

Practices Performed by the Multidisciplinary Team in Prenatal Consultations: Perceptions and Expectations of Pregnant Women

Práticas Realizadas Pela Equipe Multiprofissional na Consulta Pré-Natal: Percepções e Expectativas de Gestantes

Prácticas Realizadas por el Equipo Multiprofesional en la Consulta Prenatal: Percepciones y Expectativas de las Gestantes

RESUMO

Objetivo: Descrever as percepções e expectativas de gestantes sobre as práticas da Atenção Primária à Saúde no pré-natal. **Método:** Estudo descritivo, qualitativo, realizado em Unidades Básicas de Saúde de um município do Pernambuco, com 12 gestantes acompanhadas pela Estratégia Saúde da Família. A coleta ocorreu por meio de entrevistas semiestruturadas e a análise seguiu a técnica de análise de conteúdo de Bardin. **Resultados:** As gestantes eram majoritariamente adultas jovens, com baixa renda e inserção laboral fora do domicílio. Destacou-se o papel da enfermagem na escuta e orientação, e do Agente Comunitário de Saúde na adesão ao cuidado, além de fragilidades estruturais. **Conclusão:** As gestantes valorizam acolhimento e escuta ativa, reforçando a necessidade de cuidado humanizado.

DESCRIPTORES: Assistência Pré-Natal; Atenção Primária à Saúde; Equipe de Assistência ao Paciente;

ABSTRACT

Objective: To describe pregnant women's perceptions and expectations regarding Primary Health Care practices during prenatal care. **Method:** A descriptive, qualitative study conducted in Basic Health Units of a municipality in Pernambuco, with 12 pregnant women followed by the Family Health Strategy. Data were collected through semi-structured interviews, and analysis followed Bardin's content analysis technique. **Results:** Most participants were young adults, with low income and employment outside the home. The role of nursing in listening and guidance stood out, as well as the Community Health Worker's role in adherence to care, in addition to structural weaknesses. **Conclusion:** Pregnant women value welcoming care and active listening, reinforcing the need for humanized care.

DESCRIPTORS: Prenatal Care; Primary Health Care; Patient Care Team.

RESUMEN

Objetivo: Describir las percepciones y expectativas de las gestantes sobre las prácticas de la Atención Primaria de Salud en el prenatal. **Método:** Estudio descriptivo, cualitativo, realizado en Unidades Básicas de Salud de un municipio de Pernambuco, con 12 gestantes acompañadas por la Estrategia de Salud de la Familia. La recolección se realizó mediante entrevistas semiestructuradas y el análisis siguió la técnica de análisis de contenido de Bardin. **Resultados:** Las gestantes eran mayoritariamente adultas jóvenes, con bajos ingresos y empleo fuera del hogar. Se destacó el papel de la enfermería en la escucha y orientación, y del Agente Comunitario de Salud en la adherencia al cuidado, además de fragilidades estructurales. **Conclusión:** Las gestantes valoran la acogida y la escucha activa, reforzando la necesidad de un cuidado humanizado.

DESCRIPTORES: Atención Prenatal; Atención Primaria de Salud; Equipo de Atención al Paciente.

RECEIVED: 12/04/2025 APPROVED: 01/12/2025

How to cite this article: Oliveira EIS, Sousa MFS, Souza JSC, Silva RCM, Teles RBA, Diniz LPM. Practices Performed by the Multidisciplinary Team in Prenatal Consultations: Perceptions and Expectations of Pregnant Women. *Saúde Coletiva* (Brazilian Edition) [Internet]. 2026 [cited year month day];17(105):19314-19329. Available from: DOI: 10.36489/saudecoletiva.2026v17i105p19314-19329

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INTRODUCTION

Primary Health Care (PHC) is recognized as the gateway to the health system, playing a fundamental role in promotion, disease prevention, and chronic condition management. The World Health Organization (WHO) defines PHC as the first level of health care, characterized by a set of health actions, at the individual and collective levels, with the aim of developing comprehensive care that positively impacts the health status of communities⁽¹⁾. The National Primary Care Policy (PNAB) established by the Ministry of Health (MS) establishes that the Family Health Strategy (ESF) should be a reference in health care, aiming to reorient health practices and ensure its role as coordinator and organizer of care, longitudinality, and comprehensiveness. In the context of PHC, the family health team is responsible for offering differentiated care, focused on the needs of individuals and their families, respecting their individuality and seeking to resolve problems in a timely manner, considering a multidimensional approach.

Prenatal care (PN) should be an opportunity to offer qualified care, with reception, medical history, exams, guidance, test requests, prescriptions, and referrals within the Health Care Network (RAS). The organic and psychological changes of pregnancy require professionals trained to identify risks and intervene in a timely manner, ensuring safe outcomes for mother and baby and preventing maternal-fetal complications.⁽⁴⁾ Quality prenatal care

involves promotion, prevention, diagnosis, and treatment, reducing maternal and infant morbidity and mortality. The Ministry of Health, through the Program for the Humanization of Childbirth and Birth (PHPN), establishes essential procedures: beginning of care by the 12th week, a minimum of seven consultations, laboratory tests, vaccination, and postpartum consultation, ensuring a pregnancy with fewer complications.⁽⁵⁾ It is important to emphasize that prenatal care often represents these women's first contact with the health service, so it is of utmost importance that this consultation be well structured and well conducted by the entire team to meet their needs in a comprehensive manner, using technical and scientific knowledge and appropriate resources in a humanized environment⁽⁶⁾.

Systematic monitoring seeks to ensure the health of both mother and baby, reducing risks and promoting a safe pregnancy. PHC should provide early care, monitor high-risk pregnancies, and refer more complex cases in a timely manner⁽⁷⁾. However, the literature shows that structural difficulties persist, especially in remote areas, where there are managerial weaknesses, low integration with the Health Care Network, and limitations in the provision of services, hindering continuity of care and compromising the effectiveness of PHC⁽⁷⁾. In addition, early initiation of prenatal care is an important indicator of the quality of care and contributes to reducing maternal and perinatal mortality by ensuring early diagnosis of conditions that may affect pregnant women and newborns⁽⁷⁾.

en and newborns⁽⁷⁾.

Humanized prenatal care that follows good practices requires well-organized services, trained professionals who are sensitive to the needs of pregnant women, and the use of technologies that improve the quality of consultations. Care should be comprehensive and holistic, with early identification of maternal-fetal risk factors and timely interventions to prevent or minimize them. Thus, qualified professionals are essential to ensure safe, comprehensive, and effective care. In Brazil, the Ministry of Health establishes that high-risk pregnancies should be monitored by the Primary Health Care team, which operates in a multidisciplinary manner in defined territories. Its actions include promotion, prevention, diagnosis, treatment, rehabilitation, and surveillance. For pregnant women, it is essential to be linked to the team in their area, where prenatal and postpartum care is a collective responsibility, with consultations conducted by nurses and doctors in accordance with Decree No. 94.406/87.^(9,10)

Brazilian law authorizes nurses to fully conduct prenatal care for normal pregnancies. These professionals play an essential role in health promotion, disease prevention, and humanized care, developing care plans, providing guidance, interventions, referrals, and strengthening interdisciplinary work according to the needs of the pregnant woman.⁽⁷⁾ Building a bond of trust, dialogue, and listening with the pregnant woman and her family is a crucial strategy for effective prenatal care. This approach facilitates the relationship

between professional and patient, allowing questions to be clarified and promoting women's autonomy. This autonomy refers to the conditions that allow women to make decisions about important aspects of their lives and act in accordance with those decisions⁽⁷⁾.

The integration of various health professionals in the ESF enables different perspectives on maternal and child health care practices, ensuring comprehensive care and increasing the potential for resolution. In addition, the reception, bond with the pregnant woman, and good practices of the multidisciplinary team are seen as a way of reorganizing work processes, which greatly contributes to actions aimed at reducing maternal and fetal morbidity and mortality. Prenatal care involves essential care to protect the health of the pregnant woman and the baby, prioritizing prevention and early diagnosis of complications, in addition to the management of pre-existing maternal conditions and guidance on healthy habits. This monitoring allows for the early identification and treatment of problems that can cause irreversible damage to the mother-baby pair, such as premature birth, malformations, IUGR, gestational diabetes, and preeclampsia.⁽¹¹⁾

In view of the above, the present study aimed to describe the perceptions and expectations of pregnant women regarding Primary Health Care practices.

METHOD

This is a descriptive study with a qualitative approach that sought to understand, in depth, the perceptions and expectations of pregnant women regarding the practices developed by the multidisciplinary Primary Health Care (PHC) team during prenatal care. The research was conducted in the municipality of Petrolina, Pernambuco, located in the mesoregion of Sertão do São Francisco, 721 km from Recife, the state capital. The empirical setting included Basic Health Units (BHUs) in urban and rural areas, making it possible to capture experiences from different territories and healthcare realities.

Data collection took place from March to June 2025, using semi-structured interviews as the main research technique. To this end, a questionnaire was developed consisting of open and closed questions aimed at exploring care experiences, perceptions of the performance of the multidisciplinary team, expectations regarding prenatal care, and facilitating and limiting aspects of the care received. The interviews were conducted in private areas of the UBS or in the homes of the pregnant women, ensuring privacy, confidentiality, and an environment conducive to the participants' expression.

The study participants were pregnant women monitored by Family Health Teams (ESF), attended by nurses, doctors, dentists, Community Health Agents (ACS), technicians, and nursing assistants during prenatal consultations or at other times of care.

The selection was made for convenience, respecting the following inclusion criteria: (a) age ≥ 18 years; (b) having had at least one previous prenatal consultation with the referral team; (c) having been seen by at least three different professionals from the multidisciplinary team throughout the pregnancy. Pregnant women who did not meet the criteria were excluded. To ensure anonymity and confidentiality, the letter "G" followed by sequential numbering (G1, G2, G3) was used.

The final number of participants was determined according to the principle of theoretical data saturation, at which point the interviews did not add new elements of meaning to the emerging categories. Upon reaching saturation, a total of 12 interviews were conducted, which was considered sufficient to ensure analytical depth and interpretive consistency. All interviews were audio recorded, transcribed in full, and reviewed to ensure the reliability of the empirical material.

The analytical stage followed Bardin's Content Analysis methodological framework, comprising three phases:

1. Pre-analysis: skimming, organization of the corpus, and identification of units of record;

2. Exploration of the material: coding, categorization, and grouping of central ideas;

3. Treatment and interpretation: inference of results, analysis of convergences and divergences, and articulation with the scientific literature.

This method allowed us to identify core meanings that express pregnant women's perceptions of reception, technical and relational quality, the role of professionals, and challenges faced in PHC during prenatal care.

The study strictly complied with the ethical principles of Resolution No. 466/2012 of the National Health Council. The project was submitted to and approved by the Research Ethics Committee of the Amaury de Medeiros Integrated University Health Center (CISAM/UPE), under opinion No. 7,399,695. All participants were informed about the objectives and procedures of the research and signed the Free and Informed Consent Form (FICF).

RESULTS

Twelve pregnant women were interviewed, presenting the following characteristics: in terms of age, the average among the interviewees was 28 years, with the majority between 26 and 31 years old and the smallest portion under 25 years old.

Regarding family income: 9 had an income between 0 and 1 minimum wage, 2 had an income between 2 and 3 minimum wages, and 1 reported an income above 4 minimum wages. Regarding occupation, 4 did not work outside their homes, considering themselves housewives, and 8 worked outside their homes, predominantly as farmers.

Regarding current prenatal care: 2 pregnant women began consultations at 4 weeks of gestational age (GA); 7 pregnant women began consultations at 7 weeks; 2 pregnant women began at 8 weeks; and 1 pregnant woman began consultations at 9 weeks GA. Regarding other PN actions: 11 pregnant women reported having per-

formed all routine tests according to the protocol recommended by the Ministry of Health, while one did not. All 12 participants reported having undergone obstetric ultrasound (USG) and received the vaccines recommended by the Ministry of Health (MS) during pregnancy. Of the 12 women taking supplements, all were taking folic acid and ferrous sulfate. Among them, only one was taking calcium and two were additionally taking acetylsalicylic acid. Regarding the first prenatal consultation, 10 women were seen by a nurse and 2 by a doctor. Regarding prenatal follow-up, all 12 reported that they are followed up by a doctor and nurse. Among them, one reported having private consultations with an obstetrician, and another mentioned follow-up with a nutritionist in the private sector.

Regarding pregnancy risk and referrals, two women were referred to the municipal Reference Center because they were high-risk pregnancies, and one is undergoing investigation for this condition. Regarding dental appointments, eight of the 12 women reported having already seen a dentist, while four said they had not had an appointment. Regarding visits from the Community Health Agent (ACS), 8 reported that they receive them regularly; 3 reported that they do not receive them because they are at work during visiting hours, and one stated that there is no health agent working on her street. Regarding the approach by nursing technicians, all participants stated that they had already been seen by this professional.

Regarding the presence of comorbidities prior to pregnancy, the 12 women interviewed reported having no associated conditions. Regarding care by professionals from the Expanded Family Health Center (NASF), 11 responded that they did not receive this type of follow-up, while one reported having been seen by a nutritionist.

Analysis of the material collected through the interviews revealed content that was consistent in terms of meaning and, based on this, was organized into the following categories: primary care as a

mediator of comprehensive care for pregnant women: from reception to resolution of demands; good practices of the multidisciplinary team from the perspective of pregnant women: opinions, perceptions, and expectations.

DISCUSSION

PRIMARY CARE AS A MEDIATOR OF COMPREHENSIVE CARE FOR PREGNANT WOMEN: FROM RECEPTION TO RESOLUTION OF DEMANDS.

Primary Health Care (PHC) is the main gateway to the Unified Health System (SUS), and is a strategy for ensuring comprehensive care for pregnant women. It is at this level of care that the bond between the woman and the multidisciplinary team is established, contributing immensely to adherence to prenatal care and early identification of complications⁽¹²⁾.

Although this gateway is considered the basis for primary care for pregnant women and their main link, it was possible to identify that some pregnant women do not perceive this place as adequate for the provision of their care, as can be seen in the following reports:

The reception is terrible, they don't know how to give us the right information, they barely look us in the face, they are always in a bad mood. (G1)

[...] They leave the patient to their own devices, they don't even look at us, I'm the one who keeps asking everything [...] (G2)

[...] Little guidance, shows little interest in assisting pregnant women. (G3)

PHC plays a fundamental role as a mediator of comprehensive care for pregnant women, from reception to the resolution of their demands. Qualified listening, respect for individual differences, and the building of bonds of trust between pregnant women and the health team are essential pillars for adherence to prenatal care and the success of the proposed

interventions⁽¹³⁾. Multidisciplinary, integrated, and user-centered care strengthens women's autonomy and increases the effectiveness of care.

Quality prenatal care must be based on welcoming and humanizing health practices. Humanizing care involves recognizing pregnant women as active participants in the care process, respecting their beliefs, needs, and social context. This contributes not only to women's emotional well-being but also to good perinatal outcomes⁽¹⁴⁾.

Welcoming and effective communication also reduce barriers to access and prevent discontinuity of care. However, when there is a deficiency in this welcoming and communication, pregnant women feel insecure and helpless. In the present study, this was verified in the following statements:

[...] The doctor is terrible, she keeps training two students and leaves the patient to fend for themselves. She doesn't even look us in the face. I'm the one who keeps asking everything [...]. (G2)

He speaks very little, almost nothing, only if I ask him something, but he never speaks on his own. (G7)

The doctor didn't give any guidance, I always had questions and she just answered them. (G8)

The resolution of the demands presented by pregnant women during prenatal care is an important indicator of the quality of PHC. This involves the health team's ability to provide appropriate responses to the clinical, psychological, and social needs of pregnant women, as well as to coordinate referrals when necessary. The comprehensive care model assumes that pregnant women are not seen only as biological bodies, but as complex beings, embedded in a social and emotional network, endowed with feelings and emotions⁽¹⁵⁾.

In primary care, the quality of prenatal care depends on the service's ability to coordinate the points of the network, ensuring resolution and avoiding unnecessary referrals. Thus, only complex cases are referred to secondary and tertiary levels.

els, optimizing resources and the flow of care⁽¹⁶⁾. Some pregnant women, however, reported difficulties in relation to some structural issues and supplies at the unit, as can be seen in the following excerpts:

On the day I went to have my blood test, they took too long (...), I went home without being seen and hungry because I was fasting. (G5)
There was a time when I had an appointment for the test and I got there and they didn't do it. (G7)
[...] I couldn't have the test because of the delay. (G5)

In addition to human resources, the availability of basic supplies, such as medications, vaccines, rapid tests, and materials for laboratory tests, and waiting times are key components of quality prenatal care. The lack of these supplies compromises the effectiveness of the service and negatively impacts the pregnant woman's experience with prenatal care. Thus, the adequate structuring of health units is an indispensable condition for quality care⁽¹⁷⁾. This can be seen in the following excerpts:

[...] There have been times when the exam was scheduled and I got there and they didn't do it [...] (G7)
[...] I couldn't have the tests because of the delay [...] (G5)
Sometimes I don't go to the appointment because there are too many people and too few professionals, and it takes too long [...] (G5)

Primary care faces structural barriers that compromise its performance. Many UBS lack infrastructure, equipment, connectivity, and technology, hindering flows between levels of care⁽¹⁸⁾. In addition, regional funding inequalities limit resources for personnel, supplies, and maintenance, widening disparities in service quality⁽¹⁹⁾.

In management, problems such as lack of strategic planning, weak governance, and high staff turnover accumulate, undermining continuity and bonding. Added to this is insufficient management training, with managers ill-prepared to

deal with budgeting, logistics, monitoring, and evaluation.⁽²⁰⁾

Qualified investment in PHC is essential to improve prenatal care, ensuring early detection of risks, continuous monitoring, and promotion of maternal and child health. Studies show that regular prenatal care, with adequate infrastructure, trained staff, laboratory support, and network integration reduces premature births and adverse events.²¹

Thus, investment in PHC for prenatal care should include adequate infrastructure, continuous training of professionals, and increased resources for educational activities and screening for diseases such as syphilis, HIV, hypertension, and gestational diabetes. Monitoring systems allow for the identification of failures and adjustment of interventions, strengthening the bond with the pregnant woman and ensuring effective and decisive prenatal care in the SUS.

GOOD PRACTICES OF THE MULTIPROFESSIONAL TEAM FROM THE PERSPECTIVE OF THE PREGNANT WOMAN: OPINIONS, PERCEPTIONS, AND EXPECTATIONS

The adoption of good practices in prenatal care requires a holistic and evidence-based approach, centered on the biopsychosocial context of the pregnant woman. The Ministry of Health highlights early start, regular follow-up, adequate records in the health booklet, and strengthening the bond between the team and the pregnant woman as essential elements.

Essential prenatal practices include a multidisciplinary approach, health education, skilled listening, promotion of breastfeeding, groups for pregnant women, a humanized approach, and partner involvement. The WHO recommends individualized, respectful, and welcoming care, with clear communication, emotional and social support, as well as rapid access to services, tests, iron, folic acid, and calcium supplementation, and immunizations (dT, dTpa, hepatitis B, influenza/COVID-19) during pregnancy monitoring.

Guidance must be provided continuously and by all professionals. When asked, pregnant women indicated that they received guidance from various professionals on basic care such as vaccination and good practices:

[...] She (the technician) tells us the days we have to go get vaccinated and which vaccines we have to take. (G4)
[...] She (CHW) tells us to get the vaccines on the right day, to be careful with water and raw meat. (G9)

The efficient performance of PHC professionals is essential to reduce maternal and infant morbidity and mortality. Early detection of risks, adequate monitoring, and guidance on warning signs prevent complications. However, the quality of care depends on trained professionals who act based on evidence and are committed to the principles of the SUS.⁽²⁶⁾

Technicality in health, by prioritizing practical knowledge and rationality, depersonalizes care and weakens the professional-patient relationship. Although it increases the efficiency of treatments, this model transforms the patient into a diagnostic object, reducing them to biological aspects and neglecting their integral human dimension.⁽²⁷⁾ Training that is still predominantly focused on instrumental rationality and professional individualism favors a technical approach, often lacking in sensitivity or empathy, resulting in low levels of ethical-relational commitment to the population served.⁽²⁸⁾

Practices such as welcoming, active listening, health education, and participatory management are essential for human-centered care. The National Humanization Program (PNH) and continuing education highlight the importance of empathy, dialogue, and effective communication for ethical and comprehensive care.⁽²⁹⁾ This aspect can be seen in the following statements:

The biggest problem is the doctor's appointment, he doesn't write anything in my notebook, he just makes a mark [...] (G7)

[...] The doctor hardly says anything. (G11)

Communication with the doctor is very difficult, and she doesn't show much interest in the pregnant woman's needs. (G8)

Continuing education, valuing professionals, and using updated protocols are essential for safe care. In addition, encouraging reflective practice strengthens self-assessment, ethical thinking, and critical learning, reducing dehumanization and promoting safer, patient-centered interventions.⁽³⁰⁾

In this context, the fundamental role of Community Health Agents, nursing technicians, and NASF professionals in prenatal care stands out, especially due to the bond of trust established with pregnant women. Because they live in the community and make home visits, CHAs act as a direct link for guidance and support. Pregnant women also value the welcome they receive from nursing technicians and assistants, who promote safety and adherence to care. NASF actions are recognized as important for comprehensive care, especially in educational groups and multiprofessional activities.⁽³¹⁾ In the present study, these aspects were evident in the following statements:

She (ACS) is very attentive, I've known her for many years, she's like a mother to me. She schedules my exams, if any results come in, she gives them to me, she tells me to put my legs up, not to eat too much salt. (G3)

She (CHW) tells me to get my vaccinations on the right day, to be careful with water and raw meat. (G9)

She (technician) tells me the days I have to go get vaccinated and which vaccines I have to take. (G4)

Nursing plays an essential role in promoting the health of pregnant women, offering comprehensive care that directly influences their quality of life. Its role in prenatal care includes sociocultural as-

pects and humanized practices. When there is dialogue, acceptance, and understanding, pregnant women become more confident and participatory, favoring adherence to preventive and educational actions⁽³²⁾.

In addition, active listening and welcoming, as provided for in the National Humanization Policy, serve as a gateway to woman-centered care, contributing to the ongoing bond between professional and patient and, consequently, to the continuity of comprehensive care⁽³³⁾. Research with pregnant women in primary care has shown that those cared for by nurses often report greater satisfaction, confidence, and empowerment, especially when their subjective needs are recognized and considered in the care process.

She (the nurse) gives us lots of advice, especially asking if we understand about food and walking. (G1)

The nurse is always very attentive, talking about food washing, not eating undercooked or raw meat, exercise, weight. (G8)

She (the nurse) tells us to be careful with cats so we don't catch diseases, to wash food, and to be careful with water. (G9)

In this scenario, nurses stand out in health promotion by performing systematic assessments, providing qualified guidance, and ensuring continuity of care. Their work promotes humanized care, reflected in the preference of pregnant women, who value clear communication, active listening, and the sense of security conveyed during follow-up.⁽³⁴⁾

The nurse is always very attentive, talking about food washing, not eating undercooked or raw meat, exercise, and weight. (G8)

[...]I always show everything to the nurse at appointments because he (the doctor) never takes notes. The doctor doesn't treat us right, the appointments are quick, he arrives late and wants to leave early (G7)

[...]The nurse is the most attentive, she has even drawn things for me to understand during appointments

(G2)

She (the nurse) gives too much guidance, above all, she asks if we understand, about food, walking [...]. (G1)

In addition to the unique role of nursing, the multidisciplinary team is essential to the quality of prenatal care, integrating clinical, psychosocial, and educational knowledge. The joint action of doctors, nurses, dentists, nutritionists, psychologists, social workers, and community health workers allows for the identification of risks, meeting emotional needs, and carrying out coordinated interventions that improve maternal and fetal outcomes.⁽³⁵⁾

He (the dentist) talked about brushing and said there were some procedures that needed to be done. (G10)

She (community health worker) is very attentive. I've known her for many years; she's like a mother to me. She schedules my exams, gives me any test results, tells me to put my legs up and not eat too much salt. (G3)

He (nurse) is excellent, he tells me what will happen each week, the changes in my body, about exercise, diet. (G7)

The doctor gives me advice on exercise, diet, drinking plenty of water, and eating foods that contain fiber because I have problems with constipation. (G10)

In this context, for prenatal care focused on good practices, it is necessary to have a welcoming environment, comprehensive care, humanization, health education, and resolution, with a qualified multidisciplinary team. The integrated work of various professionals makes it possible to address biomedical and psychosocial aspects, strengthen the bond with the pregnant woman, and expand the early diagnosis of risks.²²

Thus, investing in continuing education, interprofessional integration, and evidence-based protocols represents a

strategic step toward consolidating quality practices within the SUS and promoting positive outcomes for maternal and child health.

Recognizing the voice of pregnant women in prenatal care is an ethical principle and a strategy for improving the quality of care. Listening to their desires and difficulties strengthens their protagonism and contributes to adjustments in services. Active listening improves bonding, adherence and interventions contextualized to biopsychosocial needs.

CONCLUSION

It was possible to identify pregnant women with a profile of young adults, low income, and work outside the home, with early onset of prenatal care, examinations, immunizations, and regular use of supplements recommended by the Ministry of Health. Shared monitoring highlighted the role of nurses in guidance, listening, and bonding, as well as the importance of community health workers in mediating with the service. Weaknesses persist, such as delays in care, lack of supplies, ineffective

communication, and low multidisciplinary participation.

The study achieved its objective by describing the perceptions and expectations of pregnant women regarding PHC practices in prenatal care. The findings show that pregnant women focus their expectations on better reception, information, and continuity of higher quality care and humanization of assistance. It is recommended to strengthen communication, records, exam logistics, and team integration, valuing pregnant women as protagonists of care.

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