 pregnant women registered. The U code, followed by Roman digits from I to IV, was used to specify the units. Four nurses and 40 women participated as subjects of the study (11 of the UI, 10 of the UII, 09 of the UIII and 10 of the UIV).

Data were collected and analyzed concomitantly from January 2012 to January 2013. In the period, the units I, II and IV had on average 30 registered pregnant women, each one; and UII had 46.

Firstly, a systematic observation of 50 prenatal nursing consultations (14 of the UI, 11 of the UII, 13 of the UIII and 12 of the IIVU) was performed, ranging from 15 minutes to one hour. Out of the total, there were 12 first consultations and 38 subsequent consultations, done with women with varied gestational ages. The letters G, C and A were used to indicate the number of gestations, childbirths and abortions of each participant, respectively. For all of them, the research was clarified previously and formal authorization has been requested. In the observation, a guiding instrument was used with the specification of the items of the consultation, considering all its methodological steps. In a field diary it was noted what attracted attention and the concomitant analyzes and inquiries. Also, the conversation between the professional and the pregnant/family woman during the attendance was digitally recorded. The collection was interrupted based on the application of the data saturation criteria.¹⁷

The content of all nurses' annotations, the ongoing prenatal care of women whose consultations were observed, was also collected in 40 sheets. The difference between this number of records and the number of queries observed (50) is explained by the observation of more than one attendance of the same participant. Overall, 79 nursing records, 35 first-time consultations and 44 subsequent consultations were analyzed with a portable scanner.

After collection and partial analysis of the material derived from the observations and registration documents of prenatal consultations, an interview was conducted on average 30 minutes, guided by a script previously tested with open questions, with each participant nurse. Through digital recording, the perceptions of each one about the health needs of pregnant women and their approach through the nursing consultation were seized.

The technique of content analysis of the thematic type, of the material of each health unit, was used, establishing the synthesizing ideas of each set. Then, a cross-sectional

reading of the findings of the four units was carried out, constructing two categories presented and discussed in the following items.

The research was approved by the Research Ethics Committee of the *Hospital Universitário Júlio Muller*, Legal Opinion No. 089/2011, complying with what the established Resolution in force at the time No. 196/2006.

RESULTS

Coming next, the specific prioritized needs are distinguished in the prenatal nursing consultation and the limits of its approach are revealed, by means of two broad categories: 1) privileging obstetric needs; and 2) the social needs superficiality, the family support and the psycho-emotional state.

Privileging obstetric needs

In the consultations, the needs approach of pregnant women was limited to the maternal organic dimension and fetal body development. The first set encompassed attention with needs such as physical discomforts, inadequate dietary practices and weight changes, increased pregnancy risk and

breastfeeding for breastfeeding. The second set included attention with the adequacy of the fetal physical development and the maintenance of its vitality.

The attention to these needs manifested itself in the survey of some indicators of the general physical conditions of the woman, the vital condition and the fetal evolution, the gestational evolution and the present health-disease conditions. Likewise, it was also revealed in the evaluation of the data/information collected, which led to conclusions about normalities, possible medical obstetric problems and maternal-fetal risk, based on professional domain parameters. Finally, the same occurred in the proposition and effectiveness of certain prenatal care and in the evaluation of its effects.

In the assistance methodology, the anamnesis and the physical examination unfold in certain diagnoses and/or in the indication of exams, as well as in some care carried out by the professional or another, or indicated to the woman or the family, according to a prenatal routine established, which also included records of these various items in the medical record.

In **Table 1**, there are privileged obstetric needs and the expression of related elements in the various methodological stages of the consultation.

Table 1 - Prioritized obstetric needs in the nursing prenatal consultation, expressed in the investigated aspects, diagnoses, care and registries

Obstetric Needs	Investigated aspect	Diagnostic	Care	Record
Gestational physical discomforts	Common discomforts in the first trimester of gestation.	Commonly interpreted as typical changes in gestation.	Conducts for the relief of typical discomforts.	Record of discomforts as the woman's main complaints.
Dietary and weight changes during pregnancy	Foods consumed, or not, and their frequency. Body mass index.	Pregnancy discomfort aggravated by feeding.	Proposition to change the eating habits of pregnant women.	Weight, height and Body Mass Index. Diagnosis as "adequate" or "inadequate" weight (eventually). Conduct assumed in the food drive.
	Weight gain or loss. Discomfort associated with feeding.	Weight gain or loss higher than expected.		
Normality of fetal conditions	Fetal movements.	(In)Compatibility between uterine height and gestational age.	Request for ultrasonography. Request for medical evaluation of test results (eventually). Guidance for changes in fetal movements.	Uterine height, fetal movements and fetal heart rate. Transcription of ultrasound data.
	Fetal statics. Verification of the uterine height. Checking of fetal heart rate.	(Ab)Normal heartbeat and fetal movements.		
Anatomical-functional conditions of breasts for breastfeeding	Size of the breasts. Characteristics of the nipples.	Suitability or not of the anatomical and physiological characteristics for future breastfeeding.	Guidance for prevention of nipple injuries, including mentions to the benefits of sunbathing, use of moisturizing and exercise, among others.	Size and symmetry of the breasts. Features of the nipples. Presence or not of colostrum. Guidelines (usually without specifying content).
	Presence or not of colostrum. Previous experience of breastfeeding and interurrences or not.			

(To be continued)

(Continuation)

Obstetric Needs	Investigated aspect	Diagnostic	Care	Record
Risks and/or control of interurrences with possible maternal-fetal organic repercussions	Risk factors. Demographic, social and behavioral data.	(Ab)Normal body apparatus conditioning, laboratory tests and ultrasound.	Vaccine update. Evaluation of exams. Indication of the cervical cancer screening. Prescription of folic acid and ferrous sulfate.	Preventive aspects routinely controlled. Medical problems.
	Maternal physical signs and symptoms, related to interurrences.	Vaccine status specification.	Guidance of signs and symptoms suggestive of interurrence. Referral for exams and new consultation to the physician and other services, if necessary.	Diagnosis of gestational evolution. Transcription of laboratory test data.
	Vaccine conditions.			

Source: Research empirical material, *Cuiabá - MT*, Brazil, 2013.

At the first visit, the professional usually explored risk factors (personal, family and obstetric health history, skin color/race, age, marital status, occupation and schooling, alcohol, tobacco and drug use, sports), discomfort (nausea, vomiting, headache, cramps, changes in appetite and sleep, urinary and vaginal disorders) and nutritional status of the woman (according to the Food and Nutrition Surveillance System form and the Body Mass Index - BMI). Likewise, he collected and/or evaluated some vital data - blood pressure, pulse and respiration, obstetric history data and Last Menstruation Date in order to calculate the Gestational Age (GA). Intercurrent control was also performed by requesting or evaluating routine exams.

In subsequent consultations, the nurse investigated and evaluated complaints, general physical conditions (e.g. blood pressure, urinary symptoms, vaginal losses and edema), test results (if any), preventive measures (medications and vaccination indicated) and, again, food aspects, if the pregnant woman had manifested a related difficulty if there were changes in her weight and BMI or she thought that the discomfort could be alleviated with the food change. As the gravid abdomen developed, she checked for vitality (Fetal Movement and Fetal Heart Rate), uterine accommodation and fetal growth, and gestational evolution (GA and fetal/uterine growth compatibility). Regardless of GA, she evaluated the breasts, and eventually questioned the woman's experience with breastfeeding and whether or not there was any interurrence.

The control by means of examinations followed the routine (blood typing, RH factor, simple urine, blood count, fasting glucose, serology for syphilis, cytomegalovirus, hepatitis B and C, toxoplasmosis, rubella and HIV), which is commonly requested in the first consultation, around the 20th week (ultrasonography) and also from the third gestational trimester.

The ducts adopted by the nurse in general included the indication of the tetanus and hepatitis B vaccine, which comprised the routine of immune control of the pregnant woman, preventive supplementation of folic acid and ferrous

sulfate (to prevent fetal malformations and gestational anemia, respectively). It has been made several succinct guidelines to the woman, in general, to relieve discomforts, to change eating habits considered incorrect, to adherence to preventive measures of prenatal routine, to prevention of nipple lesions and attention to signs and symptoms that could indicate interurrence. When an abnormality or greater risk was detected, she referred the pregnant woman to more complex services or to the unit's doctor, and provided specific guidelines related to the problem identified. He also referred the woman to schedule the cervical cancer screening test (performed on most pregnant women) and the next prenatal visit, reinforcing the need for return to service for these actions.

The risk classification was based mainly on demographic data (usually age) and on the presence of medical and obstetric complications considered of greater severity or risk to the mother and/or the baby. Problems such as hypertensive disease, diabetes, urinary tract infections and vagina, premature amniorrhexis, hemorrhages and premature labor, cardiorespiratory system problems, and other complications were brought under control.

The social needs superficiality, the family support and the psycho-emotional state

Although the emphasis of the nurse's prenatal consultation has been on the approach to organic needs, it has also touched on social, family and emotional needs, either on its own initiative or by women attending. In the consultation, these and/or members of their family usually expressed, spontaneously or from questions made by the nurse, physical needs. However, they have also opened space to manifest broader needs.

Regarding the social needs, nurses from UIII and UIV questioned some pregnant women about whether or not to access the *Programa Bolsa Família* (Family Funding Program) social benefit, directing them to seek it. This particularly occurred when the practitioner questioned women about who they lived with, their occupation, income,

schooling, and the situation of the partner, concluding that their family had an important financial need. Some women spontaneously reported family concerns and conflicts due to insufficient financial conditions for food and housing, and the negative repercussions of these on family well-being. Faced with financial problems, in addition to the aforementioned conduct, in particular the UIV nurse reported having mobilized women from the area, who had grown children, to obtain donations of support to pregnant women in the supply of clothing for the child to be born. Eventually, the register of referrals for a given social support service (UIII), as well as diagnoses specified as “social problem” and “serious social problem” (UIII and UIV) were found in the pregnant women recordings.

In relation to the needs of pregnant women related to family support, UII and UIII nurses investigated the family assistance they had in a situation in which the pregnant woman's partner worked outside his residence and before the anxiety of another pregnant woman to childbirth. However, in both situations they interrupted the approach. It was found the desire for participation of a pregnant woman's partner during the care (present in the unit), especially at the time of auscultation of the heart-fetal heart rate.

Some emotional needs were also tainted in the consultation, at the nurses' initiative. In UI, he asked the teenager's acceptance of the pregnancy, the father and family, as well as the support received from them. In the IVU, the collection of this data was routine in the first consultation of all the pregnant women and was sometimes resumed in subsequent consultations. At UIII, this data was eventually explored and in UII there was no related approach. In some UI and UIV medical records, pregnancy records were recorded by the pregnant woman, the child's father and the family. In the UI, this registry was specially made for adolescent pregnant women.

In addition to the difficulty of accepting pregnancy, women reported having fear of childbirth and pain during the event (particularly adolescents) and also concerns about self-image due to physical changes from pregnancy. However, the diagnoses and behaviors related to emotional needs were little valued in the consultation. Some behaviors of emotional support to the pregnant woman were performed at the IVU. One of them consisted in the referral of a pregnant woman, after reporting a feeling of sadness, discouragement and social isolation, for evaluation by the unit's doctor. In the same situation, the nurse also sought to accommodate the pregnant woman, and placed the unit as a space to which she could come back to assistance.

Pregnant women presented information or knowledge needs to understand the gestational process (such as the correspondence between weeks and months of gestation and the date of childbirth), their health condition (expected weight gain and normal blood pressure levels) and the newborn well-being, and also the risks of some care situations (vaccination and medication use during pregnancy).

Furthermore, they inquired as to how they could take part in some care (from exam preparation), care offered at the institution (the routine of consultations) and access to other rights (access to maternity leave, access to laboratory tests, gestational ultrasound and surgical resources of gestational planning). These needs expressed by the women contrasted with their devaluation in the consultations, in which the advices were punctual, very fast, without the necessary dialogue, or even absent.

DISCUSSION

As has been seen previously, the physical needs have priority in the prenatal consultation of nurses, and other orders of need are on the sidelines. In summary, the nurse basically controls physical changes of pregnancy (gestational development and related discomforts), the manifestation of possible intercurrent (medical and/or obstetric) problems and conditions of fetal growth and vitality. Moreover, it applies other recommended preventive measures.

In the consultations, this shows the privileged social purpose of prevention and control of discomforts and organic interurrences. The incorporation of this purpose is especially evident in the collection of previous reproductive risks; in the classification of risks, related to age or the manifestation of a pathology; in the investigation of signs and symptoms indicative of physical abnormalities in the course of gestation; in carrying out immunization actions, folic acid supplementation and ferrous sulfate; in the orientation to the pregnant woman of signs of physical abnormalities, among other actions.

The approach to these needs is known to be very important for the health of the pregnant woman and the baby, since they facilitate the fulfillment of the goals established by the Latin American Center for Perinatology, *Salud de la Mujer y Reproductiva* and the Plan of Action established for the acceleration of the reduction of maternal mortality and severe maternal morbidity 2012 - 2017.¹⁸

In Brazil, the Health Ministry establishes and highlights, for prenatal follow-up, the provision of a set of technologies aimed at controlling risks, supporting physical-gestational development and approaching obstetric-medical problems, although it also proposes actions to link the pregnant woman to health services, the provision of educational activities for women and their families, and humanization as a reference for prenatal care. The valued actions can be found in the Low Risk Prenatal Attention Notebook,¹⁹ which in the practice of nurses have been constituted as a care protocol, then reinforcing the privilege of obstetric needs.

The approach to these needs, although insufficient, is considered essential for the anticipation and control of morbidity and death, for both the woman and the fetus and newborn. However, from a broad concept of reproductive health, prenatal care should not be restricted to them. Social, family, intersubjective and behavioral aspects are

embedded in the health constitution of the pregnant woman and her child, including historical rights in reproductive and sexual health.

These rights include self-control of the body, freedom to decide on how to conceive and how to do it, the right to access information, good quality education and services, free and consensual participation in unproductive reproductive and sexual practices, Discrimination or other forms of violence and the right to equality between men and women.²⁰⁻²¹

Despite the existence of significant advances in reproductive health care in Brazil, evidenced by the increase in the number of prenatal consultations, by the improvement of the early collection of pregnant women, there are important determinants of the health of these to be faced, such as gender issues, ethnicity, social class, access and quality of sexual and reproductive health services, among others.²²

The interference of social and economic conditions in the health of women and their children is evidenced in studies that relate it to low schooling, lack of information about the reproductive process, cultural issues, race/ skin color (black and indigenous), issues of gender, marital status, poor access to health services, and poor quality.²³ Analogously, reproductive health is linked to precarious working conditions, low income and problematic sanitation and access to community services.²⁴ This means that the health care of the pregnant woman, even for the purpose of controlling the morbidity and mortality of the woman and child requires the approach of comprehensive needs.

In order to avoid maternal and perinatal morbidity and death, it is not enough to approach only the biological factors of gestation. After all, these are crossed by sociocultural, family, psycho-emotional aspects, access to health services and community, information, among others. The approach to social, institutional, intersubjective, educational and behavioral needs, related to the reproductive process, should also constitute prenatal protocols, and influence the extension of practices of professionals, doctors and nurses.

Some studies have shown the experience of pregnant women with needs of other orders, illustrative of their importance.

A study carried out in *Cuiabá - MT*, aiming to understand the experiences and perceptions of women with higher risk pregnancies, identified that, in addition to care guided by the perspective of risk and control of medical problems, they expressed several personal, intersubjective, family, Institutional and social factors influencing their health. Nevertheless, they only recognized the family and the community social network as support for them.⁶

Seeking to understand the experience and care needs of adolescents in abortion, another study, carried out in a philanthropic hospital in Minas Gerais, showed that the service in the health service was considered satisfactory, but it was emphasized the need to receive more Attention and information through health professionals.⁷

With focus on the post-natal period, research in *Cuiabá - MT* distinguished health needs of women and men in two health territories. For the participants,⁴ the most important were the child's well-being and safety needs and the need to reconcile their various tasks and the different daily rhythms to which they were subjected. Nonetheless, they expressed important affective-social, affective-marital, relieving needs, and wished to recover conditions to take care of themselves, needing the support of the health services to recognize themselves in the experience and to understand the socio-cultural and gender aspects Involved in their needs and in the embodied modes of taking care of themselves. In turn, the men⁵ expressed the need for financial security of the family, also highlighting the child's need for well-being and the affective return that the experience brings. But they did not recognize themselves with post-natal health needs, indicating the need for support from the health services so that they can also perceive their experience of parenthood, their relationship with socio-cultural aspects, and distinguish their own needs, value their own care and a equitable gender perspective in their participation in reproduction, with effects also on women's health.

Another study, carried out in *Brasília*, with emphasis on proposing a transition program for parenting, raised health needs and identified that actions for the program should focus on the caregiver-baby relationship, marital relationship and support network management, requiring a broad view of the needs.⁸

A study that analyzes the "informed choice" of a group of pregnant women at the time of childbirth, carried out in *Londrina - Paraná*, concluded the study highlighting the importance of the recovery of a care practice centered on women's needs, with an informed decision-making process, appreciation of their ability to decide, as well as respect for the right to their own bodies and autonomy.²⁵

Relatively simple and widely used, the concept of "unsatisfied" or "unmet" needs proves challenging, in the sense of estimating their prevalence in the population.⁹ This would allow a more objective analysis of the needs of women who have not been considered in prenatal care, such as the needs pointed out here, offering elements to reorient or interact with reproductive health policies and public actions, as well as the professionals practices directly involved in this care, such as the nursing professionals.

Contradicting the positive role of the normative organization of reproductive health care, one study concluded that it may not be adequate for all populations, and it is important to consider the singularities of each. The conclusion was obtained from the identification of the health needs of couples in gestational planning in the provinces of Hebei and Jiangsu in China, selected for their marked environmental, geographic and economic differences.¹⁰

In this direction, considering the singularities of each population group, international studies also highlight the needs of specific groups of pregnant women, such as

adolescent mothers. A study of their needs, carried out in an educational context in Costa Rica, identified each family as the main source of support for adolescents. In addition, the authors described expanded needs such as school uniform that fit the physical changes of pregnancy, infrastructure with comfortable chairs and specific space for breastfeeding in the school environment, and the adequacy of schedules in order to be with their children.¹³

Some studies have emphasized the importance of taking the perspective of women in apprehending their health needs. In this sense, a study carried out in Ohio (American State) drew attention to the fact that, every once in a while, the needs may not be similar to those perceived by professionals, thus requiring strategies to support pregnant women in decisions that may have impact on their choices in prenatal care.¹¹

Aiming to identify the factors associated with inadequate prenatal use, a study conducted in Sincelejo, Colombia, found a significant association between perceived benefits and adequate use of prenatal care, demonstrating that women's perception of the prenatal care is the main factor that can explain the adherence to the control and regular fulfillment of the consultations,¹⁴ which means that their needs and perspectives regarding them should be the focus of prenatal care.

A comparative study of expectations of antenatal care in pregnant women recruited in 2009 - 2010 showed a change over time, with lower expectations for health check-ups and emotional content, and higher expectations about information needs, respect and partners' involvement.¹⁶

Ultimately, comparing models of health services, a study aimed at investigating the vision and experience of women using public antenatal care, based on population in two Australian States, found that all models of public prenatal care involving a primary caregiver, such as midwives, came closer to meeting women's need for information, individualized care, and also support.¹⁵

Based on these national and international studies, it is identified that the needs addressed in the study presented, both those prioritized and those eventually raised by nurses, are limited in face of the diversity of needs that permeate the reproductive moment, especially during gestation. This is even more important considering their counterpoint to the needs expressed by pregnant women and their family members according to the consultations analyzed.

In this regard, for example, the nurse's attention to psycho-emotional needs practically turns to the acceptance or not of pregnancy by the woman and family, while the pregnant woman expresses ambivalences and fears, which may be related to the previous reproductive experiences, even seized. Equally, while the professional focuses on the search for obstetric referral service in the event of an intercurrent event, the pregnant woman has as main concern the assurance of childbirth care, the performance of the

indicated tests and access to the contraceptive resource that she wants and knows about difficulty to get it.

At the moment of care, women do not always translate their needs, but they suggest or share them as ideas, doubts, stories, fears, compromised self-esteem, sufferings, silences, among other forms. Through their insistence on placing them, they represent their own need for overcoming, autonomy and the exercise of their rights.

This is particularly noticeable in the search for knowledge by women about what happens in their body and with their child, which can confer some autonomy and tranquility in the course of pregnancy. The same is true in your search for information about access to services and your resources. This is a valuable potential to be worked on in the perspective of women's autonomy and the recognition and exercise of rights in reproductive health.

The fact that a care profession neglects something that should be inherent to this perspective is noteworthy in the analyzed practice, albeit for historical reasons, since the characteristics of the needs approach found are in line with the predominant biomedical perspective present in health care. It has been identified that the professional is unprepared for the broader approach of needs, in a context that does not support it through corresponding services and actions, neither through the incorporation of an interdisciplinary team, integrated and qualified for such actions.

However, that does not mean that the nursing professional is not able to give space and attention to what the woman presents in the care encounter, promoting to some extent the expansion of the needs collection beyond the biological perspective, and facilitating the development of participation and Autonomy of the woman in the direction of the exercise of rights.

With a focus on integral attention to reproductive health, the challenge is also a day-to-day practice of professionals, in order to use, develop or facilitate the production of personal, institutional and collective resources that contribute to the necessary advance. In other words, making available what exists, producing new technologies and mobilizing together with other professionals the necessary partnerships and accountability.²⁶ Unquestionably, the nurse should not neglect biological clinical aspects, but should consider in the assistance the woman's life context, its individuality and subjectivity.²⁷

CONCLUSIONS

In prenatal care, nurses, as assumed, have highlighted a set of organic needs. They eventually focused on some social, psycho-emotional state, and informational and knowledge, although they encountered what the pregnant women brought and which represented at least part of their totality of life.

Even though the study confirms findings from other research, its wealth lies in making visible what are the prioritized needs and the superficiality with which non-organic needs are addressed in the consultation. It has also raised new questions, in particular, the need to produce technologies appropriate to the broader approach to needs and to explore and understand the experiences and views of women around them. It is essential to give women the voice to speak, from their places, about their health needs.

The challenge is to increase the nurse's care in prenatal care. This challenge is to be confronted through action-reflection on actual practice, and in the sense of producing changes in nurses' training and performance, and also in the established public policies and practices, especially in basic care.

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