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Experiences of primary health care nurses in the prenatal care of adolescents

Experiências de enfermeiras da atenção primária à saúde no atendimento pré-natal de adolescentes

Experiencias de enfermeras de la atención primaria a la salud en el atendimiento pre-natal de adolescentes

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This study aims to know the experiences of primary health care nurses (PHC) in the prenatal care of adolescents. This was a qualitative research using semi-structured interviews with 19 nurses working in PHC in the prenatal care of adolescents, analyzed according to the Analysis of Thematic Content of Bardin. Three subcategories belonging to the category "Prenatal care" were identified: Prenatal care for adolescents; Biological risk versus social risk approach; and, Priority aspects of prenatal care. The adolescent does not receive specific and directed prenatal care. There is a need for more consultation time, including differentiated reception, encouragement of the creation of the link and improvement of the quality of information to adolescents, as well as measures to prevent prenatal abandonment. The difficulties cited were prenatal adherence, lack of professional-adolescent dialogue, and the situations experienced by these adolescents, besides to social difficulties.
Descriptors: Prenatal care; Pregnancy in adolescence; Primary health care; Nursing care.

Este estudo tem como objetivo conhecer as experiências de enfermeiras da Atenção Primária de Saúde (APS) na assistência pré-natal de adolescentes. Tratou-se de uma pesquisa qualitativa usando entrevistas semiestruturadas com 19 enfermeiras atuantes na APS no atendimento pré-natal de adolescentes, analisadas segundo a Análise de Conteúdo Temática de Bardin. Foram identificadas três subcategorias pertencentes à categoria "Atendimento de pré-natal": Atenção pré-natal às adolescentes; Enfoque de risco biológico versus risco social; e, Aspectos prioritários para assistência pré-natal. A adolescente não recebe atenção pré-natal específica e direcionada. Há necessidade de mais tempo de consulta, incluindo: acolhimento diferenciado, estimulo a criação do vínculo e de melhoria da qualidade das informações às adolescentes, bem como, medidas para evitar o abandono do pré-natal. As dificuldades citadas foram a adesão ao pré-natal, a falta de diálogo profissional–adolescente, e as situações vividas por essas adolescentes, além das dificuldades sociais.
Descritores: Cuidado Pré-Natal; Gravidez na adolescência; Atenção primária à saúde; Cuidados de enfermagem.

Este estudio tiene como objetivo conocer las experiencias de enfermeras de la Atención Primaria de Salud (APS) en la asistencia pre-natal de adolescentes. Se trató de una investigación cualitativa usando entrevistas semi-estructuradas con 19 enfermeras actuantes en la APS en el atendimiento pre-natal de adolescentes, analizadas según el Análisis de Contenido Temático de Bardin. Fueron identificadas tres subcategorías pertenecientes a la categoría "Atendimiento de pre-natal"; Atención pre-natal a las adolescentes; Enfoque de riesgo biológico versus riesgo social; y, Aspectos prioritarios para asistencia pre-natal. La adolescente no recibe atención pre-natal específica y direccionada. Hay necesidad de más tiempo de consulta, incluyendo: acogida diferenciada, estimula la creación de vínculo y de mejoría de la calidad de las informaciones a las adolescentes, así como, medidas para evitar el abandono del pre-natal. Las dificultades citadas fueron la adhesión al pre-natal, la falta de diálogo profesional-adolescente, y las situaciones vividas por esas adolescentes, además de las dificultades sociales.
Descriptores: Atención prenatal; Embarazo en adolescencia; Atención primaria de salud; Atención de Enfermería.

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INTRODUCTION

Some definitions of adolescence are associated with age parameters[1] according to the development phase corresponding to the age group of 10 to 19 years old.

Preliminary data for 2015, from the Department of Informatics of the Unified Health System (DATASUS) through the Information System for Live Births, reveal that births with a maternal age between 10 and 19 years represented 18.1% of the total live births in Brazil, with a higher incidence in the Northeast and Southeast regions[2].

Pregnancy in adolescence is a phenomenon with social, cultural, legal, psycho-emotional and corporal repercussions, and a careful view of the maternal-fetal health care perspective is needed[3,4].

Pregnancy in adolescence is not necessarily a problem. However, the pregnant woman, especially in adolescence, demands attention with an interdisciplinary approach and intersectoral support so the pregnancy experience has possible minimized unfavorable effects[3,4].

From this perspective, to promote safe maternity for adolescents, health care programs specially designed for this public are prioritized as basic health care, since although their clinical needs are the same as those of other women, they need more support to develop skills for health care during the puerperal pregnancy cycle[5].

The importance of prenatal care is evidenced, which includes a set of activities aimed at promoting the health of pregnant women and the concept, with the identification of risks for both, aiming at timely and adequate assistance, early pregnancy, ensuring maternal and fetal well-being[6].

The health professional is a key element in the structuring and/or strengthening of social support and support networks. These professionals should be able to assist the adolescent who experiences pregnancy in all dimensions of care, with an action that emphasizes an integrated approach to health, health promotion, and articulation of the social sectors for adolescent care[3].

The direct and systematic performance of adolescents, from conception to care with their child means that the insertion of the nurse in the health of adolescents is a way of providing the knowledge to be built and/or reformulated about the experience in this phase[7].

In view of the above, the research question of this study was: How does the health professional called as the nurse act in the primary care of the pregnant adolescent?

This study is justified by understanding that teenage pregnancy consists of a process of vulnerability in knowing the experience of the nurse working in primary health care (PHC) can contribute to the better reception. Therefore, this research had as objective to know the experiences of primary health care nurses in the prenatal care of adolescents, in the region of São Miguel Paulista, the eastern zone of São Paulo (SP).

METHODS

A qualitative approach was used to investigate the performance of the nurses in the prenatal care of adolescents since it is believed that they can help to understand the professional experience with adolescent pregnant women.

The study was carried out in 14 Basic Health Units located in the region under the responsibility of the Regional Health Coordination East composed of the sub-municipalities of Tiradentes City, Ermelino Matarazzo, Guaianases, Itaim Paulista, Itaquera, São Mateus and São Miguel Paulista[8].

The Traditional Basic Health Units (UBST), Mixed Units (UM) and Basic Units Family Health Strategy (UBESF) operate in the Basic Health Units (UBSs) that made up the study scenario, and in all them, regardless of the modality of health care, prenatal care is guided by the protocol "Protection Network for the Paulistana Mother/*Rede Cegonha*" [9,10].

The Protection Network for the Paulistana Mother was established in the city of São Paulo in 2006, and it was linked to the guidelines and updates of the Rede Cegonha, a nationally comprehensible program, five years later.

Data collection was completed with a sociodemographic and educational profile questionnaire to characterize the research subjects and semi-structured interviews were conducted with nineteen nurses who provided prenatal care in these services in the second half of 2012.

The individual selection criteria were to perform prenatal care, as part of the PHC services team, and to express voluntary acceptance to participate in the study.

As a qualitative data analysis technique, it opted for Bardin's Thematic Content Analysis[11]. For the storage and management of demographic and educational profile data, a spreadsheet was developed using the Microsoft Excel® program, the database was transported to the Statistical Package for Social Science program (SPSS), version 17.0, to carry out the descriptive analysis using absolute and percentage frequencies.

The research was based on guidelines and norms nº466/12 of the National Health Council, approved by the Research Ethics Committee of the Municipal Health Department of São Paulo, under the opinion nº 104/11. All the participants accepted voluntarily to join the research and signed the Free and Informed Consent Form.

RESULTS

There were 19 professionals interviewed, predominantly female (89.5%). These professionals were between 29 and 57 years old, 63.2% of them were older than 35 years old. Regarding marital status, 57.9% were married and 73.7% had 1 or more children.

The university education was mainly in private institutions of the metropolitan region of São Paulo (94.3%). Regarding the training time, 21.1% were up to 5 years; 52.6% between 6 and 15 years and 26.3% had 16 years or more of graduation.

Regarding the lato sensu post-graduation, only 15.8% had not attended it. The courses were from areas related to basic care (71.4%) such as obstetrics, public health, family health, collective health, and acupuncture; 23.8% of the courses were related to the hospital area: hospital administration, cardiology, emergency, medical-surgical and intensive care unit, and 4.7% focused on teaching. When it comes to post-graduate stricto sensu, only one professional received a master's degree in Emergency Care.

According to the years of work in prenatal care, there were 31.6% up to 6 years; 47.4% from 6 to 10 years and 21% were 11 to 18 years.

In the interviews with the nurses, the following category emerged: ***Prenatal care of adolescents*** with three subcategories (Figure 1).

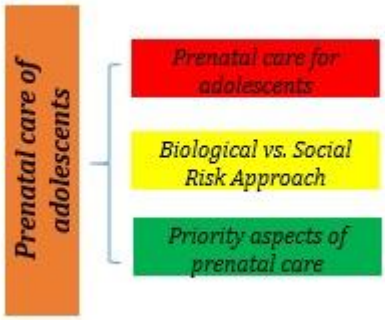

Figure 1. Category and subcategories. Regional Health Coordination East City of São Paulo, 2013.

Prenatal care of adolescents

Women with suspected pregnancy who arrive at the service are welcomed by a nursing professional who will send them and guide them as the result of the examination. Once the pregnancy is confirmed, the consultation calendar of the Network of Protection for Mother Paulistana/Rede Cegonha begins with the nurse, as it is evidenced in the speech:

At the first consultation: she does the pregnant test [...]. I already open SisPrenatal, I ask for the routine exams, I make the necessary guidelines, I prescribe the folic acid and I ask her to make the next appointment. I make the request for the SPtrans card, we have the pregnant woman's agenda that comes with all the guidelines [...]. This is a very rich consultation because practically the time we have is 20 minutes to meet each pregnant woman, but we ended up taking a lot more, 40, 50 minutes. It is because SisPrenatal is a form with a lot of data, it is not simply filling in the data of the pregnant woman, checking weight, height, pressure, the guidance (Nurse 12).

Intervened care between doctor and nurse, recommended by the protocol of the Protection Network to the Paulistana Mother/Rede Cegonha happens only in the UBESF. In the traditional UBS, the nurses attend the pregnant women only in the first and last prenatal visit, or even, in some fitting or unforeseen:

Our unit is traditional, so the pregnant woman is welcomed, we do it. The appointment stays with the obstetrician monthly. Then, normally the pregnant woman goes through the first and last prenatal visit with the nurse. Although at any time, she has any doubts the nurse is here able to elucidate these doubts or even to direct so they give a solution to the reported problem (Nurse 1).

The nurses were asked how the adolescent care service was organized:

We focus a lot on the pregnant woman, but there is nothing specific for the adolescents (Nurse 11).

It has been found that there is no difference. All pregnant adolescents are treated in the same way as those in other age groups, even when the participants of the study affirmed that adolescent care was "differential", they were referring only to more attentive listening:

For prenatal care of adolescents, the differential is a greater care, more guidance, mainly because most of them come without a companion, without the mother, a responsible adult, so we have to give, we have to guide (Nurse 4).

Qualified listening for "differential" care was mainly concerned with social and vulnerability determinants, evidenced by the statements:

(...) the first thing we do in the welcoming is to study the situation of the adolescent if she is at risk, if they are daughters of separated parents, if they are drug users, then you have to do a whole anamnesis, a history of her (Nurse 14).

We do the test, if the test is positive, we guide them to participate in the groups of adolescents, which are educational groups in the position where they will be aware of the problems involved in a teenage pregnancy (Nurse 1).

Biological vs. Social Risk Approach

Adolescents younger than 16 years old are sent to prenatal care at high risk, when necessary, but they must also continue concomitant care at the healthcare unit. However, they are not taken care by the nurses, only by the doctors:

(...) an adolescent of fewer than 16 years old, we also do not monitor, she is accompanied in the prenatal risk with the doctor of the unit. The nurse only participates in guidelines, but he does not attend in prenatal consultation, because it is considered a prenatal risk in adolescents under 16 years old (Nurse 9).

During the interviews, few nurses specifically commented on the criteria that classified the adolescent as a pregnant woman at risk and therefore sent to specialized prenatal care. However, there was a nurse who considered a gestational risk in her speech:

By precocity, she did not reach the fullness of maturity and suddenly her body will have to function as if it had already reached it, this imposes some changes. Risk of developing a specific gestation hypertension, gestational diabetes, in fact, several factors that can trigger, we try to be alert (Nurse 1).

The social risk was also part of the nurses´ speeches

a child is not generated, a social problem is generated (Nurse 5).

Here, it is a social risk area too, there is a large number of school dropouts, a high number of drug users, and there is a lot of drug dealer too, what happens? Sometimes, they see these people as a chance to escape, because sometimes she is indoors, they live in a room or two, with their father, mother and ten brothers, everyone is starving. Then a guy appears, supposedly a thug who's going to have money, he will get her out of that situation, how can she do that? Getting pregnant. So, we see that it is an illusion that they have a better life expectancy, they do not stop to think that it will be another person to support, that it will stay one more inside the mother´s house (Nurse 13).

Priority aspects for prenatal care

Quando questionadas sobre o que consideravam como prioritário para a assistência pré-natal das adolescentes, as enfermeiras elencaram diversos elementos, como: repetir várias vezes as orientações para gravarem; manter diálogo aberto e sem julgamentos para apoiar, acolher e criar vínculo; ouvir com empatia tudo que têm a contar mesmo que não se relacione à gestação.

When questioned about what they considered as a priority for adolescent prenatal care, the nurses listed several elements, such as: repeating the guidelines several times to record; maintain an open and non-judgmental dialogue to support, welcome and create a link; listen with empathy all they have to tell even if it does not relate to gestation.

The professionals recognize the importance of support for the adolescent throughout the pregnancy-puerperal cycle. This can be exemplified by the following statement:

I consider support, it is psychological support, because I think that in adolescence a big problem is the psychological issue, they do not have much notion of what gestation is, while they are pregnant, they are still thinking that it is a joke; I think it is very important to have this accompaniment and attention, especially in the puerperium, because afterwards in the puerperium there is a great risk that this teenager will reject this child (Nurse 13).

Another priority is differentiated care, focused on adolescents and aimed at establishing bonding and adherence to prenatal care. The demand is different and nurses need to adapt to this:

We should keep a different look for the teenager, or have a free demand, that she could have this condition to come at the time she could, even in the matter of the group, could have a differentiated group, because thus, all are pregnant, we do not separate, so I think we could think of differentiated care (Nurse 5).

Welcome is the first thing you can not miss. You need to know the family of this teenager, in what context it is inserted because from the time you know the reality of it is easier to follow and even if there is a need, we will approach the family, especially the mother (Nurse 18).

The model of health care with a reductionist, curativist and biological-centered view permeated some discourses:

(...) and then we close the siege with gynecological issues, secretions, the search for streptococci B. Priority is to see the situation of the fetus, if the heart is beating, if not, ultrasound, if formed, if not, and then we get to see her dental part and so on (Nurse 05).

In general, the nurses were unable to trace a single priority and claimed that all care is important for the care of the pregnant adolescent:

I think everything. Because I do not think I have one thing more priority than another; talk about breastfeeding, talk about a method (...) does not have a priority thing. And specific for the adolescent is the psychological work after birth, because the pregnancy thinks it is less, the worse is after it is born (Nurse 8).

DISCUSSION

When performing prenatal care, the nurse and other professionals can carry out educational activities, early pregnancy screening, stimulation of normal birth, examination request, nutritional status assessment, prevention and treatment, risk classification, anamnesis, examination physical, among others[12].

What can be verified with the interview regarding the first consultation of the pregnant adolescent is the bombardment of information and questioning, possible fear that can be a great and perhaps frightening investigation, with requests for examinations, vitamin prescriptions, transport request, besides the pregnancy confirmation where the adolescent will experience an internalization process.

According to the Ministry of Health (MS), the prenatal consultation constitutes a set of clinical and educational procedures with the purpose of promoting health and early identification of problems that may result in a risk to the health of the pregnant woman and the concept[12,13].

This consultation can be performed by the obstetrician and/or obstetrical nurse and/or obstetrician doctor, and also by the nurse or family doctor. It is composed of simple actions, where the professional provides assistance of promotion and prevention to the health of the woman and the newborn.

When considering the question of the welcoming, it can be observed a series of difficulties, not only in the professional exercise towards the pregnant woman but in the understanding of the meaning of the term "welcome".

For MOH, welcoming is accepting, listening, giving credit to wrap up, receive, attend, admit, that is, welcoming is an act of approximation, a "being with" and "being close to", an attitude of inclusion[14,15].

Every place where a meeting takes place as a health work generates a professional/patient relationship, where it produces listening and accountability relationships, and links and commitments are formed in intervention projects[16].

Welcoming in health production practices is present in all relationships and meetings with patients, even when we do not take care of them[14]. However, the study presented here seems to have been difficult to verify in everyday practices. It was observed a reception that was not fully or completely the

one proposed by the MOH in the nurses' interviews in the relationship between professional/expectant.

In this observation, the pregnant adolescent welcoming that should be singular and specific to the attributions of her age may be aggravated because the adolescent who has not yet reached maturity can begin to be treated as a mature woman or in the process of maturing due to maternity.

It should aim to understand the subjectivity of this adolescent, perceive its human dimensions, treat health in an integral way, encompass the process of caring to promote, maintain and/or recover dignity and human totality to understand the situation and provide care to the pregnant woman. Care is understood as an action that goes beyond technical procedures since it has involvement and commitment with the other and becomes a humanized action that recognizes the patient as an active individual and participant in the process of health production[7].

It was possible to observe that the nurses´ statements were rooted in moral judgments and prejudices, which most probably influences the care given to this adolescent during prenatal care. One study[18] found that about prenatal care to the adolescent among the interviewed nurses, value judgments were present as: "they were barely born and are already having sex" or "these children, because fifteen, fourteen, sixteen, get pregnant by carelessness".

Calling the adolescent as a child, as careless, precocious can be understood as offenses and judgments. This negatively influences the professional assistance, and the judgments most of the times have already been reinforced by friends and family.

Other studies[19,20] share the same theory that professional action on maternal health requires the satisfaction of the patient, especially in the professionals, a behavior of respect and attention, without previous judgments, providing a healthier gestation, considering that this is a phase, in which the physical and psychic changes make her more vulnerable and fragile.

Therefore, it is recommended to use strategies such as open listening, without judgments and without prejudice, besides to frank dialogue, allowing women to talk about their intimacy with safety, expressing their doubts and needs, enabling the establishment of the professional-client link[19].

Regarding the biological risk and social risk approach, the Ministry of Health[12] published a Basic Attention Report, called "Attention to low-risk prenatal care", which aims to guide care according to the most current evidence, with the aim to carry out a humanized and integral practice, guaranteeing the standard of access and quality.

In the prenatal, there is a classification of gestational risk, indicating risk factors that allow prenatal care by the primary care team; those that may indicate referral to prenatal care at risk and those that indicate referral to emergency/obstetric emergency.

Regarding the risk factors that allow prenatal care by the primary care team, there are those related to individual characteristics and unfavorable sociodemographic conditions. Attention is given to the age of fewer than 15 years old; the insecure family situation and the non-acceptance of pregnancy, especially in the case of adolescents[12].

However, it is emphasized that pregnant adolescents do not have greater clinical and obstetric risk in relation to pregnant women of other age groups, just because they are adolescents. Adequate prenatal care is critical to ensuring low risk. However, it is necessary to be attentive to the pregnant women between 10 and 14 years old, since they present higher maternal-fetal risks. However, when they receive qualified attention, the results are close to those of the general population[12].

Even MOH considering a gestational risk factor for gestation among adolescents aged 10 to 14 years old (which can be minimized with qualified attention) we can see a progression in relation to the approach taken. For example, in the prenatal manual published in 2000, it did not make any reservations about the attention offered to the adolescent[21].

In view of this, it is important to emphasize that even the MOH with important considerations related to the assistance to adolescent pregnant women, the protocol in force in the city of São Paulo, still characterizes gestation in adolescents under 16 years old as being at risk. Consequently, the nurses cannot perform this care, as it is verified in the speeches of these professionals.

Regarding the risks of maternal death, 50% of deaths are related to direct obstetric causes, which are complications during pregnancy, delivery or puerperium. Caused by interventions, omissions or incorrect treatment, they are prevented with an adequate prenatal follow-up, for a better knowledge of the pregnant woman's health and the development of the pregnancy, not excluding educational and family planning measures[22].

When dealing with the biological risks of adolescents, there is no evidence to prove unfavorable obstetric evolution related to the single factor of maternal age. The most frequent biological risk situations among very young adolescents are gestational hypertension, prematurity, and low neonatal weight, related not only to maternal age, but also to inadequate psychosocial conditions, and the quality of prenatal care and childbirth[23].

In another study[24], inadequate prenatal care significantly contributed to increased gestational risk in adolescents, such as increased prematurity, increased risk for low birth weight, fifth-minute Apgar below seven, among others.

It is currently believed that quality care would solve or minimize biological risk since one of the main objectives of prenatal care is precisely the identification of factors that could put the binomial at a greater risk of an adverse outcome, as well as intervene to avoid iatrogenias[25].

The situation of social, political and economic inequality found in Brazil has a direct influence on the family dynamics and the increase in the number of children and adolescents in situations of social and personal risk. In this context, teenage pregnancy has traditionally been treated as a public health problem, although different studies attribute positive meanings to the experience of motherhood from the perspective of adolescents[23,26].

These non-medical risks involving the adolescent may be the need for financial help, housing problems, family tensions about unplanned pregnancies, fear and failure to take on responsibilities and roles as adolescent and mother, life (smoking, alcohol, drugs), build a new stable family structure, self-structure and raise their children with health. Even after gestation, the need for financial and physical help to care for the child remains, since the adolescent usually does not have the mate's endorsement or he or she is also an adolescent and the two cannot afford the child's total expenses and care[23,26].

This confirms that by providing prenatal care (maintaining attachment and identifying difficulties) as well as a puerperal follow-up at UBS can prevent maternal deaths if the care is of quality. In this sense, the advantage and importance of home visits in the puerperium and of the Family Health Strategy, implemented in some health units in the city of São Paulo are promoted.

In the ESF, the family must be understood comprehensively and in its social space and to understand the person must be analyzed the socioeconomic and cultural context, recognize it as a social subject bearing autonomy and corroborate that it is in the family that interactions occur and conflicts that directly influence people's health. Thus, the focus of care should be on helping and empowering the family so it can meet the needs of its members, especially in the health-disease process, mobilizing resources, promoting mutual support and growth[27].

Knowing this, a critique of the nurses' practice in the program is that they believe they are taking care of the family even when their work process is not different from the adopted in the care of the individual, that is, they are assisting the individual who has relatives and not the assistance to the family in the aspect of care unit[27].

A comparative study of Traditional Basic Unit and Basic Unit of Family Health Strategy, in the different strata of social exclusion,

showed that for the patients, the basic attention index, in general, the UBESF was superior to the traditional UBESF, while for the professionals and managers, this index did not reveal relevant differences[28,29].

The prenatal period is a time of great expectation and biological and psychological preparation for childbirth and motherhood. During the prenatal period, the nurse seeks to contribute to the health promotion of the binomial through information and reflections on the experience of motherhood, changes in the body, adoption of health maintenance practices and changes in habits to solve problems caused by a gestation.

After intense discussions and reflections on prenatal care for women, a consensus on the greater receptivity of pregnant women to health care strategies reinforces the effective participation of women in prenatal care that allows the acquisition of new knowledge, broadens their perception body for its ability to gestate, to give birth and to mother[7,30].

It is interesting to think that some aspects cited as priorities were also identified as difficulties in care. This enables to infer that, despite the difficulty nurses have in giving attention, supporting, welcoming the daily demand in these units, positions such as these become fundamental for adolescents, who feel welcomed and cared, and provide a higher prenatal adherence, according to the perception of some nurses.

Assistance to adolescent pregnant women should occur through actions aimed at improving the access of these women to health services, with professionals continuously trained to meet the specific needs of this age group. In the Health Units, it is necessary to make multidisciplinary educational interventions for adolescents, not in a fragmented way and that values the biological, but seeking holistic care, geared to biopsychosocial needs[24,27,31].

When valuing the relational aspects, the pregnant women consider that the attention should be directed toward an approach that perceives them in their totality, emphasizing the need for a greater bond with the health professionals. In this perspective, paths can be traced towards the reformulation of the hegemonic and current health system, in order to maybe make it more oriented to the support of the different subjects that compose the (complex) reality in favor of a health care more humanized and supportive[32].

A research with pregnant adolescents addressed the distinct specificities in adult pregnant women, with the doctor and nurse having fundamental roles in a unique and differentiated care. As members of the women's support network, these professionals need to understand the physical, emotional and social changes experienced by the adolescent, as well as the resources they have and how they cope with these situations. Thus, prenatal care given to pregnant adolescents must be "differentiated" and personalized due to the characteristics of this group[33].

The relationship between the health professional and the adolescent should be worked out, so there are changes in the pre-established knowledge and preconceptions. When doing it, professionals can reflect and find a way to behave towards adolescents, provide participation and provide information, as well as being able to offer attention and care to adolescents[33].

Then, adolescent motherhood is not only a biological-reproductive act but a social process that significantly affects the relationships between men, women and family members, defining new social identities. In this way, beyond the biological physical questions, a holistic vision must have a focused view, centered in the respect and acceptance of the adolescent pregnant, so the humanized action can cover all the concepts[34].

CONCLUSION

The study allowed the reflection about the humanized care and the posture adopted by the nurses in front of the prenatal care of the adolescents.

It is noticed that the adolescent pregnant does not receive, in her totality, a specific and directed attention, that attends to the unique needs of her age group and condition of gestation.

Regarding the professional characteristics of nurses providing prenatal

care, few of them had specialization in areas related to PHC, in which most were not specialized. This is a factor that can have a severe impact on the assistance regarding the lack of specific preparation and professional qualification.

The professionals recognized fragilities in the care of the adolescent pregnant woman and listed some difficulties, such as the lack of preparation in the training for this action, sociodemographic and cultural issues, and those related to health policies.

It is extremely necessary to implement public policies aimed at adolescent pregnant women in the services, as well as investing in the training/awareness of the nursing professional to assist the adolescent, promoting changes in the care structure with interdisciplinary and multi-professional teams for a directed and efficient care.

Thus, it is necessary to carry out actions aimed at comprehensive assistance to adolescents, not only in the pregnancy-puerperal period. For this, it is fundamental to welcome, strengthen ties between professionals and patients, professional resolutive, permanent discussions and permanent staff training.

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