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Original Article

Nurses' perception of autonomy in primary health care in rural and urban settings

Percepção de enfermeiras sobre a autonomia na atenção primária à saúde em cenários rurais e urbanos

Percepción de enfermeras sobre la autonomía en la atención primaria de salud en contextos rurales y urbanos

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ABSTRACT

Objective: To analyze the perception of nurses in Primary Health Care regarding their professional autonomy in rural and urban municipalities. **Methodology**: Qualitative, descriptive, and exploratory study derived from the multicenter study Nursing Practices in the Context of Primary Health Care: a national mixed methods study. The participants were 53 nurses from three rural and three urban municipalities in Bahia, Brazil. Data were collected through semi-structured interviews and analyzed using thematic content analysis. **Results**: Data analysis revealed two thematic categories: the first highlights the area of identification of nurse autonomy, while the second addresses autonomy for prescribing and requesting tests and its limits in in Primary Health Care. **Final Thoughts:** Nurses perceive their professional autonomy as associated with a specific care group, based on care protocols. In most cases, they do not need another professional to complete the care.

DESCRIPTORS:
Primary Health Care; Nurses; Professional Autonomy.

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RESUMO
Objetivo: Analisar a percepção das enfermeiras na Atenção Primária à Saúde sobre sua autonomia profissional em municípios rurais e urbanos. **Metodologia**: Estudo qualitativo, descritivo e exploratório, derivado do estudo multicêntrico Práticas de Enfermagem no Contexto da Atenção Primária à Saúde: estudo nacional de métodos mistos. As participantes foram 53 enfermeiras de três municípios rurais e três munícipios urbanos da Bahia, Brasil. A coleta de dados foi por meio de entrevista semiestrutura e analisado por meio de análise de conteúdo temática. **Resultados:** A análise dos dados revelou duas categorias temáticas: a primeira destaca a área de identificação da autonomia da enfermeira, enquanto a segunda aborda a autonomia para prescrição e solicitação de exames e seus limites na Atenção Primária à Saúde. **Considerações Finais:** As enfermeiras percebem sua autonomia profissional associada a um grupo específico de atendimento, baseado em protocolos assistenciais. Na maioria das vezes, não precisam de outro profissional para concluir o atendimento.

DESCRITORES:
Atenção Primária à Saúde; Enfermeiras e Enfermeiros; Autonomia Profissional.

RESUMEN
Objetivo: Analizar la percepción de las enfermeras de atención primaria sobre su autonomía profesional en municipios rurales y urbanos del estado de Bahía. **Metodología:** estudio cualitativo, descriptivo y exploratorio, derivado del estudio multicéntrico Prácticas de enfermería en el contexto de la atención primaria: estudio nacional de métodos mixtos. Las participantes fueron 53 enfermeras de tres municipios rurales y tres municipios urbanos de Bahía, Brasil. La recopilación de datos se realizó mediante entrevistas semiestructuradas y se analizó mediante análisis de contenido temático. **Resultados**: El análisis de los datos reveló dos categorías temáticas principales: la primera destaca el área de identificación de la autonomía de la enfermera, mientras que la segunda aborda la autonomía para la prescripción y la solicitud de exámenes y sus límites en la Atención primaria de salud. **Consideraciones finales**: Las enfermeras perciben su autonomía profesional asociada a un grupo específico de atención, basado en protocolos asistenciales. En la mayoría de los casos, no necesitan a otro profesional para completar la atención.

DESCRIPTORES:
Atención Primaria de Salud; Enfermeras y Enfermeros; Autonomía Profesional.

INTRODUCTION

Throughout history, nurses have faced numerous challenges in ensuring their professional credibility, as their work has long been subordinated to medical practice. In this context, the nurse's autonomy, although a structuring element for their practice and professional development, was conditioned by another profession[1-2].

Professional autonomy refers to the nurse's ability to manage their knowledge and conduct their practices independently of other professions[3-4]. It is associated with the application of nursing knowledge and skills to the management of complex clinical situations[5-6]. In this sense, it encompasses independence in decision-making and the exercise of one's own competence, which strengthens accountability, ownership of work, and professional satisfaction[7]. Furthermore, it enables the provision

of patient-centered care, favoring safe decisions, collaborative interactions, and better quality of care[1,2-8].

However, autonomy is influenced by multiple factors such as mastery of professional knowledge, political positioning, and working conditions that directly contribute to the advancement of the nurse's performance in various areas of practice. Technical and scientific knowledge forms the basis for the development of autonomy, as it empowers nurses, legitimizes their conduct, and produces knowledge and power relations that guide their actions and constitute their professional identity[4,9].

Political positioning favors a critical understanding of the organizational scenario and the ability to intervene in it, while working conditions can expand or restrict the concrete possibilities of practicing independently, organizing care, and acting professionally, impacting the nurse's performance in various areas of practice[4-9].

Among these areas, Primary Health Care (PHC) is recognized as conducive to nurses developing the core knowledge of the profession, allowing them to expand their professional autonomy with a more independent practice aligned with the comprehensive care of users, families, and communities [3].

In PHC, the nurse's autonomy is related both to the freedom to make clinical decisions based on protocols, to the scientific knowledge of the profession, and to multiprofessional action[10]. It is worth noting that although the work process in PHC is collective, with the sharing of knowledge, autonomy is not absolute, as it is linked to the specific competencies of each profession, being considered fundamental for the development of professional work[3,10].

In this context, the nurse develops care practices with autonomy within the scope of their competence[11]. This is reflected in the coordination and development of problem-solving care, in nursing consultations supported by care protocols[5,12]. Furthermore, some studies point to a partial distancing from subordination to the physician, seeking to establish greater autonomy in clinical practice[10].

The exercise of nurse autonomy in primary health care is supported by Law 7498/86, which regulates professional practice, by the ordinances of the Federal Council (Cofen) and the Regional Nursing Councils (Coren), such as COFEN Resolution - 0564/2017, which provides for the profession's code of ethics. As well as by the National Primary Care Policy (PNAB), which defines the care and management competencies of nurses' work, in addition to the protocols of the Ministry of Health (MH) and the municipalities[11,13].

These protocols are instruments that allow nurses to make their practice in primary health care more autonomous and decisive, assisting in clinical decision-making and supporting conduct[14,15]. A study carried out on the implementation of nursing protocols in primary health care, in a municipality in Santa Catarina, showed that their adoption gave nurses greater security and decisiveness in their practices[16]. Nevertheless, these protocols should be instruments to support nurses' practices and not the central

element of these practices[17]. Furthermore, the literature points out that, when there are no established protocols, the nurse's autonomy is limited, directly interfering with their practice[18].

Despite advances, studies show divergences and limitations in the exercise of nurse autonomy in primary health care. It often remains conditioned by dependence on other professionals, especially the doctor[12-13]. On the other hand, research carried out with nurses in the municipality of São Paulo identified an increase in professional autonomy, especially due to clinical practice supported by care protocols[10]. Another study with nurses from the capitals of the Southeast of the country pointed out that, although nurses recognize the importance of autonomy for their practices, interferences still persist in the daily work, for example on the part of management, which limit their exercise[19].

Given the increasing demands on health in primary health care, there is also a growing need for a more autonomous and problem-solving profile on the part of nurses[5]. This scenario is even more challenging when considering the diversity of territories in which nurses work[11]. The literature indicates that the autonomy of nurses has a plural character, assuming different conceptions and forms of practice according to the context of action[13]. Studies highlight important differences in health care needs between urban and rural areas, determining that nurses in primary health care have competencies appropriate to such contexts[20-21].

Primary health care in rural contexts faces challenges such as isolation, long distances, and difficulty accessing services in the Care Networks. In these scenarios, it is common for nurses to provide initial care more independently, due to the absence or intermittency of other professionals, which requires greater clinical autonomy and decision-making capacity[21,22]. On the other hand, in urban areas, although there are more resources, primary health care nurses face obstacles to autonomy, such as a lack of governance over their activities, the restriction of some practices to what is set out in protocols, and structural limitations [19].

Understanding that nurses play a unique role in caring for the population, it is pertinent to ensure the exercise of autonomy in all areas of practice, including primary health care[9]. Authors affirm the need to further explore and research the professional autonomy of nurses to encourage reflection on their practice[4,13]. Despite its relevance, the literature is still incipient regarding comparative analysis of how the autonomy of nurses in primary health care is expressed in different territorial contexts, particularly between urban and rural areas.

Thus, the question arises: how do primary health care nurses in rural and urban municipalities in Bahia perceive their professional autonomy? Understanding how this autonomy is configured can contribute to improving care and strengthening the nurse's performance. Therefore, it becomes relevant to understand the perspective of nurses in primary health care in different settings, in order to identify how they perceive and exercise their professional autonomy.

OBJECTIVE

To analyze the perception of nurses in Primary Health Care regarding their autonomy in rural and urban municipalities.

METHODOLOGY

Study type and site

This is a qualitative, descriptive, and exploratory study, using the Consolidated Criteria for Reporting Qualitative Research (COREQ)[23] as a guiding instrument for the methodology.

The study setting encompassed primary health care services in municipalities with urban and adjacent rural typology in the state of Bahia, Brazil. Six municipalities in Bahia were selected, classified according to the typologies existing in the state: three urban and three adjacent rural. This study is an excerpt from the national multicenter study entitled “Nursing Practices in the Context of Primary Health Care: A National Mixed Methods Study”.

Study participants

The study participants were 53 nurses who met the following inclusion criteria: who had been working in primary health care for at least three years, with experience in primary health care assistance or management, and who, at the time of data collection, were working in traditional primary care units or family health teams in municipalities with adjacent urban and rural typology in the state of Bahia, Brazil.

Among the exclusion criteria, vacation or leave of any kind was established, as well as the absence of a formal employment relationship with the health service, such as preceptor and consultant nurses.

Data collection and organization

Data collection was carried out through semi-structured interviews, from November 2020 to May 2021, conducted by undergraduate and graduate nursing students, under the coordination of nursing faculty. For quality control and assurance, the entire research team underwent training and the instrument was pre-tested prior to data collection.

The selection of participants was carried out through contact with the municipal health departments of the municipalities, which provided contact information for nurses who were subsequently randomly selected by the research team.

The interviews were conducted virtually via the Google Meet platform, previously scheduled with the participants via email, telephone, or WhatsApp, according to the professionals' availability, and recorded with prior consent in audio and video for later transcription. The interviews lasted between 30 and 60 minutes.

The data collection instrument was a semi-structured script, with questions focused on social data: date of birth, gender, and race; professional training: year of graduation, type of institution (public or private); and professional experience: length of service.

Regarding the questions about the work, for this study, the answers to the following questions were selected: 1) In your activities, tell me in which area you identify having autonomy as a professional? 2) Do you need an evaluation/prescription from another professional to complete a service you have started, whether in reception or consultations? 3) In case of verification of an inflammatory and/or infectious process in a sexually transmitted disease, do you prescribe drug treatment? Why? 4) In case of treatment of skin lesions of users in your unit, are you qualified/authorized to prescribe ointments and dressings without resorting to a medical prescription? 5) Here in your unit, is it part of your activities to request examinations such as endoscopy, ultrasound, X-ray, biochemical tests?

Data analysis

Thematic content analysis was used according to Minayo[24], which allowed the identification in the nurses' discourses of central themes related to autonomy, understood as core meanings that were repeated or stood out due to their relevance to the object investigated. The process is divided into three phases: pre-analysis, with reading of all collected material in order to understand the structure, organize the corpus and define the cuts and units of records; exploration of the material, with interactive and reflective rereading in order to identify the most relevant points of investigation, with coding and categorization occurring; and treatment of the data obtained and its interpretation, in order to support the discussion and answer the objective.

In the data analysis, the Web Qualitative Data Analyses (webQDA) software was used, a qualitative analysis support tool that allows organizing, coding and systematizing data[25]. The software made it possible to group speeches according to their similarity and to carry out more structured coding. Furthermore, it contributed to greater rigor and transparency in the process of categorizing and interpreting the data.

Ethical aspects

This study was approved by the Research Ethics Committees of the coordinating institution (CAAE: 20814619.2.0000.0030) and the research participant (CAAE: 20814619.2.3019.5531). All participants signed the Informed Consent Form (ICF), and the anonymity of the participants was ensured. Participants were identified as ENF (Nurse) followed by the order in which the interviews were conducted and the typology, for example, ENFU1 and ENFR2.

RESULTS

Characterization of participants

Fifty-three professionals were interviewed, of whom 43 were female and 10 were male. The participants were between 29 and 51 years old, and most self-identified as mixed-race. Regarding their years of experience, more than half of the nurses had been practicing for between 8 and 15 years, and their length of service in the unit ranged from 1 to 15 years. The socio-professional characteristics are presented in Table 1.

Table 1. Characteristics of the study participants. Bahia, Brazil, 2022.

Variables	Adjacent rural area	Urban area	Total
Sex			
Female	17	26	43
Male	4	6	10
Age			
29-35	13	12	25
36-40	2	7	9
41-46	4	7	11
47-51	1	3	4
>51	1	3	4
Race/Color			
Yellow	2	-	2
White	4	8	12
Indigenous	-	-	-
Brown	14	14	28
Black	1	10	11
Years since graduation			
1 - 7 years	2	2	4
8 - 15 years	13	17	30
≥ 16 years	6	13	19
Time working at the unit			
Up to 1 year	3	4	7
1 - 5 years	12	13	25
6 - 10 years	3	13	16
11 - 15 years	3	2	5

Among the 32 nurses working in municipalities with an urban typology, 26 were female, aged between 29 and 51 years, and self-identified as mixed-race. The length of service in the health unit was mostly concentrated between 1 and 10 years, with predominance of graduation in public higher education institutions. As for the professionals in the adjacent rural typology, 17 were female and 4 were male, self-declared mixed-race, with a higher concentration in the age range between 29 and 35 years. Of the 21 nurses in this typology, 14 were trained in private institutions.

From the data analysis, two categories emerged, presented below.

Area of identification of nurse autonomy in PHC

The area in which most nurses from urban and rural municipalities identified professional autonomy was women's health, mainly in prenatal care activities, as illustrated by the statements below:

> Ah, it's prenatal care and women's health, I have a lot of autonomy in prenatal care as a nurse (ENFR5).
>
> I think women's health (ENFU25).
>
> I think prenatal care is where I have the most autonomy (ENFU26).
>
> Autonomy... It's obstetrics, in relation to prenatal care, we have quite a bit of autonomy (ENFR12).

In the speeches of nurses only from urban municipalities, there was a prominence regarding autonomy associated with wound care and dressing activities. This finding may be related to working conditions and greater access to healthcare resources, such as special dressings, available in these contexts, compared to rural municipalities.

> Today, what I believe I have the most autonomy in, and what can be a feeling among my colleagues as well, is the issue of wound care [...], so within nursing, it's an area that gives us a certain amount of autonomy (ENFU8).
>
> In wound assessment, I think we have quite a bit of autonomy (ENFU15).
>
> Now, the part about dressing changes was something we were responsible for; we had autonomy in that (ENFU21).

On the other hand, among nurses working in rural municipalities, mentions of team management and supervision emerged as another area related to autonomy. This emphasis may be associated with the specificities of these territories, such as geographic location and difficulties in access and transportation, which tend to broaden the scope of nurses' work and emphasize their managerial skills.

> I think it's the unit management, we've always had autonomy, supervision of the team (ENFR2).
>
> So, as the unit coordinator, I have autonomy over some things, in relation to the team, directing the team I have autonomy (ENFR11).

The nurse's autonomy in prescribing and ordering tests and its limitations in PHC

Regarding the need for another professional to prescribe or complete care, the results indicate that, most of the time, nurses of both types do not depend on another professional. This only occurs in situations that exceed the ethical and legal scope of the profession, such as medical diagnoses or medications that are not included in institutional protocols.

> No, I will need to refer if I encounter problems that go beyond nursing care, when I encounter problems related to diagnostic procedures, then yes, I will need to refer, because I may need a medical diagnosis, in those cases, yes (ENFR10).
>
> For things that nursing does not have the competence and ethical-legal support to resolve, yes (ENFU4).

In cases of sexually transmitted infections (STIs), testimonies reveal that most nurses carry out prescriptions based on municipal or Ministry of Health protocols. This indicates a similar practice between rural and urban municipalities.

> Yes, I prescribe it because it's in the protocol (ENFU27).
>
> Being within the protocol, within, let's say, we have - let's say I collect a cervical cytology sample, the Pap smear, and then I detect a sexually transmitted infection, I base myself on my protocol, or the Ministry of Health's protocol, on what the nurse can prescribe, and then yes, I prescribe it (ENFR15).
>
> Yes, so, the municipal protocol supports me in this, right, depending on the type of sexually transmitted infection, so, if it is clearly diagnosed by clinical examination or by the laboratory, we can prescribe, for example, a pregnant woman with syphilis, we have the autonomy to make this prescription and administer Benzetacil, which is the treatment (ENFR12).

However, some nurses from adjacent rural municipalities reported preferring to refer the patient to a doctor, even when there is a protocol supporting the prescription. This stance may indicate that the exercise of nurse autonomy is not determined solely by norms, but is mediated by factors related to safety, interprofessional relationships, and work organization, demonstrating that autonomy is constructed and negotiated in daily practice.

> I refer them to a professional. I prefer to refer them so we can be sure what it is (ENFR10).
>
> No, I see them, assess them, and pass them on to the doctor for the doctor to prescribe or medicate (ENFR20).

Regarding the treatment of skin lesions, specifically wounds and dressings, nurses in rural areas prescribe only what is available at the health unit and reported not having specific municipal nursing protocols for this.

> Yes, for wounds and injuries, I prescribe, we use it, there are very few available, we basically have sunflower oil, for dressings silver sulfadiazine and collagenase [...] we have these three available in the service, but many times I ask the patient to buy them, we prescribe, the patient can acquire, for example, papain, now these specialized dressings are available in the hospital service, so when we need a dressing like that we refer the patient for hospitalization to use these more specialized dressings (ENFR21).

> What we have is silver sulfadiazine and sunflower oil. The patient can afford to buy them, they can't, so we assess. Sometimes we see if they need an antibiotic dressing or something else like that, we refer them for normal cleaning, we do what is within our reach (ENFR5).

A similar situation was mentioned by professionals from urban municipalities, with the exception of nurses from Salvador, who follow the specific municipal protocol for wounds and dressings, and are able to prescribe various dressings and make them available to the population.

> So, if the skin lesions are wounds, including the protocol I use from the municipality, which supports the nurse to make all the prescriptions for the patient with wounds, there are special dressings (ENFU6).

Regarding examinations, professionals from both categories mentioned that they request biochemical tests, obstetric ultrasounds, and X-rays in cases of tuberculosis:

> [...] I can only request a chest x-ray for suspected tuberculosis; endoscopy is a medical request; ultrasound is only requested for obstetric purposes and in relation to any complaint that you want to follow up on; and laboratory tests, we can request all of them (ENFR12).

> I order obstetric ultrasound during prenatal care, chest x-ray if I do the first consultation of a patient who is being admitted for tuberculosis treatment, because it's in the protocol (ENFU4).

Nevertheless, one point that emerged in the statements of nurses from both types of professions, related to autonomy, was the non-acceptance of the nurse's stamp in pharmacies and health services, necessitating the use of another professional, in this case, a doctor.

> The only problem we have with autonomy [...] is that there are manuals and protocols stating what indications you can use. [...] for a pregnant woman, Cephalexin, for example, is standard in the manual, but when you go to a pharmacy, they don't want to dispense it because it's not prescribed by a doctor, even though it's protocol; [...] you prescribe it for a child, everything is correct, the age, weight, and you follow the manual, but they say you can't because it wasn't prescribed by a doctor [...] so it's a contradiction in the system because if we have the training and qualifications to prescribe, and the pharmacy in the municipality itself doesn't release it (ENFU21).

> It ends up being frustrating because the person returns with the prescription, thinking you prescribed it, but you didn't have the authorization to do so (ENFR13).

The fact that this limitation is reported by nurses from different municipalities indicates that the recognition of nursing practices still faces institutional barriers that cut across different contexts of action, not being restricted to territorial specificities.

DISCUSSION

The analysis of the results demonstrated that nurses from rural and urban typologies recognize women's health, related to prenatal care, as the area of greatest professional autonomy in primary health care, which corroborates findings from other studies carried out in Brazil[5,19]. This scenario can be explained, in part, by the historical focus of public health policies on actions aimed at the maternal-infant cycle[19]. Another part is that nurses have normative support, scientific knowledge, technical competence, recognition and consolidation of practice that enables them to carry out low-risk prenatal care in primary health care, including consultations, requests for examinations and educational guidance[12].

In rural municipalities, nurses highlighted the autonomy associated with the management and supervision activities of the team, which demonstrates the nurse's leading role in organizing the work process. This finding is consistent with studies that point to the centrality of managerial functions by nurses in these contexts, often associated with territorial specificities, such as limitations of access, geographical dispersion and a greater need for organization of care flows[15,25]. In this scenario, these working conditions tend to demand the development of managerial skills, sometimes more pronounced than in urban municipalities[26].

On the other hand, among professionals in urban municipalities, there was greater emphasis on autonomy in practices related to wounds and dressings, which is in line with the literature[5,15]. This finding may be associated with working conditions and the greater availability of care resources, such as specialized dressings, when compared to rural municipalities, highlighting how structural factors influence the exercise of autonomy.

Concerning dressings, nurses are responsible for guiding, executing and supervising the nursing team. And to have autonomy, the nurse must possess technical and scientific knowledge, but what directly affects autonomy is the interference of another professional, especially the doctor, and the lack of protocols[27].

In this study, among urban municipalities, only the capital, Salvador, had a municipal protocol for wounds and dressings. The difference in the discourses of professionals from other cities, including rural nurses, was evident, with restrictions regarding wound treatment and the prescription of dressings, which generates consequences for the quality of care for the population and the legitimacy of the profession. The absence or limitation of protocols in some municipalities, including rural ones, restricts the performance of nurses in this field, corroborating studies that point to the direct relationship between the existence of protocols and the expansion of professional autonomy[18,28]. From this perspective, care protocols, in addition to having legal support, act as guiding instruments for practices, contributing to the organization of the work process and to the provision of more effective and safe care[5,10,14].

Based on the statements of nurses from both types of nurses, in most cases, they do not depend on another professional to finalize them and prescribe medications, mainly due to the existence of municipal or Ministry of Health protocols.

However, as can be seen in the statements of some rural nurses, even with the protocol, they still prefer to refer to a doctor for validation, which may be related to professional insecurity, hierarchical relationships and work in health, and lack of technical and institutional support. A similar result was found in the study with primary health care nurses in São Paulo, where even though clinical practice is based on protocols, professionals are not always fully confident in the work they perform[10], revealing a tension between what is standardized and what is experienced in daily life. But it also exposes the need for nurses to appropriate the legislation and the law governing professional practice in order to develop autonomy[19].

Regarding the request for laboratory tests and the prescription of medication, these practices are legally guaranteed to nurses in public health programs in Brazil [12,29]. However, their implementation still faces legal obstacles. Nurses reported difficulties in the acceptance of their prescriptions in pharmacies and requests in health services, requiring a doctor's signature for release. This refusal contradicts the legislation governing professional practice and generates negative consequences such as access for the population and the effectiveness of primary health care, regardless of the municipalities in which they work.

Starting from the principle that autonomy is related to the ability to conduct practice independently, based on their professional knowledge, it was observed that nurses of both types demonstrate a certain degree of autonomy. However, the perception in some areas reveals limitations that still permeate their practice and reduce the potential for autonomy. Thus, although nurses exercise some independence in their actions, autonomy is limited because recognition of the totality of actions in primary health care is fragile. Therefore, the pursuit of consolidating this autonomy must be continuous, based on strengthening the core knowledge of nursing and on the social and institutional recognition of their competencies.

Moreover, it is concerning to observe that, in this study, nurses tend to restrict the notion of autonomy to the care of certain population groups or to the execution of specific procedures, not recognizing it as a principle that guides all dimensions of their work in primary health care. This perspective reveals not only a limited understanding of the concept of professional autonomy, but also reflects the effects of the organization of the work process and professional training, still strongly oriented by a biomedical and prescriptive model, which can restrict the full exercise of nursing practice[19].

Study Limitations

A limitation of the present study concern the data collection period, which took place during the pandemic, with interviews conducted virtually instead of in person, and the inability to conduct non-participant observation of the work, which could have allowed for the collection of more elements to

compose the corpus of analysis.

Contributions for the Nursing Area, Health or Public Policy

This study makes significant contributions by highlighting aspects of nurses' autonomy in primary health care in different municipal contexts, allowing for a broader understanding of how this autonomy is configured in daily practice. Furthermore, it reinforces the importance of developing and implementing municipal protocols that consider the health needs of individuals and the community, in order to strengthen the autonomous, qualified, and effective practice of nurses.

FINAL THOUGHTS

The results of this study show that nurses working in rural and urban municipalities in Bahia perceive their professional autonomy as associated with specific prenatal care, based on care protocols. The difference was in the managerial aspects of the nurse's work, recognized only by professionals from rural municipalities, and in the assessment of wounds and prescription of dressings, highlighted by nurses from urban municipalities. It was also observed that, most of the time, they do not need another professional to complete the care.

The recognition of the nurse's professional autonomy in primary health care is a central and determining aspect for her to perform her practice in a way that strengthens her professional identity, increases the effectiveness of care, and contributes to professional satisfaction. However, having a perception of a specific area, nurses reveal limitations in the full exercise of autonomy in the various duties they perform. For example, the nurses did not mention autonomy to carry out educational and continuing education activities, health surveillance actions, health promotion, and disease prevention. This reveals that the perception of autonomy is linked to the imaginary of the biomedical model, in which the prescription of medications and tests is the benchmark of professional autonomy. Other studies are recommended to deepen the understanding of the autonomy of primary health care nurses in different municipal contexts across the country.

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