Revista de Enfermagem e Atenção à Saúde
REAS
ORIGINAL ARTICLE
DOI: 10.18554/reas.v6i2.2092

SITUATIONS OF PROGRAMMATIC VULNERABILITY EXPERIENCED BY PREGNANT WOMEN DURING PRENATAL CARE

SITUAÇÕES DE VULNERABILIDADE PROGRAMÁTICA VIVENCIADAS POR GESTANTES NO PRÉ-NATAL

SITUACIONES DE VULNERABILIDAD PROGRAMATICA EXPERIMENTADA POR LAS MUJERES EMBARAZADAS EM EL PRENATAL

Anne Jacob de Souza Araújo[1], Jeane Freitas de Oliveira[2], Priscilla Nunes Porto[3]

ABSTRACT

Objective: to identify situations of programmatic vulnerability experienced by pregnant women during prenatal care. **Method:** semi-structure interviews were carried out with eight pregnant women. Data were analysed using Content Analysis technique. **Results:** based on the reports of the pregnant women interviewed, it is inferred they experience significant situations of vulnerability. These women are in an unfavourable socio-economic context. The pregnancy monitoring is done exclusively through the public Brazilian Unified Health System, named Sistema Único de Saúde (SUS), through the Prenatal Care Program actions. However, access to these actions are shown to be incipient, which is evidenced by the reports of wandering to find a public health unit to receive prenatal care. **Conclusion:** the situations of programmatic vulnerability that were identified show weaknesses in the fulfilment of the principles of integrability, regionalisation and humanization of assistance to pregnant women and indicate challenges to the quality of the public health system and the actions developed within the Unified Health System.
Keywords: women's health, pregnancy, health vulnerability, nursing.

RESUMO

Objetivo: identificar situações de vulnerabilidade programática vivenciadas por gestantes no acompanhamento do pré-natal. **Método:** realizaram-se entrevistas semiestruturadas com oito gestantes. Os dados foram analisados segundo a técnica Análise de Conteúdo. **Resultados:** a partir dos relatos das gestantes entrevistadas, depreende-se que essas vivenciam significativas situações de vulnerabilidade. Estão inseridas em um contexto socioeconômico desfavorável. O acompanhamento gestacional realiza-se exclusivamente no Sistema Único de Saúde, mediante de ações do Programa de pré-natal. Entretanto, o acesso a essas ações revela-se incipiente, o que é evidenciado pelos relatos de peregrinação em busca de uma unidade de saúde pública para o acompanhamento do pré-natal. **Conclusão:** as situações de vulnerabilidade programática identificadas revelam fragilidades no atendimento aos princípios de integralidade, regionalização e humanização da assistência a gestantes e apontam desafios para a qualificação da rede pública de saúde e das ações desenvolvidas no Sistema Único de Saúde.
Palavras-chave: saúde da mulher, gravidez, vulnerabilidade em saúde, enfermagem.

[1] Enfermeira. Mestre em enfermagem pela Escola de Enfermagem da UFBA.
[2] Enfermeira. Doutora em Saúde Coletiva, Professora da Universidade Federal da Bahia.
[3] Enfermeira. Doutoranda em Enfermagem na Universidade Federal da Bahia.

RESUMEN
Objetivo: identificar situaciones de vulnerabilidad programática vivenciadas por gestantes en el acompañamiento prenatal. **Métodos:** se realizaron entrevistas semiestructuradas con ocho gestantes. Los datos fueron analizados según la técnica de Análisis de Contenido. **Resultados:** a partir de los relatos de las gestantes entrevistadas, se desprende que ellas vivencian significativas situaciones de vulnerabilidad. Están inseridas en un contexto socio-económico desfavorable. El acompañamiento gestacional se realiza exclusivamente en el Sistema Único de Salud, mediante acciones del Programa de Prenatal. Entretanto, acceso a estas acciones son incipientes, lo que es evidenciado por los relatos de peregrinación en la búsqueda por una unidad de salud pública para el prenatal. **Conclusión:** las situaciones de vulnerabilidad programática identificadas revelan fragilidades en el atendimiento a los principios de integralidad, regionalización y humanización de la asistencia a gestantes y apuntan desafíos para la cualificación de la red pública de salud y de las acciones desarrolladas en el Sistema Único de Salud.
Palabras-chave: salud de la mujer, gravidez, vulnerabilidad en salud, enfermería.

INTRODUCTION

Vulnerability is an indicator of inequity and social inequality. It is an interdisciplinary concept that involves individual aspects and collective conditions that may generate more susceptibility to injuries and death.[1,2] In this context, the analysis of vulnerability involves three interdependent dimensions: individual, programmatic and social.[3]

The programmatic dimension, the one observed in this article, is about the development of institutional actions, which subsidize the social resources people need to not be subject to harm, especially the ones regarding healthcare, education, social and cultural well-being[1].

Regarding the programmatic vulnerability related to women's health, it is acknowledged in the history of public health the need to prioritise actions focused on the female population, especially on the mother-child group, as can be seen through the supply of services and actions intended to reduce the mother-child mortality rate. From this perspective, women's health care in the gestational period is part of the public healthcare policies agenda.

In 2005, in order to meet the objectives of the Política Nacional de Atenção Integral à Saúde da Mulher (PNAISM), a national policy regarding women's health, it was released a technical manual named “Pré-natal e Puerpério: atenção qualificada e humanizada” (Prenatal and Puerperium: qualified and humanised care). [4] The aforementioned manual was formulated with the intention to subsidize the organisation of healthcare network, professional qualification and the standardization of healthcare practices to ensure qualified and humanised care for all women in the country during the prenatal period and puerperium.

To promote the improvement of mother-child care, the Brazilian Ministry of Health proposes measures such as the reduction of the high maternal, perinatal and neonatal morbidity and mortality rates registered in the country; the adoption of measures that ensure the improvement of access, coverage and quality of care; and the expansion of actions aimed at pregnant women in order to expand prenatal care. The implementation of these measures caused the increase of prenatal care appointments attended during pregnancy.[5] Therefore, while in 2003 there were 8.6 million appointments through the public health system, in 2009 that number increased to 19.4 million appointments.[6]

Despite those numbers, it was observed through a cross-sectional study carried out with 1,640 mothers from three towns in the state of Piauí, from July through September 2008, that one in every five pregnant women had received inappropriate prenatal care.[7] In Brazil, attention to low-risk prenatal care, despite having good coverage, needs to be revisited since the norms established by the Programa de Humanização no Pré-natal e Nascimento (PHPN), a program created to ensure the humanisation of prenatal care and childbirth, are not being thoroughly followed due to the delay to get pregnant women to their first appointment and the amount of appointments and complementary exams carried out being insufficient, lower than recommended.[8]

Healthcare professionals are committed to promote actions that ensure safe motherhood.[9] Therefore, a trusting relationship amongst the healthcare staff, the pregnant woman and her family members is necessary in order to allow for situations of vulnerability to be identified and for strategies to be outlined to minimize such situations, strengthening protective factors.[10] Given the context presented, the guiding question of this article is: What are the programmatic vulnerabilities that pregnant women experience during prenatal care? In this sense, the objective in this article is to identify situations of programmatic vulnerability experienced by pregnant women during prenatal care.

METHODOLOGY

The data presented derive from the research “Vulnerabilidade de mulheres envolvidas com álcool e outras drogas” (Vulnerabilities of women involved with alcohol and other drugs), carried out by professors and students linked to the Grupo de Pesquisa Sexualidades, Vulnerabilidades, Drogas e Gênero (SVDG), a research group focused on sexualities, vulnerabilities, drugs and gender, of the College of Nursing of the

Federal University of Bahia (EEUFBA), financed by the National Council for Scientific and Technological Development (CNPq).

It is a descriptive research with a qualitative approach carried out with eight pregnant women registered and cared for at the prenatal program of a public maternity unit in the city of Salvador, in Bahia. The definition of maternity as an empirical field of the research is justified by the fact that it is recognized as a reference in the state public health system in prenatal care, family planning and childbirth care.

The participation of the pregnant women happened through the fulfilment of the inclusion criteria previously established: being registered at the prenatal program of the maternity unit; and being in good physical and mental condition to answer the questions presented in the semi-structured interview script. The exclusion criterion adopted was: pregnant women under the age of 18.

The interviews were scheduled according to availability of the pregnant women and carried out individually in an environment safe from external interferences to ensure the interviewees' privacy, during the period from July through November 2014.

The script of the interview, previously elaborated, addressed issues related to sexual and reproductive health, and focused especially on information about the pregnant woman's social context, and the access to services and prenatal care. The statements were recorded in digital media, which allowed for a reliable record of every information provided by the participants. The information was grouped by similarities of content and organized in thematic categories as recommended in the Content Analysis proposed by Bardin.[11]

The project was evaluated and approved by the Ethics Committee of the EEUFBA (Report No 268,646/2013). In the research, the pregnant women were identified by fictitious names to guarantee their anonymity.

RESULTS AND DISCUSSION

According to the information obtained, it was understood that the pregnant women were in an unfavourable socio-economic context. With regard to age, the predominant group was of subjects between 21 and 35 years of age. Family income was about two minimum wages. With regard to skin colour, five women identified themselves as black and the others self-identified as brown. For six participants, the first pregnancy happened between the ages of 12 and 17 and was named as the main reason for interrupting their studies. Amongst the interviewees,

one was an autonomous artisan, and two were currently employed, one of them was on leave from work.

Regarding access to healthcare, the participants declared they depended exclusively, for pregnancy monitoring, on the service provided by the Brazilian Unified Health System, named Sistema Único de Saúde (SUS), through the Prenatal Care Program.

The pregnant women mentioned difficulties to start prenatal care and carry on with it. That indicates situations of programmatic vulnerabilities and occurs due to the following main reasons: the lack of appointments available in the Family Health Unit, named Unidade de Saúde da Família (USF), located in the geographical area where the pregnant women live, rules for scheduling appointments, constant rescheduling of appointments, deficits in access to immunization and routine prenatal exams, poor communication between professionals and patients, poor access to information about healthcare, and a lack of educational activities.

The lack of appointments available for prenatal care in the USF located in the geographical area where the pregnant women live causes these women to search for care in other units, which delays the start of prenatal care. Fragments of the interviews with the pregnant women confirm those suspicions:

"*I went to other [maternity units], and did not succeed. I went to maternity unit A, to maternity unit B, but could not get an appointment. I could only get an appointment here.*". (Larissa, E5)

"*I started prenatal care when I was already entering the sixth month, because there was a strike and it was hard to do it in the public health centres. I was not being able to get an appointment, but then I got one here. Everybody told me it was better to come to the maternity unit because in here I would get an appointment...*" (Índia, E2)

According to the guidelines of the PHPN, the geographical proximity between the healthcare unit and the pregnant woman's home is a criterion for definition of where to do prenatal care.[5] The coverage of the Family Health Strategy (ESF), in Bahia, in January 2013, was of 2,756 functioning units with estimated coverage for 8,691,232 people, or about 61.65 % of the population. In Salvador, during the same period, there were 110 units with estimated coverage for 379,500 people, or 14.09% of the population.[12]

In the maternity unit where the interviews were carried out, the scheduling of appointments was previously made by telephone. According to the pregnant women's reports, that type of service made access to care more difficult and, consequently, delayed the start of prenatal care. To schedule appointments for

prenatal care, the women needed to make many telephone calls, which resulted in financial cost and demanded availability of time. The following reports are about the scheduling, by telephone, of appointments for starting prenatal care.

"*It only took so long because I called. I called when I was in the fourth month. I was in the fourth month and I could only get an appointment for when I was already in the fifth month.*" (Beatriz, E4)

"*I called, came here, got information, and they told me I had to call... only by telephone, and then I called over and over again and then I got it... Well, it took a while for someone to answer the phone... then in the evening I finally got it.*" (Marlení, E8)

Added to that, there is the frequent rescheduling of appointments previously scheduled by the healthcare unit. The definition of the new appointment date is done by the unit, which implies a delay of prenatal care since the new appointment is usually scheduled to about thirty days after the previous one. The following report is about the rescheduling of appointments.

"I did not call from somewhere else... I called from inside the hospital itself... then I called and scheduled it... then the first appointment... the one that was supposed to be the first appointment, it did not happen because the girl called to cancel it..." (Índia, E2)

The Brazilian Ministry of Health recommends at least six appointments for prenatal care, at least one in the first trimester, two in the second and three in the third one [5] However, the late start of prenatal care alongside the rescheduling may lead to a smaller number of appointments than recommended by the Ministry of Health and, therefore, to situations of vulnerability to mother and foetus. A situation singled out by the pregnant women was the late immunization during the pregnancy, as can be seen in the fragment below:

"*I already got the shot, but my vaccination is late... That is because I started my prenatal late*" (Beatriz, E4)

The immunization of pregnant women with the tetanus, hepatitis B and influenza vaccines is also a standard procedure recommended by the Ministry of Health.[5] That action aims to protect mother and foetus. However, the late start of prenatal care, amongst other factors, may interfere in that condition.

Most of the interviewees reported having started prenatal care in the second trimester of the pregnancy. The delay to start prenatal care was also mentioned in a qualitative cross-sectional research carried out with 211 pregnant women who were interviewed at the prenatal service offered by Amparo Maternal, in São Paulo, from March through August 2000.[13]

In search of prenatal care, the pregnant women interviewed reported wandering to do the routine prenatal exams. The reports also indicate the difficulties to do the exams and the partial receipt of the results. The problem may be observed through the following interview fragments:

"*I already got half of it... the other half she told me I can get in 15 to 20 days... The blood ones were easy... those I did here... but there were some they did not do here... I did in [public hospital of the Unified Health System] And the preventive examination I only managed to get scheduled now... The ultrasound was hard... very hard... The two I did... both were hard... every day I had to go to the clinic in the morning to try to schedule it... a sacrifice...*" (Beatriz, E4)

"*All... all... I already did all of them... right now the doctor told me my exams are all fine. Then she requested other exams... the preventive... she requested the preventive examination and more blood tests... for me to do to check... Now I am going to repeat only a few... blood tests... I tried to do the exams through the Unified Health System... I was not able to... I paid to do it... But not the ultrasound, that I did in the [public hospital of the Unified Health System]. There is one I already scheduled to do here...*" (Maria, E3)

The Ministry of Health has as one of its guidelines the realization of routine laboratory tests at least once during pregnancy.[5] In a historical cohort study carried out from 2008 through 2010 with 95 users of the Unified Health System who did prenatal care in the Family Health Strategy (ESF) in Jardim Cascata, Porto Alegre, it was identified that the amount of exams done by pregnant women who started prenatal care in the first trimester was higher than the amount done by pregnant women who had started prenatal care later.[14] In the current research, even the women who started prenatal care in the first trimester had difficulties to do the exams.

The situations reported reflect the fragility of the primary care network in the city, given the limited population coverage of the Family Health Strategy and, therefore, the population's unmet demand.

To face this problem, the Ministry of Health recently launched and has been implementing the Rede Cegonha program in the entire country. This program is to implement a network of care and ensure women's right to reproductive planning and to humanized attention during pregnancy, childbirth and puerperium.[15]

Besides the situations presented regarding healthcare services, the interviewees mentioned insufficient communication between professional and patient including in the provision of information related to prenatal care. The patients are entitled to information regarding their health condition in order to engage in the decision making..[16] However, misinformation about the supply of vaccines in the prenatal service and the exams requested and their importance in disease prevention for mother and child were reported by the pregnant women:

"*Some, that she repeated here... she said I did not do them... I handed the paper but the woman only gave me half of the exams done... the ultrasound was easy because it is in a private clinic... Only one in the Unified Health System. I went today and could not do it.*". (Isadora, E7)

"*I got one, there is only one left which I was supposed to have gotten in the 19th but I forgot... I am going to get it this week... I did not know they did it here*". (Marlení, E8)

According to the pregnant women, the medical appointment is mostly a technical service and there is no space for revealing personal situations that may have influence in the health of pregnant woman and foetus, such as the use of psychoactive substances..

The pregnant women interviewed disclosed involvement with alcohol and other drugs but stated that such situation was not disclosed to the healthcare professional because the theme did not come up in the questions they were asked in prenatal appointments.

"*I did not talk about (drug use by her brother)... Because, I do not know... she did not ask me... She only wants to do her job and that is it... She does not want to know about my problems... my family issues... that is what I think... I do not know...*" (Patrícia, E1)

Communication in a relationship contributes to the perception of feelings and emotions, and makes interaction easier.[17] Understanding the space occupied by drugs in the family life, especially in the life of the pregnant woman, and subjectively evaluating the impact of the subject/drug relation and stimulating self-care and care of others is necessary to perform actions that minimize harm to both the pregnant woman and foetus.

According to prospects of the Ministry of Health, establishing a trusting relationship amongst pregnant women, family members and healthcare professionals makes it easier to identify situations of individual, social and programmatic vulnerability related to involvement with alcohol and other drugs, making it possible to reduce the repercussions of such situation to pregnancy and childbirth.[10]

Strategies like open listening and open dialogue, without prejudices or judgement, may be used to allow the pregnant women to explain their needs, allowing for the establishment and strengthening of the bond with the healthcare professional.[18]

Regarding knowledge about alcohol and other drugs, in general, the pregnant women interviewed reported not having received any information during prenatal care. One of the women interviewed said she partook in an educational activity about the theme in another unit during an appointment for her son.

"*I was already oriented about (alcohol and other drugs)... At the healthcare unit nearby my house... there was a lecture, I had an appointment with my*

son's pediatrician, so I stayed to watch". (Isadora, E7)

Educational activities should address any problem situation relevant to the population attended. They should be included in standard healthcare practices, being performed by all staff professionals. They should be part of all activities and happen in every meeting between healthcare professional and patient.[19], including in prenatal care, according to the Ministry of Health.[5]

The provision of educational activities during prenatal care may promote the adoption of healthy practices by pregnant women. However, according to the pregnant women's reports, educational activities are not routinely offered in prenatal care. And when it is, there is no active participation from patients. Amongst the participants of this research only one received orientation through an educational activity.

"*No... I only received in social service on the first appointment, and in physiotherapy.*" (Maria, E3).

The PNAISM stressed the importance of educational activities in the area of women's healthcare as a form of empowerment, highlighting the importance of this practice and characterizing it as the distinction between it and other programs. These activities aim to cause a reflection and the adoption of practices for the improvement of the population's living habits, with the intention to contribute to the information women have about their bodies and the appreciation of their life experiences.[19] The incorporation of the educational dimension in the healthcare provided in the units should contemplate this prospect because the knowledge acquired by pregnant women might prevent injuries.

In a qualitative descriptive study carried out in a prenatal care service in the interior of the state of Rio Grande do Sul, from September to October 2010, through home visits to women in the puerperium, in which prenatal care was addressed, it was identified that most of the interviewees did not partake in educational activities.[20] In the present research, the situation is the same, in disagreement with the guidelines of the Ministry of Health.

In addition to the scarcity of educational activities, the pregnant women interviewed reported long waiting times for the appointments and rude approach, especially on the telephone, as shown in the following statements:

"*I think the care is not really good. They do not treat us very well...*" (Maria, E3)

"*I think the staff should treat the patients better... Even on the telephone they are really rude...*" (Beatriz, E4)

"*The care... So-so... Today it was kind of good, there is nobody... last time I came early and left at three in the afternoon*" (Isadora, E7).

Pregnant women expect being welcome when they come to the healthcare unit, and they yearn to be respected and listened to without judgement or prejudice, in a way that a bond is formed and they feel comfortable to talk about their intimacies. It is worth emphasizing that the adherence to prenatal care by pregnant women is directly related to the quality of the care provided by the healthcare professionals.[13]

Another situation pointed out by the pregnant women regarding the service received in the unit concerns the deficiencies in the physical structure, as shown in the fragments below:

"*It needs to be improved, right? Imagine you are pregnant and laying here and a piece of that thing falls on your face... the other room, only Jesus can get to the bottom of it*". (Isadora, E7)

"*I think it needs to get better, there is no place for a person to pee... poop... nothing...*" (Maria, E3)

"*It lacks space and I get stuffy when I am short of breath, and a fan for ventilation would be good too.*" (Beatriz, E4)

The physical structure of the maternity unit in which the research was carried out includes four doctor's offices, a reception room, a support room for employees, and a small waiting room poorly ventilated with insufficient seating for the amount of pregnant women awaiting.

In the qualitative cross-sectional study in which 211 interviews were carried out with pregnant women cared for at the Amparo Maternal, in São Paulo, in 2000, the reports from the interviewees allowed us to stablish that 36% of pregnant women are bothered by or would change things about the facilities in which they are assisted as well as the service, specially of the administrative area.[13]

It is well established, in the literature, the importance of prenatal care in preventing complications during pregnancy and after childbirth. However, the lack of structure in the unit combined with the lack of care, the insufficient number of appointments, the scheduling of appointments, the delay or failure to perform exams, and the lack of communication between professionals and patients imply situations of vulnerability, in a way that these factors may cause frustration and non-adherence of pregnant women to prenatal care.

CONCLUSIONS

The research allowed for the identification of situations of programmatic vulnerability experienced by pregnant women during prenatal care, which are: wandering to find prenatal care, difficulties to schedule appointments and exams, and delayed vaccination. As well as

situations linked to the performance of healthcare professionals, the facilities and structure of the healthcare units, together with the organization and the connection between all of these and the care provided to pregnant woman.

The vulnerabilities identified evidence the precariousness of the service and the non-compliance to the principles of integrability, regionalisation and humanization of care, guidelines of the Unified Health System, which have a direct influence in prenatal care. Prenatal care is the first step to humanised labour and childbirth.

Pregnant women need more than follow-up appointments, they crave humanised care and a service that provides appropriate assistance, that meets their actual needs and expectations.

Even though the data is limited to the number of participants registered at a single healthcare unit in a city in the state of Bahia, the information obtained was enough to identify situations of programmatic vulnerability that indicate serious fragilities in the healthcare network for pregnant women. It is therefore obvious the need to implement actions for management and assistance provision in order to adhere to the guidelines suggested by the Ministry of Health regarding the health of women during pregnancy and puerperium.

REFERENCES

1. Ayres JRCM. Risco, vulnerabilidade e práticas de prevenção e promoção da saúde. In: Campos GWS, Minayo MCS, Akerman M, Drumond Júnior M, Carvalho YM, organizadores. Tratado de Saúde Coletiva. São Paulo: Hucitec, 2006; p. 375-417.

2. Kalichman AO, Ayres JRCM. Integralidade e tecnologias de atenção à saúde: uma narrativa sobre contribuições conceituais à construção do princípio da integralidade no SUS. Cad Saúde Pública. 2016; 32(8): e00183415.

3. Ayres JRCM. O conceito de vulnerabilidade e as práticas de saúde: novas perspectivas e desafios. In: Czeresnia D, Freitas CM, organizadores. Promoção de Saúde: conceitos, reflexões, tendências. Rio de Janeiro: Fiocruz, 2003; p.117-139.

4. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Área Técnica de Saúde da Mulher. Pré-natal e Puerpério: atenção qualificada e humanizada – manual técnico/Ministério da Saúde. Brasília (DF): Ministério da Saúde; 2005.

5. Ministério da Saúde (BR). Secretaria de Políticas de Saúde. Programa de Humanização no Pré-natal e Nascimento (PHPN). Brasília (DF): Ministério da Saúde; 2000.

6. Ministério da Saúde (BR). Saúde da Família terá reforço de US$ 166,9 milhões [Internet]. Brasília (DF): Ministério da Saúde; 2009 [citado 2016 Jan 12]. Disponível em: http://portal.saude.gov.br/portal/aplicacoes/noticias/default.cfm?pg=dspDetalheNoticia&id_area=124&CO_NOTICIA=10524.

7. Dias-da-Costa JS, Cesar JA, Haag CB, Watte G, Vicenzi K, Schaefer R. Inadequação do pré-natal em áreas pobres no Nordeste do Brasil: prevalência e alguns fatores associados. Rev Bras Saúde Matern. Infant. 2013;13 (2): 101-109.

8. Polgliane RBS, Leal MC, Amorim MHC, Zandonade E, Santos Neto ET. Adequação do processo de assistência pré-natal segundo critérios do Programa de Humanização do Pré-natal e Nascimento e da Organização Mundial de Saúde. Ciênc saúde col. 2014; 19(7): 1999-2010.

9. Ministério da Saúde (BR). Secretaria de Atenção a Saúde. Departamento de Ações Programáticas Estratégicas. Gestação de alto risco: manual técnico/Ministério da Saúde. Brasília (DF); 2010.

10. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Atenção ao pré-natal de baixo risco. Brasília (DF); 2012.

11. Bardin L. Análise de conteúdo. São Paulo: Edições 70, 2011. 223p.

12. Ministério da Saúde (BR). Histórico da Cobertura de Saúde da Família. [Internet]. 2013. [citado em 2016 Jan 10]. Disponível em: http://dab.saude.gov.br/dab/historico_cobertura_sf/historico_cobertura_sf_relatorio.php

13. Oliveira VMO. Um lugar no cuidado pré-natal: possibilidades e opções das gestantes [Dissertação]. São Paulo: Universidade de São Paulo - USP; 2001.

14. Hass CN, Teiseira LB, Beghetto MG. Adequabilidade da assistência pré-natal em uma estratégia de saúde da família de Porto Alegre-RS. Rev Gaúcha Enferm. 2013;34(3): 22-30.

15. Ministério da Saúde (BR). Portaria n. 1.459, de 24 de junho de 2011. Institui, no âmbito do Sistema Único de Saúde - SUS, a Rede Cegonha [Internet]. Brasília; 2011 [acesso em 10.12.13]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt1459_24_06_2011.html

16. Leite RAF, Brito ES, Silva LMC, Palha PF, Ventura CAA. Acesso à informação em saúde e cuidado integral: percepção de usuários de um serviço público. Interface. 2014; 18(51): 661-672.

17. Bezerra IMP, Machado MFAS, Duarte AS, Costa EAP, Antão JFL. Comunicação no processo educativo desenvolvido pelos enfermeiros: as tecnologias de saúde em análise. Sau. & Transf. Soc. 2014; 13(5): 42-48.

18. Gonçalves MD, Kowalski ISG, Sá AC. Atenção ao pré-natal de baixo risco: atitude dos enfermeiros da estratégia saúde da família. Rev. Enferm. UERJ. 2016;24(6): e18736.

19. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Política nacional de atenção integral à saúde da mulher: princípios e diretrizes. Brasília (DF): Ministério da Saúde, 2004.

20. Cabral FB, Hirt LM, Sand ICPVD. Atendimento pré-natal na ótica de puérperas: da medicalização à fragmentação do cuidado. Rev Esc Enferm USP. 2013; 47(2): 281-287.

RECEIVED: 11/04/2017
APPROVED: 18/11/2017
PUBLISHED: 12/2017