

NURSING CARE ACTIONS IN THE PARANAENSE MOTHER NETWORK PROGRAM

AÇÕES DE CUIDADO DO ENFERMEIRO NO PROGRAMA REDE MÃE PARANAENSE

ACCIONES DE CUIDADO DE ENFERMERÍA EN EL PROGRAMA REDE MÃE PARANAENSE (PROGRAMA RED MADRE DEL ESTADO DE PARANÁ)

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ABSTRACT

Objective: Understanding the nursing care actions from the Programa Rede Mãe Paranaense – PRMP (Paraná Mother Network Program).

Methods: Qualitative study found on the Social Phenomenology of Alfred Schütz. Eight (8) nurses from different cities of the Tenth Regional Health in Paraná state participated in this research. A semi-structured interview was carried out from August to December 2014. **Results:** Three categories were identified: Knowledge about the Paraná Mother Network Program; Nursing care actions in Paraná Mother Network Program and Expectations for the Program. The nurse knows the goals, commitments and Program indicators. The nurse also develops early identification actions, usual risk stratification, intermediate and high risk and referrals according to the risk. They provide qualified care to pregnant, parturient, puerperal and children. From care actions, they seek to qualify even more the nursing care actions to this people. **Conclusion:** The actions of the multidisciplinary team can contribute effectively to reducing maternal and infant morbimortality. It is necessary higher investment in health programs achieve excellence in care actions.

Keywords: Primary Health Care; Maternal and Child Health; Nursing Care; Qualitative Research.

RESUMO

Objetivo: compreender as ações de cuidado do enfermeiro a partir do Programa Rede Mãe Paranaense (PRMP). **Métodos:** estudo qualitativo alicerçado na fenomenologia social de Alfred Schütz. Participaram oito enfermeiros dos municípios da 10ª Regional de Saúde do Paraná. Realizou-se entrevista semiestruturada de agosto a dezembro de 2014. **Resultados:** identificaram-se três categorias: conhecimento sobre o PRMP; ações de cuidado do enfermeiro no PRMP; e expectativas quanto ao PRMP. O enfermeiro conhece os objetivos, os compromissos e os indicadores do PRMP. Desenvolve ações de captação precoce; estratificação de risco habitual, intermediário e alto risco e encaminhamentos conforme o risco. Proporciona cuidado qualificado à gestante, à parturiente, à puérpera e à criança. A partir das ações de cuidado, vislumbram qualificar ainda mais as ações de cuidado a essa população. **Conclusão:** as ações da equipe multidisciplinar poderão contribuir de forma eficaz na redução da morbimortalidade materna e infantil. Faz-se necessário mais investimento nos programas de saúde para o alcance da excelência nas ações de cuidado.

Palavras-chave: Atenção Primária à Saúde; Saúde Materno-Infantil; Cuidados de Enfermagem; Pesquisa Qualitativa.

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RESUMEN

Objetivo: Comprender las acciones de cuidado de enfermería en el Programa Rede Mãe Paranaense (PRMP). **Métodos:** Estudio cualitativo basado en la Fenomenología Social de Alfred Schütz. Participaron 8 (ocho) enfermeros de los municipios de la Décima Regional de Salud de Paraná. Se realizaron entrevistas semiestructuradas de agosto a diciembre de 2014. **Resultados:** Se identificaron tres categorías: Conocimiento sobre el PRMP; Acciones de cuidado de enfermería en el PRMP; Expectativas frente al PRMP. Los enfermeros conocen los objetivos, compromisos e indicadores del PRMP, que desarrolla acciones de captación precoz; estratificación de riesgo habitual, intermediario y alto riesgo y derivaciones según el riesgo. Proporciona cuidado cualificado a la embarazada, a la parturienta, a la puerpera y al niño. A partir de las acciones de cuidado, se espera cualificarlas aún más para esa población. **Conclusión:** las acciones del equipo multidisciplinario podrán contribuir de forma eficaz a la reducción de la morbimortalidad materna e infantil. Habría que invertir más recursos en los programas de salud para lograr la excelencia en las acciones de cuidado.

Palabras clave: Atención Primaria de Salud; Salud Materno-Infantil; Atención de Enfermería; Investigación Cualitativa.

INTRODUCTION

When discussing health policies, programs, and evaluation, it is necessary to highlight that at the global and Brazilian levels strategies are studied and elaborated capable of qualifying services through effective, efficient and equitable actions aimed at the promotion, prevention, assistance and rehabilitation. In this context, there are the Health Care Networks (RAS), with three elements: the population, the operational structure and the model of Primary Health Care or Primary Care bringing mainly the first contact, the longitudinal, completeness and coordination of services and care.^{1,2} Primary Care is the guiding principle of health care in the Unified Health System (SUS), being the main health policy for health, through the Family Health Strategy (ESF). It offers care for acute and chronic conditions, except those considered rare, and it coordinates or integrates the care provided to the patient.²

In the women's and children's health area at the national level, the Program for Integral Attention to Women's Health, the Prenatal Humanization Program and Nascimento, the Program of Integral Attention to the Health of the Child among the policies and programs of the Ministry of Health (MS) are highlighted, culminating with the current Network Program Stork (Rede Cegonha), based on the principles of the Unified Health System (SUS) regarding maternal and child care.³⁻⁶

Therefore, considering the policies and programs that aim to reduce maternal and infant morbidity and mortality rates in the state of Paraná, the Paraná Mother Network Program (PRMP) was launched in 2012, recommending that prenatal care and puericulture are attributions of the nurse and/or the physician. Thus, as part of the interdisciplinary health team, nurses need to provide quality prenatal care, early capture of the pregnant woman and the child less than one year old, in the active search, in the stratification of habitual, intermediate and high risk, in referral and counter-referral, as well as in monitoring the child's growth and development.⁷

All actions recommended by the PRMP to the woman and the child are developed by the multi-professional team,

especially the nurse, the doctor and the community health agent. Regarding nurses' care actions, they start from the pre-conception consultation, the SIS-prenatal registration, the encouragement of family involvement, the request for laboratory tests, guidance, dietary assessment and prescription, according to the need for the health of each one, and the correct filling of the pregnant woman's record. The first consultation should take place until the end of the third month of gestation. Six consultations are recommended in the prenatal and one in the puerperium, being one consultation in the first trimester, two in the second trimester, three in the third trimester of gestation and one in the puerperium.⁷

Regarding the risk situation of the pregnant woman, it is up to the nurse to stratify the risks in all prenatal consultations, since the PRMP in the state of Paraná established the usual intermediate risk and high risk. The early recruitment and search of pregnant women, as well as the referrals of the pregnant woman to the outpatient clinic and/or reference hospital according to the gestational risk, are also attributions of the nurse. For labor and delivery, it is up to the nurse to schedule a guided visit at the reference maternity center around the sixth gestational month and during admission to labor. She should be aware of the discharge and return to the health unit for the puerperal consultation, emphasizing the guidelines on puerperal and child care, encouraging breastfeeding, aspects related to postpartum depression and the closure of the SIS-prenatal. Special attention should be given in cases of abortion or fetal death.⁷

In this same thinking, a study showed that nursing followed the public policies and programs adopted in Brazil. Nursing care actions are present since the enrollment of women, in the nursing consultation, examination request, vaccination, home visit, health education, food and nutritional supplementation.⁸

Regarding child care actions, they should be started on prenatal care, with intrauterine growth monitoring from the evaluation of fetal vitality, during the nursing visit. At hospital discharge, the mother receives the child's booklet with all the necessary guidelines for follow-up. The neonatal heel prick,

the ear, and the eye test are performed. The home visit on the fifth day of the puerperium should be performed by the multi-professional team, especially by the nurse who will evaluate the mother and the child, at which time breastfeeding and immunization will be stimulated, as well as the Live Birth Certificate. During this visit, consultations and childcare should be scheduled to evaluate the child's growth and development. All children should be stratified according to the usual risk, intermediate and high-risk situations. The early recruitment and search for missing children is an indispensable action. Special care should be given to children at intermediate risk and high risk, referring them to the outpatient clinic or reference hospital according to the risk presented.⁷

The study revealed the nurse's actions in the integral care of the child, encouraging the involvement of the family in the process of mother-child-father-family attachment, the establishment of the therapeutic relationship, monitoring of child growth and development, immunization actions and nutrition. The humanization of perinatal care and the integration between the levels of maternal and child care are considered actions of the nurse. These aspects not only provide theories but practical actions to be carried out by the teams, especially those of nursing.⁹

This study is justified by the still incipient production of studies on the Paraná Mother Network Program, as well as on nursing care actions for the maternal and child population of this program, considering that the implementation of this program is still recent, beginning in 2012. It is important to develop research capable of analyzing and evaluating the effectiveness of Primary Care, specifically regarding PRMP. Then, the following question arises: how do Primary Care nurses perform their care actions in the PRMP? Thus, the objective of this study is to understand the actions of nurse care in the PRMP.

METHODOLOGY

This study has a qualitative approach based on Alfred Schütz's social phenomenology.^{10,11} The social phenomenology is pertinent in this present study, among the various modalities of qualitative research, since it allows the understanding of human phenomena in everyday life from concrete experiences. In the case of this research, there is the nurses' experience regarding care actions in the PRMP.¹⁰

Social phenomenology is concerned with the social world in which people have a face-to-face relationship, establishing social action among them. It also expresses the reciprocity of intentions, the stock of knowledge, the biographical situation and human motivation in the social world.¹⁰ The social world is the scenario in which human interactions happen from the stock of knowledge acquired by the individuals, transmitted to others, being contemporaries, that is those who preceded or

succeeded, for the meaning or interpretation of their experiences. This occurs from the social, cultural, ideological and intersubjective context called the biographical situation, allowing the individuals to reflect and understand the actions and the social relation with the world.¹⁰

People act, interact and develop their actions with reciprocal intentions driven by motivations. In this sense, the "reason why" is related to the past and present experiences from the stock of available knowledge. An objective category and accessible to the researcher. The "reason for" is the guidance for future action.¹⁰

Therefore, eight nurses who developed care actions for pregnant women and children in the PRMP in Primary Care in cities within the area covered by the 10th Regional Health (10th RS) of Paraná were included in this study. The criterion adopted for the inclusion of the participants in the research was the performance of the professionals in Basic Health Units (UBS) or Family Health Strategy (ESF) in the assistance, from the beginning of the implementation of the program and their consent. The people who did not fit the above criteria were excluded.

Initially, the directors of the 10th RS were contacted to obtain authorization for the research, as well as the health departments of each city, to enter the health services, such as the UBS and ESF. Subsequently, a telephone contact was made with the nurses, proposing a meeting to clarify the purpose of the research. Those who agreed to participate in the study signed the Informed Consent Term (TCLE). All subjects volunteered to be interviewed on the same occasion. The interviews were conducted in a private setting, in an individualized manner, in the rooms or clinics, so they could speak freely and without interference on the study questions.

The participants' reports were obtained through a semi-structured interview with the following guiding questions: what is your understanding about PRMP? Talk about the health actions you develop for the pregnant woman and the child in the PRMP. What are your expectations about PRMP? The number of participants was not defined a priori. In this study, it was sought for the knowledge, actions, and expectations that resembled the social group of nurses studied. The interviews were conducted from August to November 2014 and closed when the participants' information was repetitive, sufficient for analysis and discussion, according to the study objective. The organization of information in categories occurred as suggested by some researchers of social phenomenology: careful reading of each testimony to capture the global meaning of the experience of lived actions; grouping of significant aspects present in the lines to compose the categories; analysis of the categories, seeking to understand the "reasons why" and the "reasons for" the participants' action; and discussion of results based on the social phenomenology and other references related to the theme.^{10,11}

The research was authorized by the direction of the State Department of Health of Paraná (SESA/PR) and approved by Opinion N° 544.107 on February 27, 2014, of the Ethics Committee in Research with Human Beings of the State University of Western Paraná (CEP- UNIOESTE). The anonymity of the subjects was preserved, being identified as nurses 1 to 8, following the principles of ethics in research with human beings.¹²

RESULTS

The referential of social phenomenology enabled the understanding of the nurse's care actions in the PRMP, not in an individualized way, but in the scope of social relationships.^{10,11} Thus, three concrete categories of lived experience were identified from the individuals' speeches. Two were concerning the "reasons why": knowledge about the PRMP; Nursing care actions in the PRMP. One category refers to the "reasons for": PRMP expectations.

The PRMP *knowledge* category translates the knowledge of the nurse's care actions regarding the PRMP, the commitments, and objectives, as well as the training offered to work in the program. It also talks about the work process and autonomy.

We are starting with the protocol Paranaense Mother Network. Before, the care was very focused on the doctor. And now, the nurse has support and autonomy in the care of pregnant women. The PRMP came to organize the flow of care to the pregnant woman, in prenatal, childbirth and puerperium. The commitments of the program have to give more attention both in the prenatal, puerperium and to the child (Nurse 1).

Not everything is being fulfilled in prenatal and outpatient care. We are trying. The hospital linked to the Paranaense Mother Network has failed (Nurse 3).

The program is very beautiful on paper, but when you see in practice, it does not work. It is a deployment process, and there is no way to say that it is right on paper. The PRMP came to improve the quality of care of pregnant women and to reduce the risk of maternal and infant mortality in the state of Paraná (Nurse 5).

We do consultations, exams, referral to dentistry, referral to make preventive. Everything that follows the PRMP protocol we do. Before, it was not done. The goal is to reduce infant and maternal mortality (Nurse 8).

The training of nurses to work in the PRMP was also approached in this study as one of the ways to aggregate knowledge for the development of care actions.

All physicians and nurses were trained (Nurse 1).

We are doing a course, but not necessarily following the Paranaense Mother Network. A random course by the Department of Health (Nurse 7).

The category of action in the PRMP brings the experience of the nurse in the actions focused on prenatal, puerperal and child care. It refers to prenatal care as recommended by the PRMP on the access of the pregnant woman to the health service and its early capture, to the stratification of risk, to the health indicators. Also on Health Information Systems (SIS):

Yes [...] I perform the prenatal care, I request tests as recommended by the PRMP (Nurse 1).

We do the consultation according to the protocol of the Paranaense Mother Network. Until the seventh or eighth month, there is a monthly consultation. A month ago, with me, a month with the gynecologist, from the eighth month only with the gynecologist and he evaluates for the return, following the protocol (Nurse 4).

As far as I can go and I can, I do the prenatal (Nurse 5).

Today, with the arrival of the Cuban doctor, I do prenatal with her (Nurse 8).

As for the early recruitment of the pregnant woman and the child, the following responses were made:

It is necessary to do a prenatal quality follow-up, bringing the pregnant woman in the first trimester, performing all exams. If she has any problems during pregnancy, refer her to high risk (Nurse 2).

We guide the community health agents to give the information, guiding the family in the home visit. Prenatal care should occur early in the first trimester with a minimum of seven visits. (Nurse 3).

Risk stratification for pregnant women and children has always been a priority in prenatal care. In PRMP, nurses and physicians need to stratify habitual, intermediate and high risks, developing care actions in Primary Care or referring the pregnant woman and child to another professional or service such as Specialized or Hospital Care. When asked about risk stratification, the following responses were obtained.

Yes, the one who does this at first is the nurse according to the MH program. They have already given this worksheet, and we know that this risk pregnant woman cannot be seen at UBS, she is referred to the specialized unit that attends the high-risk pregnancy, which is in the central outpatient clinic (Nurse 1).

At the first consultation of the pregnant woman or the child, the risk classification is observed, when it is high risk, it is referred to the outpatient clinic of the University Hospital, and there is followed up. Continued follow-up is also given here in the city (Nurse 2).

In fact, as recommended by the PRMP protocol, every time you have a consultation, the risk should be stratified, either with the nurse or the doctor. We usually do it on the first visit. The stratification is not fixed, during which the woman can develop a pregnancy-specific hypertensive disease (DHEG), then the risk level of the pregnant woman and the child is evaluated in every consultation (Nurse 4).

Regarding the attachment of the pregnant woman and child to the specialized outpatient clinic and the high-risk hospital, the following responses were given.

If she is born with some problem, she is already followed up there from the hospital. So, she already comes with the ambulatory follow-up and the scheduled return. If they diagnose anything after the child leaves the hospital, she is referred to specialists in the city. It has few specialists, Neuropediatric and Cardio-pediatric. Then, in these cases, a referral is made to Curitiba (Nurse 1).

At the first consultation, risk stratification is performed. When the patient is at high risk, the pregnant woman is referred to the outpatient clinic of the University Hospital, but there is also continuity in the follow-up here in the city (Nurse 2).

Here in the city, there is no hospital, and we depend on reference hospital, which is the University Hospital. If the pregnant woman arrives here complaining of abdominal pain, the driver takes her straight to the hospital (Nurse 5).

We do the risk stratification. But this is not very common here. It is one of the requirements of the PRMP (Nurse 6).

Then, it is automatic for us, the usual risk goes to the hospital here in the region and the intermediary, and the high risk goes to the University Hospital (Nurse 8).

About the return of the puerperium, the recruitment of the mother and the child, the nurse replied:

Then, through the home visit of ACS. If she knows that the child was born in the area, then the nurse is notified, and a home visit is carried out (Nurse 2).

Regarding the child, I try to visit the pregnant woman and the child according to the protocol until the seventh day at home. I often end up doing this visit inside the hospital. As we have a municipal hospital, they give the number of born daily, so, as we have the municipality divided into two areas when someone from my area is born, they communicate me (Nurse 4).

Because our unit is linked to the hospital, we know when this mother will have the baby. I have a list of likely deliveries dates. So, when it is close to the probable date of delivery, I keep an eye on the first visit by the ACS (Nurse 6).

The Health Information Systems (SIS) as a tool to support health planning were also considered in this study. Thus, when the nurse was asked about the knowledge and performance in the SIS, the answers were as follows:

It is a monthly report [...] with a nurse responsible; she reports all the pregnant women followed up, tests done ... she puts everything in that report sent to the system in the information sector. A trained person launches the system and the system should work when we need a report (Nurse 2).

Yes, I work with SIS-prenatal care. I fill in the record, I send it to the woman's clinic, and it is typed, the Basic Care Information System (SIAB). Now it is going to change with E-SUS, but it is still not implemented here. All ESFs use it, feeding it through daily consultations (Nurse 3).

I feed daily the SIS-prenatal. After attending the gynecologist, I already collect the records of care of the pregnant woman and feed the system (Nurse 4).

I only write when I have a break. Registrations and the consultations they have in the month. I try to put everything, I look at the medical records, and I write down, because the doctors write everything down, if they asked for an examination, if they asked for an ultrasound, if they were referred (Nurse 8).

The expectation category in the PRMP refers to the "reasons for" and reveals what the nurse expects to the health ser-

vices, health professionals and the population of pregnant women, puerperal women, newborns (NB) and children attended.

In the health services, the nurse expected.

I hope the health service is always available to the pregnant woman. The nurse, the doctor and the team can receive the pregnant women in the interurrences, as well as in the usual health status, being well treated, well received, well informed about all changes during pregnancy, birth, NB care (Nurse 2).

That the service improves more and reduces the infant mortality and the mortality of the mother (Nurse 8).

Nurses' expectations regarding health professionals reveal that team conflicts can interfere with professional performance.

I hope mainly from the older professionals that they respect the autonomy of other professionals to work together in the care of the pregnant woman and the child (Nurse 1).

That they make the adherence, that they study, that they are perfected every day more to attend the pregnant woman. To know how to tell her when there is a change. Have a broad view of the health of a pregnant woman and the newborn (Nurse 2).

I hope they have training so they can act better, in a more humanized way. I still think there was a lack of training. There are people who do not even have contact with Paranaense Mother Network; they do not even know what it is. That they have more commitment, that all should look the same, because the program came to improve the quality of the pregnant and the child, but not all have that point of view (Nurse 8).

When asked what he expects from SIS, the nurse replied:

That the information system reports the information, we need. That the data entered is reliable (Nurse 2).

Make it easier, faster, and more affordable. Because it works over the internet, sometimes the system stops and more time is lost to open and type than to talk to the patient (Nurse 3).

I hope it gets better. The SIS-Prenatal, a program they have placed and are using, is a time-consuming program. Maybe it is due to the internet network. I wish the doctors

would have access to this program for them to be feeding. If you had the time, staff and material to feed, it is a good system (Nurse 7).

DISCUSSION

The nurses in this study know about the commitments, indicators, and objectives of the PRMP, demonstrating their knowledge. For them, this program emerged as a government strategy to provide quality public health, with humanized care for pregnant women and children.⁷ The acquired knowledge comes from their training and performance in health services. Throughout life, this knowledge is restructured from concrete experiences, and it is the basis for subsequent actions.¹⁰

The PRMP describes the early recruitment of the pregnant woman and the child under one year as an objective and commitment, the active search, referral and counter-referral in cases of intermediate risk and high risk and the attachment of the pregnant woman to the outpatient clinic or referral hospital.⁷ Also, it advocates a quality prenatal and follow-up of the child's development and focused on the reduction of maternal and infant morbidity and mortality, following the conceptual framework of RAS.¹ It is emphasized that a large part of maternal and child mortality indicators is intimately related to the quality of prenatal care, especially regarding the number of consultations, clinical and laboratory examinations.¹³ In general, nurses were able to describe the main indicators, as recommended by the PRMP.

The PRMP also shows that the pregnant woman should perform at least seven consultations and each of them should be stratified by the risk - habitual, intermediate and high. When some risk is identified during pregnancy, it should be referred to the specialized service according to the risk presented.⁷ After the implantation of PRMP, the nurse reported having more autonomy in the care of women throughout the puerperal pregnancy cycle and the care of the newborn and the child. The autonomy referred by nurses involves the actions of prevention, care, and health promotion. As described in the Professional Nursing Practice Law, nurses have the independence to perform all nursing activities, and it is the sole responsibility of the pregnant, parturient, and puerperal assistance.¹⁴ Autonomy presupposes guided attention, with care actions that contemplate completeness, quality, and organization of care.¹⁵

It is necessary for the professionals to receive training to ensure that the care offered by the PRMP takes place effectively.⁷ In this study, the nurse reports that there was face-to-face training promoted by the State Health Department (SESAU) and the 10th RS. Some stated that to understand the operation of the program better, they sought information directly from the PRMP guideline. The study presented similar characteristics in

the nurses' speeches, emphasizing that it is necessary to initiate the professional himself to require help from other professionals, to have curiosity, dedication and to seek training to confront the new to overcome difficulties in the face of the new.¹⁶

The search for knowledge/improvement of health professionals should be guided by the uniqueness and subjectivity of the individuals involved and as they become the daily services, allowing the pedagogical methods to become present in the knowledge and actions.¹⁷

When questioned about the uptake of the pregnant woman, the nurse revealed that the early recruitment occurs with the help of the ACS in their routine home visits, commonly called active search. It was also said that the woman comes to the unit and requests the pregnancy test. PRMP brings the best of getting the pregnant woman before the 12th week of gestation and can be performed by any primary care professional, and the ACSs are extremely important for this task since they have more contact with the patients of the health service.⁷

The early collection of pregnant women is identified as a relevant factor in maternal morbidity, since it assists in the early identification of gestational risks, as well as enables the necessary interventions. Its practice until the end of the third trimester is intended to reduce risks to mother and child.¹⁸ In the Nascer Brasil database, which evaluates prenatal care in the five regions of the country, it was identified that 76% of pregnant women registered during 2012 and 2013 began prenatal care until the 16th gestational week. However, only 60% of these pregnant women fall into the current recommendation of the Stork Network, that the pregnancy is captured until the 12th gestational week.¹⁹

In this study, it was possible to perceive the constant concern of the nurse with the quality of the health care of the pregnant woman, with the intention that the gestation, the delivery, the birth, the puerperium and the care with the newborn take place in the best possible way by the professionals and with the family approach. Not different from other studies^{8,9}. Therefore, at any moment of life, care in particular care for the pregnant woman, precedes any social or professional action to take care of it, this care is perceived as something inherited naturally, that is, a natural attitude, as the case of gestation. This natural attitude is something cultural and intersubjective.¹⁰ What is often perceived if this natural process is taken by some professionals as a biomedical, technological and pharmaceutical event.

The PRMP also recommends that the follow-up of the child be initiated during pregnancy. On the day of discharge, the hospital/maternity where the child was delivered, they give child's health booklet with the data recorded for the mother and must communicate to the UBS reference on the health conditions of the mother-newborn. The UBS health team must schedule the home visit until the fifth day after delivery to assess the mother-newborn. By that date, UBS should already

have received the Live Births Certificate (DNV) and Child Risk Stratification for the early identification of risk factors.

Promoting and restoring child health and well-being has long been a priority for the health care of the population. Thus, it is necessary to ensure that the child grows and develops in a healthy way, in physical, emotional and social ways. Thus, child-care should be understood as a tool for health surveillance, in which the nurse, together with the interdisciplinary team, should be attentive to biopsychosocial signs and symptoms, consciously and responsibly assessing the child to ensure their right to health, encompassing the access, quality and resolution of actions and services.^{9,20,21} This joint action of care goes beyond care during a consultation, and it is necessary for the professional to know their situation allowing him to reflect and understand his actions and his relationship with the world, so later, in a face-to-face relationship, the professional and the subject of care are conscious of each other and turned towards each other at the same time and space.^{10,11}

When questioned about the risk stratification, some nurses said they performed it, but it is notorious that some professionals use the stratification recommended by MH, where it is classified as high and low risk only.⁶ Other professionals use the classification recommended by PRMP. That is habitual risk, intermediate risk, and high risk. Intermediate risk was established considering a group of women presenting complications to their health and their child due to individual characteristics (race, ethnicity, and age), socio-demographic (education) and previous reproductive history.⁷ Also, women in the extremes of age (less than 20 and over 40 years old) present a risk of mortality 1.97 higher than in the other age groups. Similar data is found between indigenous and black women, who show a mortality rate twice as high as white women. The risk values are similar to mothers with at least three live children in a previous gestation (2.3 times higher) and mothers who had at least one dead child in a previous gestation (2.2 times greater).⁷

Regarding the bond, according to the risk presented as a way to typify the groups represented by pregnant women and children, the typification of the subjects happens according to each need. This fact is constituted by the experience of care and experiences among patients and health professionals¹⁰ - in this case, nurses, pregnant women, and children. Typification is characterized by the comprehension of the individual, his social interactions, the interference of the society involving the understanding of the cultural and psychosocial experiences and knowledge of the patients.

The PRMP defines the attachment of the pregnant woman to the child in the three points of care when necessary, and Primary Care is responsible for capturing the pregnant woman, stratifying the risk and linking the other levels of care (both specialized and hospital), both in cases of gestational risk (in-

termediate and high risk) and for the time of delivery.²³ Also, specialized care is of outpatient aspect, in which specific health conditions are sought, articulating with Primary Care, both for the child and for the pregnant woman. It consists of an integral and multi-professional action. The tertiary level aims to guarantee care to high-risk pregnant women and corresponds to the hospitals in the macro regions, containing the Intensive Care Unit (ICU), Neonatal and adult.²³ Thus, it will be possible to ensure pregnant women and children full care and access to services in the three levels of health care.

The SIS were also approached by the nurse of this study as essential for health planning. The need for training and qualification to work with the SIS was also verified. The SIS allows the management of health care through the monitoring of care for women and children, which will allow guidance to the decision process and implementation of new health care measures.⁷ After the implementation of the SUS, the SIS have become tools necessary for the health team to monitor all data production, providing periodic assessments and monitoring health conditions of patients.²⁴

Regarding the nurses' expectations, with the implementation of the PRMP, they expect the best care for the child and the pregnant woman, through the recognition of their work in an efficient and humanized way. This study showed similar results, in which the nurses expressed expectations about the definition of specific roles, increasing the hope regarding the definition of their professional function, as they wanted autonomy, professional identity and decision making on specific issues within their area. These aspects constitute the classification of this group of their projects of maternal and child care.²⁵

Regarding what health professionals expect after the implementation of the program, nurses expect professionals to seek new knowledge, new skills so they can correctly follow the PRMP guidelines. The care provided by the interdisciplinary team needs to contemplate communication and interpersonal relationship, meeting the needs of those involved in this scenario, pregnant women, and children, through dialogue, face-to-face relationship and exchange of information between professional and patient.^{10,11}

Regarding the SIS, the participants of this study emphasized having knowledge of some programs, but they need further study, and to an effective system that does not present access failures. For this, it is necessarily technical and structural support, qualification of the professionals to use this tool and the very disclosure of it. In the opinion of nurses, the information system can contribute to the care, but it needs changes. It is clear in this study the importance and necessity of a continuous and permanent education program with the professionals involved in the direct assistance, as well as in the feeding of SISs – indispensable for constructing and structuring public health policies.²⁴

The actions of nurse care to the maternal and child population of the PRMP were evidenced in this study, identifying advances in the nurse's work. They revealed expectations, challenges, and possibilities for improvement about the reduction of maternal and infant morbidity and mortality recommended by all maternal and child health programs at the global, national level, especially in the PRMP in the state of Paraná.

CONCLUSION

The set of concrete categories of life that emerged from nurses' statements allowed to highlight common aspects in their actions regarding the knowledge of this social group. They described the PRMP's objectives, indicators, and commitments, helped implement the program and participated in the training to act on it, understanding and carrying out the habitual, intermediate and high-risk stratification of the pregnant woman and the child. They refer to a social/professional group that recognizes the importance of early recruitment of the pregnant woman and the child, mainly to improve maternal and infant morbidity and mortality rates. They expect pregnant women and children attending the PRMP to receive quality health care, as well as expect professionals to be more committed and able to dialogue with each other. They underscored the importance of SIS to subsidize care planning, but they indicated the need for investments in professional training to strengthen their performance.

This study has the limitation of the recent implementation of the PRMP, beginning in 2012, which only allows evaluation and analysis of the process of its development in the Primary Care. It has the nurse's point of view who works in the PRMP in a regional health center of Paraná since other looks can be investigated by the nurse and multi-professional team. Thus, the development of this study did not limit the possibility of reflection on the topic, but it was opened with new debates to understand nurses' care actions regarding strategies and protocols for maternal and child health care, such as PRMP.

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