Federal University of Rio de Janeiro State

Journal of Research Fundamental Care Online

UNIRIO PPgEnfBio PPGENF

ISSN 2175-5361
DOI: 10.9789/2175-5361

RESEARCH

Avaliação da assistência pré-natal na perspectiva da integralidade

Evaluation of prenatal care from the perspective of completeness

Evaluación de la atención prenatal en términos de integralidad

Francisca Jessica Lima dos Santos Costa [1], Joseneide Teixeira Camara [2], Kelly Rodrigues Costa [3], Elaine Cristine Santos Serejo [4], Aliny de Oliveira Pedrosa [5], Amanda Karine Araújo Lima [6]

ABSTRACT

Objective: evaluating prenatal care from the perspective of completeness. **Method:** this is an evaluative study whose purpose is the completeness of prenatal care focusing on the size of the organization of services, where two dimensions were analyzed. Professionals who work directly in prenatal care and health managers participated in the survey. **Results:** dimensions assurance resources and health surveillance model were analyzed and, from the respective notes, it was possible to obtain notes from management which respectively were considered regular notes (1st dimension 7,3, 2nd dimension 5,4, note of the 6,4 management). **Conclusion:** it is inferred for this municipality with respect to prenatal care interventions that are needed in this area to achieve a standard of quality founded on the completeness, municipal management must provide the necessary resources in order to have a more structured assistance. **Descriptors:** Prenatal care, Completeness health, Program evaluation.

RESUMO

Objetivo: avaliar a assistência pré-natal na perspectiva da integralidade. **Método:** trata-se de um estudo avaliativo cujo objeto é a integralidade da assistência pré-natal com foco na dimensão da organização dos serviços, onde foram analisadas duas dimensões. Participaram da pesquisa, profissionais que atuavam diretamente na assistência pré-natal e os gestores de saúde nesse âmbito. **Resultados:** foram analisadas as dimensões garantia de recursos e modelo de vigilância em saúde e a partir das respectivas notas foi possível obter a nota da gestão onde, respectivamente, foram obtidas notas consideradas regulares (1° dimensão 7,3, 2° dimensão 5,4, nota da gestão 6,4). **Conclusão:** infere-se para este município, no que tange a assistência pré-natal, que são necessárias intervenções nesta área; para alcançar um padrão de qualidade pautado na integralidade, a gestão municipal precisa prover os recursos necessários para que se tenha uma assistência mais estruturada. **Descritores:** Assistência pré-natal, Integralidade em saúde, Avaliação de programas.

RESUMEN

Objetivo: evaluar la atención prenatal desde la perspectiva de la integralidad. **Método:** se trata de un estudio de evaluación cuya finalidad es la integridad de la atención prenatal, centrándose en el tamaño de la organización de los servicios, donde se analizaron dos dimensiones. Participaron de la encuesta, los profesionales que trabajan directamente como gestores de la atención y de salud prenatal en esta área. **Resultados:** los recursos de garantía de dimensiones y el modelo de vigilancia de la salud se analizaron y desde las respectivas notas fue posible obtener una nota de gestión que se obtuvieron notas regulares consideradas respectivamente (primera dimensión 7,3, segunda dimensión 5,4 nota de la gestión 6,4). **Conclusión:** se infiere de este municipio, con respecto a las intervenciones de atención prenatal, que se necesitan en esta área para lograr un estándar de calidad basada en la integralidad, la gestión municipal debe proporcionar los recursos necesarios con el fin de tener una ayuda más estructurada. **Descriptores:** Atención prenatal, Salud integral, La evaluación de programas.

1 Graduation Student of Bachelor's Degree in Nursing, University of Maranhão – UEMA, Graduated in Biological Sciences, Postgraduated in Interdisciplinary in Environmental Management and Environmental Education 2 Doctor in Tropical Medicine and Public Health (UFG), Assistant Professor of Nursing and Medicine Courses at the State University of Maranhao (CESC-UEMA)
3 Academic of Nursing, State University of Maranhao - Higher Studies Center of Caxias- CESC 4 Academic of Nursing, State University of Maranhao - Higher Studies Center of Caxias- CESC 5 Academic of Nursing, State University of Maranhao - Higher Studies Center of Caxias- CESC 6 Academic of Nursing, State University of Maranhao - Higher Studies Center of Caxias- CESC

INTRODUCTION

Prenatal and postpartum quality and humanization are critical to maternal and newborn health and for their integrity and qualification it is necessary to build a new look at the health/disease process, to understand the person as a whole (body/mind), and consider the social, economic, cultural and physical in which he lives, to establish a new basis for the relationship of the various subjects involved in the production of health - health professionals, users and managers.[1]

This way so that quality care is guaranteed to women, fetus and neonate, the Ministry of Health (MOH) established in 2000, the Program for Humanization of Prenatal and Birth (PHPN), in which the respect for their rights and the perspective of humanization appear as structuring element.[2] Currently, along with the PNHPN comes the Stork Network to organize and implement a network of care to ensure women the right to reproductive planning and humanized attention to pregnancy, childbirth and the postpartum period, children the right to birth insurance, healthy growth and development.[3]

In this sense, so there is a coordinated prenatal care and in line with the guiding landmarks of the MOH are required to occurring completeness of the shares. So, completeness is defined as an articulated and continuous set of actions and preventive and curative services, individual and collective, required for each case at all system levels of complexity, one of the doctrinal principles of the SUS.[4]

Initially, the principle of completeness was thought of only as a link between the services where the patient was seen in a fragmented way, showing thus a dislocation of health services.[5] Currently, completeness is put as a major challenge in health practices in sphere of technical actions.[6]

Pacheco[7] reports that to achieve an integrated health care system requires that the system guarantees the necessary services for the population in the three levels of care and that these services of different complexity are articulated from the perspective of a network that works in an organized and harmonious manner.

In this context, comprehensive prenatal care is an important protective factor for the mother's health to include preventive routine procedures, curative and health promotion. When properly conducted can work around obstetric problems, prevent damage and ensure healthy births and births,[8] and to happen this there is the need for evaluation of health actions.

The evaluation of the health system is in a powerful guiding tool for managers and professionals of health.[9] Thus, the assessment makes up a research activity aimed at resolving

issues relating to the particular community, through the effectiveness analysis or not of social interventions. This type of activity values the formulation and implementation of the program, considering principally problematic social conditions.[10]

Given the above, this research aims to evaluating the prenatal care from the perspective of Completeness, in order to support professionals and managers to develop strategies and address the existing gaps in the daily practice of health services.

METHOD

It is an evaluative research that aims to analyzing the relevance and the theoretical foundations (strategic analysis), goals (analysis of intervention), productivity, effects (effectiveness analysis) and the yield of an intervention and the context (implementation analysis) in which it is located.[11]

The study was conducted in the city of Caxias - MA, located in the middle region of Maranhao east, north of the state, occupying a total area of 5.312.2 Km^2 and has an estimated population of 155.129 inhabitants.[12]

The city is enabled in full management of the Municipal System, according to the hierarchy of health services, prenatal care is distributed in the three levels of care: primary care, secondary and tertiary. The county is still in the process of implementation of the Stork Network.

The Primary Care (AB) is structured in SF, in 31 municipal health units work 683 professionals and 55 doctors, 55 nurses, 108 nursing technicians and/or nursing assistants, 55 dental surgeons, 53 technicians in oral health and/or auxiliaries in oral health and 357 Community Health Agents, totaling a population coverage of 96% across the county and developing their shares in the recommended groups by NOAS-01/02 and reaffirmed by the National Primary Care Policy.[13]

In secondary attention to women's health there is a Specialty Center for Maternal and Child Care (CEAMI) where medium complexity of shares is tendered. In this center of expertise work in prenatal care 4 obstetricians who have residency in obstetrics and gynecology.

In tertiary care are performed service referenced pregnant women from primary and secondary care. Motherhood carries about 400 births per month, with reference to maternal and neonatal care at high risk for 49 municipalities that are part of the health macro-region.

Participated in the study 27 subjects, 22 nurses of the Family Health Units (USF), a healthcare manager of AB, a medical obstetrician's CEAMI, a manager of CEAMI, an obstetrician nurse motherhood, one obstetrician motherhood and maternity manager, who

agreed to participate in the study by signing the Informed Consent (IC) and answered the questionnaire.

To evaluate the completeness of prenatal care, it was elaborated a logical model based on Pacheco[7] and adapted using the MOH PHPN recommendations (Figures 1, 2). It has therefore developed an instrument for extracting all relevant information for assessing the completeness of prenatal care, resulting six questionnaires for data collection, two for primary care, two for secondary and two tertiary.

For data collection there was conducted prior contact with the participants and the visit scheduled to leave the questionnaire, and fill it performed by the research participant. Data collection occurred during the months of August and September 2014.

Data analysis was performed according to Pacheco assessment model. [7.] There were analyzed two dimensions, nine subdimensions and 17 indicators that are distributed in the questionnaire included questions. In the 1st dimension Resource warranty is up to the city manager to provide the necessary conditions to structure a system of services that logic. In this dimension the following sub-dimensions will be analyzed: Human Resources with respect to the qualification of professionals and are in proper proportion. Infrastructure regards physical support and resources for professionals acting in health surveillance model. Information allows an expanded look and helps in planning activities and aspects related to the public view. Support and regulation are mechanisms favoring an organization of flows at different levels and provide diagnostic support for therapeutic choice of professional and material resources (material inputs).

The 2nd Dimension Model of Health Surveillance aims to guide the work of professionals in the logical completeness and recommends the adoption of some strategies and tools. In this dimension will be analyzed the following sub-dimensions: strategic actions that are activities that enable to define and organize guided services in the care model proposed by health surveillance. Appropriation of reality that includes actions that allow an appropriation of health social context of the community reveal their needs, knowledge of reality also express the points that need to be improved by professionals so that they organize the services according to the care model proposed by the Surveillance health. Longitudinality of this professional approach enables a grasp of the needs and continuity of care offered to the user, fundamental to the health surveillance. Attention is the organization of shares offered for consistent users to strategic actions and to local reality.

Each dimension was scored according to the Pacheco[7], assessment model, where it proposes assigning values according to the following parameters: GOOD when the action got investigated score less than 7,5; The Regular 5,1 and 7,4; and Bad for the smaller notes or equal to 5,0.

To obtain the notes were analyzed questionnaires where the values in percentage were transformed to decimal scale which thus obtained a score from 0 to 10. The issues that the answer to the question was negative corresponded to zero. Data were organized in a frame consisting grades of each sub dimension, size and indicator in this order respectively.

This project was approved by the Research Ethics Committee (CEP) of the Maranhao State University/Center for Advanced Studies Caxias- CESC/UEMA with the opinion number 845.370. The study followed the Resolution 466/12 of the NHC/MOH. To ensure the ethical

aspects provided herein, the research subjects signed the Informed Consent (IC) before answering the questionnaire. The project was submitted for analysis.

RESULTS AND DISCUSSION

Questionnaires were analyzed in two dimensions: Resources Guarantee where this dimension becomes essential part when thinking about organizing services from the perspective of completeness. It is for the city manager to provide the necessary conditions to structure a system of services that logic.[7] Within this dimension analyzed the following sub-dimensions with their respective indicators: Human resources (qualification, coverage), Infrastructure (appropriateness of the physical structure, availability, complexity), Information (update information) and Support and Regulation (Support diagnostic and Regulation), Strategic actions (Planning), appropriation of reality (territory and continuing education), longitudinality (bond and continuity), Warning (Actions promotion and prevention, Interdisciplinary , Home), material resources (material inputs).

In the second dimension Surveillance Model Health says that for completeness be present in the organization of services is necessary to adopt a care model that enables the professional recognition and apprehension of the population's needs under its health responsibility. The health surveillance model is directed toward this goal because conceives health Full Screen from the assumption a comprehensive view of the health-disease. [14] In this dimension analyzed the following sub-dimensions and indicators: Strategic actions (planning) appropriation of reality (territory, permanent education) Actions of promotion and prevention (Interdisciplinary, host) longitudinality (bond continuity).

Dimension 1: Guarantee of Resources (Figure 1)
Subdimension: Human Resources

These factors are crucial, as they allow the construction of models of care focused on completeness. It is important that they are qualified and in proper proportion, expressed in two proposed indicators.[7]

Qualification

According to this indicator for prenatal low risk there were analyzed qualifications of top-level professionals in the FHS who had graduate in public health or family health, and 34 (35%) have is 76 (65%) do not have or are nearing completion.

Regarding the professionals working in high-risk prenatal it was found that in secondary care working doctors residing in gynecology and obstetrics already in tertiary care work nurses specializing in obstetrics and doctors who have residency in obstetrics and gynecology.

Coverage

The care structure for prenatal care in the municipality is made in the AB by 46 teams of Family Health Strategy (FHS) distributed in 31 FHU, totaling population coverage of 68% of FHS and developing their shares in the recommended groups by NOAS-01/02 and reaffirmed by the National Basic Attention Policy[13]. According SIAB data (Warning Information System Basic) it was observed that in 16 (73%) of these units FHT covering the enrolled population, while 6 (27%) of teams is insufficient for the demand of registered families. In 2014 it was registered in 2833 pregnant women seen in the city in FHU making a monthly average of 236 pregnant women.

In the center of maternal and child specialties CEAMI (medium complexity) work four doctors who have residency in obstetrics and gynecology. However, only one doctor works with prenatal care at high risk. Monthly are referenced about 20 pregnant women for prenatal care. The service at CEAMI occurs by scheduling only once a week.

With regard to tertiary care it was observed that monthly are referenced approximately 90 pregnant women for high-risk prenatal care in the maternity ward. Professionals working in the maternity ward are 11 doctors with residency in obstetrics and gynecology and 11 midwives. However only two professionals work directly in prenatal care at high risk, being an obstetrician who is serving a schedule of 20 hours and a nurse specialist in obstetrics/neonatology and maternal and child health with a workshift of 30 hours.

Subdimension: Infrastructure

It is an important aspect to give physical support and resources for professionals to act consonants health surveillance of care model.[7] There are three proposed indicators for the subdimension:

Adequacy of the physical structure

Each MOH's recommendations is that each FHU has a space for educational activities. With regard to this condition 13 (59%) do not have a space for educational activities and 9 (41%) units do.

In the city of the FHU, between one or two teams work into different shifts, because the physical space is not enough structure to work more than two teams concurrently.

Compared to the same CEAMI has specialized center structure with minimum requirements for assistance to pregnant women, but only to scheduled appointment because does not meet any urgency procedure. They do not have a room for conducting health education group, and this type of action is not performed in this health service.

Availability

The city has a maternity ward that works full time to care for pregnant women at any time to occur complications, but does not have enough beds for the demand of births, there are no beds for intensive care units, unit of intensive care and sufficient Kangaroo for users, there is also no adult ICU, if any complications during childbirth the woman is transferred to the general hospital in the city.

Complexity

The complexity is related to reference and counter reference in the city. The municipality has a specialized maternal and child center and a reference to the Maternity prenatal high risk the city. This occurs when referencing in primary care was diagnosed a problem where women need to follow up with more resources. However women continue to be assisted by the FHU team. However the CEAMI and motherhood only perform prenatal monitoring of high risk.

Subdimension: Information

The integrated and updated information allows an expanded look and helps in planning activities and aspects related to the public view.[7] For this sub dimension analyzed two indicators:

Updating of information

About updating and use of the data of the SIAB/SISPRENATAL for planning actions in prenatal care in 13 (59%) units this data is used, as in 9 (41%) units such data are not used. We can see that the SIAB and SISPRENATAL data now incorporated in the E-SUS are used for the planning of actions in most health facilities.

Integration of information

According to managing patient information are available to all professionals in the medical records only, available in three levels; however, this record is not computerized, the only resource used is the pregnant woman's card which is recorded all call the same and in any health facility that the pregnant woman is referenced can present it. And that could lead to some difficulty to access this information in accordance with the need of the professional who will perform the care of pregnant women.

Subdimension: Support and Regulation

Support and Regulatory services are mechanisms favoring an organization of flows at different levels and provide diagnostic support for therapeutic choice of professionals.[7] elected indicators for this sub dimension were:

Diagnostic support

The municipality is supported in the care network to prenatal nine-insured private laboratories and a public laboratory for carrying out the tests recommended by MOH. The ultrassound and other tests are performed in specialized reference center and maternity.

Regulation

According to management there is a central control performed for specialized consultations and the provision of services for exams are for public service/concession or hired by the municipality.

Regarding the mandatory tests for prenatal in 22 FHU exams are offered by the municipal network, however in 9 (41%) units some tests are not received in a timely and among those who were cited below: serology for rubella, toxoplasmosis IgG and IgM, anti-HIV, cytology, HCV, HBV, VDRL.

Maternity exams to prenatal high risk are all offered by the city and all are received in a timely manner, as in CEAMI all examinations are offered; however, there is delay in receiving some tests such as rubella, Anti-HIV and toxoplasmosis.

Subdimension: Material resources

Material inputs

Regarding the units having rapid test for HIV/Syphilis, 22 (100%) reported not having rapid testing, however it was reported that is being implemented in healthcare facilities, the supplementation of iron and folic acid in 16 (73 %) FHU this supplementation and guaranteed to the demand of pregnant women attending monthly. In 6 (27%) FHU demand is not met. Vaccination against tetanus and hepatitis B supply the demand in 17 (77%) FHU, as in 5 (23%) this vaccination is not guaranteed.

In secondary and tertiary care supplementation with iron and folic acid and vaccination is guaranteed and basic medicines and other specialized medications are offered.

Dimension	Subdimension	Indicators	Measures	Measure note	Indicator note	Subdimension note	Dimension note	Management note
GUARANTEE OF RESOURCES	RH	Qualification	Training with a specialty in the area of public health and family health	3,5	6,75	7,6		
			Specialty training or residency in obstetrics secondary and tertiary attention	10				
			Health team for coverage of the	7,0				

		Coverage	population assigned		8,5		7,6	6,4
			Obstetricians for the woman in attention tertiary and secondary	10				
	Infrastructure	Adequacy	Meeting space and educational activity FHU	4,0	2	5,0		
			Meeting space and educational activity in the maternity and CEAMI	0,0				
		Availability	Health units in 3° area	10	3,3			
			Insufficient of obstetric beds (ICU, Kangaroo) ALCOM	0,0				
			ICU to the mother at birth if any complication	0,0				
		Complexity	Reference in prenatal care	10	10			
	Information	Update Information	Upgrade and use the information to perform actions in prenatal care in the FHU	6,0	5,3	7,6		
			CEAMI	0,0				
			Maternity	10				

Figure 1 - Instrument for evaluation of the evaluation results of integral attention focused on the organization of services in prenatal care adapted from Pacheco.[7]

Dimension	Subdimension	Indicators	Measures	Measure note	Indicator note	Subdimension note	Dimension note	Management note
	Continuous information	Integration of the information	Accessible information on all three levels	10,0	10,0			
			Available records at all three levels	10,0				
	Support	Support	Reference to prenatal high risk	10,0	10,0	10,0		
		Regulation	Existence of central regulation	10,0	10,0			
			Quick test assurance at FHU	0,0		7,5		
			Quick test guarantee maternity	10,0				
			Vaccination Assurance FHU	8,0				

	Material resources	Material inputs	Vaccination Assurance in CEAMI	10,0	8,0			
			Vaccination Assurance maternity	10,0				
			Supplementation assurance, iron and folic acid FHU	7,5				
			Supplementation assurance, iron and folic acid in CEAMI	10,0				
			Supplementation assurance, iron and folic acid in the maternity ward	10,0				

Figure 1 cont. - Instrument for evaluation of the evaluation results of integral attention focused on the organization of services in prenatal care adapted from Pacheco.[7]

Note: For issue of value judgment were assigned the following parameters: GOOD when the action got investigated score less than 7.5; Bad for the smaller notes or equal to 5.0 and for other notes, REGULAR.

Dimension 2 Model of Health Surveillance (Figure 2)

Subdimension: Strategical actions

According to Pacheco[7] are activities that enable to define and organize guided services in the care model proposed by health surveillance expressed in the following indicator:

Planning

All teams studied the FHU 22 (100%) perform planning meeting, and in 17 (77%) FHU meetings occur monthly, and 19 (86%) of these FHU nurses are the doctor participate in this meeting. These meetings 17 (77%) units discuss the actions and services in prenatal care.

In secondary care it was reported that there conducting planning meeting to discuss actions related to prenatal care. In the tertiary are planning meetings on prenatal care and all professionals working in this assistance participate in the meeting.

Subdimension: Appropriation of reality

Includes actions that enable a community of social-sanitary context ownership revealing their needs.[7]

Territory

Regarding the map coverage area, 22 (100%) FHU's have; however, in 22 (100%) units the map contains no marker for pregnant women in the area. In 17 (77%) units there is some kind of planning for early identification of pregnant women.

Permanent education

In relation to permanent health education only 8 (36%) units perform this kind of action, in most units this kind of action is not performed 14 (64%). In the center and reference maternity was not identified this type of action.

Subdimension: Longitudinality

There was elected as an expression of the professional approach that enables a grasp of the needs and continuity of care offered to the user, the fundamental surveillance model.[15]

Bond

Compared to 183 professionals working for more than two years in USF's, 80 (44%) have between 2 or more years of bond. 103 (66%) report having less than two years, however there is no established link between the AB and the maternity ward where the pregnant woman will give birth.

Continuity

The services offered in public schools to care for pregnant women are offered within the framework of primary health care and as a reference for prenatal high risk for the continuity and monitoring of pregnant women at the center or in the reference Motherhood.

Subdimension: Attention

It is the organization of shares offered for consistent users to strategic actions and to local reality. It is based on expanded health concept that guides the health surveillance model[7]. There have been proposed three indicators for this sub dimension:

Actions of promotion and prevention

Regarding the frequency with which they are carried out preventive activities (health education) for pregnant women 13 (59%) staff reported monthly, 6 (27%) report not do preventive activities, 2 (9%) at the time of consultation, 1 (4%) weekly. Among the most frequently mentioned issues were: condom delivery, lectures in schools, family planning, CA tracking breast and cervix, immunization tell hepatitis B and tetanus.

Concerning the implementation of media strategies and educational programs related to sexual and reproductive health in 15 (68%) units are performed these actions by family health teams. In 7 (32%) are not carried out this type of action. In secondary care has not been reported there is no type of action that addresses this indicator. Maternity are conducted health education activities in groups or individually at query time, providing answers to the woman or family questions.

Interdisciplinarity

When asked about the development of any project in the community facing pregnant women, 15 (68%) reported no teams in any type of project. At 7 (32%) teams that perform some type of project reported that there is a partnership between USF and the place where

CRAS are developed several actions with pregnant women with the participation of multidisciplinary team. In secondary and tertiary care it has not been reported there this kind of action.

Hosting

Regarding the host in 4 (18%) units and performed throughout the health care team (doctor, nurse, auxiliary and technical), 3 (14%) units by nurses, three (14%) units is performed by nurses and doctor, in 3 (14%) units by nurses and auxiliary, 4 (18%) nursing technician, nurse 2 (9%), Nurse, medical and Auxiliary 1 (4%), nursing assistant 2 (9%).

Regarding the organization of care, 20 (91%) units organized to meet the needs of pregnant women at any time if you need to forward the same is given. In 2 (9%) units the service takes place according to the demand by the scheduled own health care team.

When asked about the care of pregnant women be organized in Stork network logic, ie, the host, access, quality improvement and linkage of the pregnant woman the reference maternity 18 (82%) units perform the service that logic, while 4 (18%) do not realize. In CEAMI host is performed by a nursing technician. Maternity hosting is performed directly by the nurse.

Dimension	Subdimension	Indicators	Measures	Measure note	Indicator note	Subdimension note	Dimension note	Management note
MODEL OF HEALTH SURVEILLANCE	Strategic actions	Planning	Conducting meeting and discussion of prenatal care at FHU	8,0	6,0	6,0		6,5
			Conducting meeting in secondary attention and discussion of prenatal care	0,0				
			Conducting meeting in tertiary attention and discussion of prenatal care	10				
	Appropriation of reality	Appropriation of territory	Map of coverage of the health unit area	9,0	4,5	3,75		

Figure 2 - Instrument for evaluation of the evaluation results of integral attention focused on the organization of services in prenatal care adapted from Pacheco.[7]

Dimension	Subdimension	Indicator	Measures	Measure note	Indicator note	Dimension note	Subdimension note	Management note
SURVEILLANCE HEALTH MODEL		Appropriation of continuous reality	Markers that behold pregnant women of the FHU area	0,0				
		Permanent education	Realization of training activities for the team	3,0	3,0			
	Attention	Promotion actions	Promotion projects preventive activities at USF	4,0	4,6	6,0		

			Promotion projects Preventive activities in CEAMI	0,0				
			Promotion projects Preventive activities in motherhood	10,0				
		Interdisciplinarity	Integrated therapeutic projects	3,5	3,5			
		Hosting	It occurs in the logic Stork network and throughout the period of operation of the three levels of attention	10,0	10,0			
			Multidisciplinary team included the team	10,0				
	Longitudinality	Bond	Nurse and doctor working for more than two years in FHU	4,0	2,0	6,0		
			Obstetrician accompanying the mother in the maternity ward is the same at birth	0,0				
		Continuity	specialized consultations	10	10			

Figure 2 – cont. Instrument for evaluation of the evaluation results of integral attention focused on the organization of services in prenatal care adapted from Pacheco.[7]
Note: To issue the value judgment were assigned the following parameters: GOOD when the action got investigated score less than 7.5; Bad for the smaller notes or equal to 5.0, and for other REGULAR notes.

Qualification

This indicator shows that the training of professionals needs to be consistent in the context of SUS, ie to understand the complexity and comprehensive nature of the health disease process and the actions to be performed, as well as knowledge of the services which it operates. From this perspective the qualification aimed at the area of public health allows professionals to better understand the health-disease process and leverages its actions to organize, plan and evaluate the consonants actions to health surveillance model.[7]

The data presented indicate that the primary care most professionals are generalists and do not have graduate in the fields of public health and family health, however, is condition is not a requirement of BANP. In a study conducted in the city of Cuiaba the results showed that 30% of nurses had no qualification (postgraduate degree in public health and health of the family) to work in SF, and that knowledge about prenatal was built in everyday practice.

As pointed out in another state by Cunha[16] about the skilled care to women in pregnancy and childbirth, where 72% of participants obtained informal education assistance to women in labor situation, and only 28% of nurses were considered qualified, with reference to the principles of the World Health Organization and the International Confederation of Midwives (ICM). The author's findings led to the recommendation of the need for training and standardization of skills in obstetrics as a strategy to improve the performance of professionals who attend women at the stage of gestation at delivery.

It is noteworthy that the qualification is essential for the professionals who assist the search for current scientific knowledge that subsidizes care practice and thereby provide a quality care. Thus, the qualified health professional is one who has been educated and trained to proficiency in the skills needed for the care and monitoring of normal pregnancies and births and immediate postpartum period.[17]

Several international and national bodies have set targets in the quest to make pregnancy and childbirth safer. One of the strategies for achieving this goal is the participation of a qualified professional in the care of women during pregnancy and childbirth.[18]

Coverage

According to the analyzed data, and according to what is recommended by the Ministry of Health where each team must cover between 600 and 1.000 families do not exceed the limit of 4.000 people in the PSF in Caxias city according to the data analyzed only four health units there this coverage to the enrolled population making a total coverage of 96%.

Regarding the tertiary and secondary care was established by the International Confederation of Midwives (ICM) and the International Federation of Gynecology and Obstetrics (FIGO) that for every 5.000 inhabitants there must be a qualified professional to meet the pregnant woman, which equals a qualified professional to assistance to pregnancy and childbirth for every 200 births a year in a developing country, however in some places there is a qualified professional to 15.000 births, with greater shortages in rural areas, due to professional concentrations in cities. Already in developed countries it is viewed a different reality, with a qualified professional to 30-100 live births.[17]

In a study conducted by Viellas[19] show that the coverage of prenatal care in Brazil is almost universal, with high values in all regions of the country and in women of different demographic, social and reproductive characteristics, however, the adequacy of such assistance is still low.

This indicator shows that the number of health professionals relationship and population to be served directly influences the potential for organization of guided services in full. For professionals working in the health surveillance of logic they need to perform a series of actions and activities that require organization and adaptation to the population quality services can be offered. The shortage of human resources may undermine the achievement of certain activities by overload of demand.[20]

Subdimension: Infrastructure

Adequacy of the physical structure

In primary care health facilities should be organized according to the MOH manual: reception/medical records file, wait, administration and management, meeting room and health education, warehouse, office with toilet, office, vaccination room, dressing room/ procedure, mist room, pharmacy (drug storage room), dental unit, escovário, compressor area, sanitary for user health handicapped, bathroom for staff, pantry/kitchen, deposit cleaning materials, reception room and washing and decontamination, sterilization room, utility room (support for sterilization), under solid waste, landfill, room for community health agent.[21]

According to the recommendations by the MOH, it is observed in the structures of health facilities municipality that there is no standard in the model and many of the items listed above most units do not have and that hinders a ruled assistance in full.

In relation to health facilities has space for educational activities was found that in the vast majority there is this space, hindering thus the health education process to this group of the population. The room for activities and essential to work with pregnant women the main issues that should be addressed during pregnancy and the prevention of major diseases during this period, diseases that can affect the woman and the main health problems for the baby and the main forms of prevention this information is essential to remedy the pregnant woman's family and doubt is also the time to realize the socialization of pregnant women so that they have this space to talk about this time of life that is so important. Thus, it was observed that health units are operating without the minimum structure required and without the minimum requirements recommended by MOH.

Health facilities can be seen as an enabling factor for change of practices, because the condition of these spaces influence the organization of services. The health surveillance model calls for activities outside the ambulatory space. The manager must provide adequate health facilities to the performance of the teams.[7]

Availability

According to the data we can see that although the city has a reference maternity it still does not have a suitable structure to meet the need of demand imposed on it every month, as motherhood does not respond only by the municipality of pregnant women.

Pacheco[7] reports that for the services be organized from the perspective of completeness they need to answer the demand of the population at the time she needs. According to Mattos[22] structuring of the services offered by the municipality is often incompatible with the context of social life in which users are located. Management that cares about the completeness should organize activities and services that support the health needs of individuals and available at times when they can access them.

Complexity

The city has three levels of care for prenatal care each acting according to their hierarchical level; the primary care working in prenatal low risk, secondary and tertiary care accounting for the prenatal high risk always obeying the reference and counter reference flow.

This indicator seeks to express the relationship of comprehensiveness with the continuity of care and requires the articulation of actions at different levels of attention to the resolution of the demands of users.[23] The provision of services in other levels must serve all people regardless of age.

Subdimension: Information

Atualização da informação

The data of the SIAB and SISPRENATAL now incorporated into the E-SUS are updated and used to perform actions on prenatal care and this is in accordance with the stork network where to prenatal is qualified, it is essential to system power information and the partial reports are used as input for decision making and improving the work process.

This indicator seeks to reflect the organization's information system, which is an important tool for staff to ensure completeness in the organization of services. The data collected by the teams during their work process generate important information that should be used for planning actions. For this need to be continually updated so that professionals can use them reliably in setting priorities and organizing services.[7]

Integration of information

In the city there are no computerized records, so there is the integration of information at all three levels. The only way the pregnant woman's data is accessed in three levels from the through prenatal booklet, because it is where are noted all procedures performed during the service the same.

A computerized medical record that is not the case in the city of Caxias enable healthcare professionals access to individual information in the biological, psychological and sociocultural enabling a focused approach for completeness.

The availability of information at any point of service enables dialogue between professionals, assists in providing a comprehensive care and also strengthens the continuity and coordination of care.[23]

The entirety should be considered by all professionals regardless of which system the point they are part, so the more specialized levels completeness should not be understood by these professionals only as good against reference, but as a commitment to pay a listen and qualified assistance.[24] By making available the chart, the manager provides tools for professional practice in this perspective.

Subdimension: Support and Regulation

Diagnostic support

Diagnostic support services are essential to ensure comprehensive care, as support for the professional setting of therapy and assist in resolution of treatment.[7]

According to Stork Network since it began prenatal care, pregnant women should perform the tests and have the results in due course, another important aspect based on clinical examination and the results of these routine tests should be evaluated to pregnancy

is high risk, should be guaranteed when the referral and prenatal care at high risk for a specialized service. However, the primary care team should continue to follow this pregnant in order to maintain the bond and can be given comprehensive care to pregnant women and their family.[3]

Regulation

The city offers to carry out all the tests recommended by the Ministry of Health to this there is a central control. The problem on this indicator was the delay in receiving some tests both in basic attention when in secondary care where it comes into conflict with the Stork Network, because once initiated prenatal care, pregnant women should not only make the tests more also have the results in due course. In contrast maternity exams are all made and received in a timely manner.

This is an organizational mechanism to support and integration of services at different levels of care contributing to comprehensive care. Regulation centers serve as the means of organizing the appropriate reference of consultations and specialized tests requests. The regulation centers manage the scheduling and distributed in an equitable and quickly the defendants queries. The existence of central regulation reflects the desire of management to organize and secure the services at different levels of system's attention..[25]

Subdimension: Material resources

Material inputs

According to the Directive: daily supplementation of iron and folic acid in the Ministry of Health pregnant women to daily oral supplementation of iron and folic acid is recommended as part of prenatal care to reduce the risk of low birth weight, maternal anemia and deficiency iron. This guideline provides global, evidence-based recommendations for daily supplementation with iron and folic acid as a public health intervention in order to improve pregnancy outcomes and reduce maternal anemia during pregnancy.[26]

Thus it becomes essential to have secured this supplementation for one to have an uneventful free pregnancy caused by the lack of these supplements, so in order to have integrity in this indicator and necessary that all women who perform prenatal have access to these supplements and that the three levels of care. What we observe in primary care and that some units do not yet have the required amount of supplementation to demand met monthly.

In a study performed by Silva[27]on prenatal primary care in the city of João Pessoa in line with the present study medications and supplements had a high of solving (95%). For tetanus immunization there was high coverage (94.7%) in this study. In tertiary and secondary care this supplementation is guaranteed given that the monthly demand is lower if compared to basic care.

Regarding the recommended vaccines during pregnancy in most health facilities there such a guarantee, in tertiary and secondary care vaccination supplies the monthly demand of pregnant women, but so there is integrity that vaccination would have to meet the monthly demand throughout the network health.

Dimension 2 Model of Health Surveillance (Figure 2)
Subdimension: Strategic actions

Planning

What is observed in the city of Caxias by primary care and tertiary care is that there is concern in conducting planning meetings and that prenatal care is always one criterion discussed in the meeting. In the secondary attention this is not an action that is discussed.
According to Practical Guide to USF in addition to assistance activities developed by the ESF, equally important are planning to: identify, understand and analyze the local reality, and propose actions that interfere in it. In this regard, the fundamental tasks of the USF professionals are as follows: Action Planning, Health Promotion and Surveillance, interdisciplinary teamwork, comprehensive approach to family.[28]

This indicator has been set on the grounds that to answer and solve people's needs we need to discuss, prioritize and understand the causes and consequences of the problems and develop strategies and actions for solving them. Health teams who can hold planning meetings have higher possibilities of organizing services from the perspective of completeness, because this is the right time to discuss the actions, sharing of knowledge and consequent improvement of services.[14]

Subdimension: Appropriation of reality

Territory

The territorial process provides better knowledge of the area of operation and provides data that can be transformed into markers.[7]
In all health facilities surveyed there is a map of coverage of the FHT acting area, but there is a marker that makes it possible to know in advance the pregnant women in the area and so there is the possibility of getting prenatal as early as possible and therefore gain Best results in prenatal care.

According to Trevisan[29] the early identification of pregnant women in prenatal care is an extremely important factor for the health of women and newborns, as it allows early identification of risk pregnancies, as well as the necessary interventions.

According to Stork Network it is necessary for the mother to confirm the pregnancy and get access to prenatal care before completing 12 weeks of gestation: is the early identification of pregnant women. For this to be possible, primary care teams, with the support of the municipal manager must work with women of childbearing age, with special attention to adolescents and youth in reproductive planning and in recognizing the signs of pregnancy. This will enable women to seek health unit and perform rapid pregnancy test, which will confirm the suspicion and ensure the start of Prenatal as early as possible.[3]

Permanent education

Regarding the need for professional development, Lamb of study 30 on the assessment of the skills of doctors and nurses working in the health teams of the Family of northern region of Brazil found that these professionals establish a professional profile of skills where there

are specific educational needs permanent. The authors make it clear that vocational training is poor against the required demand for training, similar to results found in Cuiabá-MT and in the present study.

According to MS, all members of the FHS should support a constant review of knowledge and practices related to its activity. The training of professionals is one of the basic points in a Family Health Unit. It is a process of lifelong learning, focused on clinical performance, epidemiological and health surveillance, each individual and each community of the family as the basis of the new approach that the Health assumes. Thus, the training of health staff should be based on the context of their work process. The permanent health education uses the elements and local problems such as reflection and training tool for overcoming the problems experienced in services.[28]

The permanent education processes in health have as objective the transformation of professional practices and organization of work itself. In this sense lifelong learning is directly related to qualification services turned to reality and enables professionals to organize them in the perspective of completeness.[7]

Subdimension: Longitudinality

Bond

Most professionals working in primary care has less than two years, which at the time still did not favor the creation of links between user and health care professional.

Gil[31] points out that the stimulus to create bonds and bonds of commitment and co-responsibility between the teams, can increase the effectiveness of health activities and the widest participation of the user as an adjunct manager of service delivery.

The bond is related to the time when the health professional working in the same territory which enables its integration with the community providing the longitudinality care. From this perspective the link enables to recognize the subject in addition to the clinical dimension, knowing people's lives and the different factors that can influence their health and thus be able to grasp and respond in an integrated manner for its needs.[32]

Continuity

In the city there is the continuity of care for women in pregnancy and childbirth, for the three levels of care support for this attention.

Faced with the impossibility of resolving needs in primary care level the user must have an answer for their demand in other levels. In this sense the system should provide assistance in an appropriate proportion to the needs of the population served.[7]

According to Neto[33] to prenatal care should cover the entire population of pregnant women, ensuring follow-up and continuity of care, aiming to prevent, identify or correct the fetal maternal complications, and also instruct the pregnant woman as pregnancy, childbirth, postpartum and care of the newborn.

According to Pacheco[7]services need to be offered continuously and this must occur at all levels of care to ensure longitudinality assistance. Thus health services must meet the needs as per your settlement ability.

Subdimension: Attention

Promotion and prevention actions

Rosenthal[34] in a survey conducted on the adequacy of prenatal care in two hospitals in Recife only a small proportion of women reported having participated in educational lectures or have received some individual guidance. The results found by this author disagreed with the research in question. One of the main goals of prenatal care is to conduct educational activities aiming to promote health, which involves low technological cost.

Anversa[9] in his work on the quality of prenatal care process the same reports that less than 20% of pregnant women had some type of educational activity on pregnancy. The author of the above results also disagrees with the findings of this study where most of the health facilities are carried out by teams educational activities.

Thus Anversa[9]reports that prenatal care is a unique and timely to develop educational activities and may be carried out in health facilities, through groups of pregnant women in the waiting room, or individually. This work strategy enables integration professionals and pregnant women, constituting a moment of welcome, listening, relationship, experience sharing, mutual exchanges, strengthen knowledge and answering questions.

Interdisciplinarity

In relation to development projects in teams, most of the units is not done this kind of action and secondary and tertiary care has not been reported there be any such practice, since teamwork is essential to perform a guided practice in full and therefore reflects services that are organized in this perspective.

From the interdisciplinary work looks different professionals contribute to better performance and avoid a reductionist practice. Assis35 for Santos and it is a potential tool to for changes in the work process with the adoption of original practices focused on completeness.

Hosting

The three levels of attention surveyed there is a concern about the care of pregnant women, at all levels there is a professional to receive this pregnant woman and provide skilled care until the time of service.

During prenatal care in the FHU team should be organized to perform host to pregnant women under their care, with qualified listening, especially to teenagers. Every controversy which leads the mother to seek FHU, especially when motivated by any complications, should be valued, welcomed and have the assessed risk and vulnerability considered. It is the host with risk assessment and vulnerability. The host should be adopted as an attitude of professionals to receive, hear and meet a humane way every user who seek health services.[36]

CONCLUSION

According to the results achieved in the following research it appears that for a prenatal care from the perspective of completeness we must observe and comply with the governing Ministry of Health policies for this population group.

Watching the two dimensions that were analyzed in this study yielded the following notes: the dimension guarantee funds obtained score was 7,4 which is considered regular, analyzing the scores of indicators that make up this dimension can perceive that they oscillated between bad, regular and good, thus showing that there is no completeness of shares offered for prenatal care.

Similarly occurs in the second dimension Surveillance Model Health in the grade from the size was 5.4 which is considered bad, observing the notes of the indicators we see once again that there is no standard in some indicators the note and considered good, however in others it is bad, which makes an attention guided in its entirety. Thus note of municipal management was 6.5 which is considered regular.

So what can we conclude for the city of Caxias with regard to prenatal care and that it requires interventions in this area for a standard of quality founded on the completeness, municipal management needs to provide the necessary resources to ensure assistance prenatal structured with a risk-free pregnancy and a healthy child birth.

REFERENCES

1. Brasil. Ministério da Saúde. Secretaria de atenção à saúde. Departamento de Atenção Básica. Política Nacional da Atenção Básica/Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Atenção à Saúde. – Brasília: Ministério da Saúde, 2006.

2. Serruya SJ, Cecatti JG, Lago TG. O Programa de Humanização no Pré- Natal e Nascimento do Ministério da Saúde no Brasil: resultados iniciais. Cad Saude Publica 2004; 20(5):1281-1289.

3. Brasil . Portal da Saúde. Rede Cegonha. Brasília, 2013. Disponível em: <http://portal.saude.gov.br/PORTAL/SAUDE/GESTOR/AREA.CFM?ID_AREA=1816>. Acesso em: 15 OUT. 2014.

4. Brasil. Ministério da Saúde. Gestão municipal de saúde: leis, normas e portarias atuais. Rio de Janeiro: Ministério da Saúde; 2001.

5. Reis CB, Andrade SMO. Representações sociais das enfermeiras sobre a integralidade na assistência à saúde da mulher na rede básica. Ciência & Saúde Coletiva,

6. Schraiber LB. Desafios atuais da integralidade em saúde. Jornal da rede feminista de saúde [on line] 1999 maio; [acessado 2003 Ago 04]; Sergio Arouca – FIOCRUZ / ENSP – Rj, 2010.

7. Pacheco FL, Modelo de Avaliação da Organização dos Serviços na Perspectiva da Integralidade. 2012. 150f. Dissertação (Mestrado em saúde coletiva) - Universidade Federal de Santa Catarina, Florianópolis, 2012.

8. Leal M C. Chamada Neonatal: avaliação da atenção ao pré-natal e aos menores de um ano nas regiões Norte e Nordeste Rio de Janeiro, Escola Nacional de Saúde Pública, 2010.

9. Anversa ETR, Bastos GAN, Nunes LN, Pizzo TSD. Qualidade do processo da assistência pré-natal: unidades básicas de saúde e unidades de Estratégia Saúde da Família em município no Sul do Brasil. Cad. Saúde Pública, Rio de Janeiro, n.28, v4, p.789-800, abr, 2012.

10. Barzelay M. Instituições centrais de auditoria e auditoria de desempenho: uma análise comparativa das estratégias organizacionais na OCDE. Revista do Serviço Público, 53,n. 2, p. 5-35, abr./jun. 2002.

11. Contandriopoulos AP, Champagne F, Denis JL, Pineault R. A avaliação na área da saúde: conceitos e métodos. In: HARTZ, Z.M.A. organizadora. Avaliação em saúde: dos modelos conceituais a práticas d a implantação de programas. Rio de Janeiro: Editora Fiocruz; 1997. p. 29-47.

12.Ibge:Disponívelemhttp://cidades.ibge.gov.br/painel/economia.php?lang=&codmun=210300&search=maranhao|caxias|infograficos:-despesas-e-receitas-orcamentarias-e-pib. Acesso dia 11/10/2013.

13. Caxias. Secretaria Municipal de Saúde. Coordenação do Pacs/ESF. Projeto Municipal de Ampliação do Programa saúde da família. Caxias - MA. SMS, 2014.

14. Oliveira CM, Casanova AO. Vigilância da saúde no espaço de práticas da atenção básica. Ciência e Saúde Coletiva. 2009 Mai/Jun 14 (3); p. 929-36.

15. CUNHA EM; GIOVANELLA L. Longitudinalidade/continuidade do cuidado: identificando dimensões e variáveis para a avaliação da Atenção Primária no contexto do sistema público de saúde brasileiro. Ciência & Saúde Coletiva, Rio de Janeiro, v.16, Supl. 1, p. 1029-1042, 2011.

16. Cunha MA, Mamede MV, Dotto LMG, Mamede FV. Assistência pré-natal: competências essenciais desempenhadas por enfermeiros. Esc. Anna Nery, jan/mar; 13 (1): 145-153, 2009.

17. Who - World Health Organization. Making pregnancy safer: the critical role of the skilled attendant: a joint statement by WHO, ICM and FIGO. Geneva; 2004.

18. MacDonald M, Starrs A. La atención calificada durante el parto: um cuaderno informativo para salvar la vida de lãs mujeres y mejorar la salud de los recén nacidos. New York (USA): Family Care Internacional; 2003.

19. Viellas EF, Domingues RMSM, Dias MAB, Gama SGN, Theme Filha MM, Costa JV, Bastos MH, Leal MC. Assistência pré-natal no Brasil. Cad. Saúde Pública, Rio de Janeiro, 30 Sup:S85-S100, 2014.

20. Connil EM. Avaliação da integralidade: conferindo sentido para os pactos na programação de metas dos sistemas municipais de saúde. Caderno de Saúde Pública. 2004 Set-Out 20(5); p.1417-23.
21. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Manual de estrutura física das unidades básicas de saúde: saúde da família / Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Atenção Básica Brasília: Ministério da Saúde, 2006. 72p. (Série A. Normas e Manuais Técnicos).
22. Mattos R, Araújo. Repensando a organização da rede de serviços de saúde a partir do princípio da integralidade IN: Razões públicas para a integralidade em saúde: o cuidado como valor. Roseni Pinheiro e Ruben Araújo Mattos. Rio de Janeiro: IMS/UERJ:CEPESC:ABRASCO, 2007. Capítulo 22, p.369 – 384.
23. Silva Junior AG, et al. Avaliação de redes de atenção à saúde: contribuições da integralidade In: Pinheiro R, Mattos RA. 1ed organizadores. Gestão em Redes: práticas de avaliação, formação e participação na saúde. Rio de Janeiro: CEPESC, 2006. p.61-90.
24. Cecílio LCO. As necessidades de saúde como conceito estruturante na luta pela integralidade e equidade na atenção em saúde IN: Os sentidos da integralidade na atenção e no cuidado à saúde. Roseni Pinheiro e Rubem Araujo de Mattos (org). Rio de Janeiro: Cepesc/Uerj IMS: Abrasco, 2001. Capítulo 4, p. 113 – 126.
25. Giovanella L. et al. Sistemas municipais de saúde e a diretriz da integralidade da atenção: critérios para avaliação. Saúde em Debate. 2002 Jan-Abr 26 (60); p.37-61
26. Oms. Organização Mundial da Saúde. Diretriz: Suplementação diária de ferro e ácido fólico em gestantes. Genebra: 2013.
27. Silva E P, Lima RT, Ferreira NLS, Costa MJC. Pré-natal na atenção primária do município de João Pessoa-PB: caracterização de serviços e usuárias Rev. Bras. Saúde Matern. Infant, Recife, 13 (1): 29-37 jan. / mar., 2013.
28. Brasil. Ministério da Saúde. Política Nacional de Educação Permanente em Saúde. Brasília: Ministério da Saúde, 2009.
29. Trevisan MR, De Lorenzi DRS, Araújo NM, Ésber K. Perfil da assistência pré-natal entre usuárias do sistema único de saúde em Caxias do Sul. Rev Bras Ginecol Obstet. 2002; 24: 293-9.
30. Cordeiro H, Romano V, Santos EF, Ferrari A, Fernandes E, Pereira TR, Pereira ATS. Avaliação de competências de médicos e enfermeiros das equipes de Saúde da Família da Região Norte do Brasil. Phyisis 2009; 19 (3):695-710.
31. Gil, CRR. Avaliação em saúde. Revista Olho Mágico, Londrina, v. 5, n. 19, 1999. Disponível em:http://www.ccs.uel.br/olhomagico/N19/especial.htm. Acesso em: 12 Mar. 2013. GIOVANELLA, L (Org). Políticas.
32. Gerhardt T E, Riquinho D L, Rocha L, Pinto J M, Rodrigues FE, Determinantes sociais e práticas avaliativas de integralidade em saúde: pensando a situação de adoecimento crônico em um contexto rural. In: Roseni Pinheiro; Paulo Henrique Martins. (Org.). Avaliação em Saúde na perspectiva do usuário: Abordagem multicêntrica. 1 ed. Rio de Janeiro: Cepesc-Ims/Uerj - Editora Ufpe - Abrasco, 2009, v. 1, p. 287-298.
33. Neto, F RGX, Leite JLZ, Fuly PSC, Cunha KO, Clemente AS, Dias MAS, Pontes, MAC. Qualidade da atenção ao pré-natal na Estratégia Saúde da Família em Sobral, Ceará. Rev Bras Enferm. v. 61, n. 5, p.595-602. 2008.

34. Rosenthal HC. Influência da assistência pré-natal sobre os resultados perinatais e maternos na Maternidade da Encruzilhada [dissertação mestrado]. Recife: Faculdade de Ciências Médicas da Universidade de Pernambuco; 2000.
35. Santos AM, Assis MMA. Da fragmentação à integralidade: construindo e (des) construindo a prática de saúde bucal no Programa de Saúde da Família (PSF) de Alagoinhas, BA. Ciência e Saúde Coletiva, Rio de Janeiro, v.11, n.1, p.53-61, jan/mar 2006
36. Brasil. Ministério da Saúde. Acolhimento à demanda espontânea. Brasília: Ministério da Saúde, 2011.

Received on: 01/06/2015
Required for review: No
Approved on: 08/01/2016
Published on: 03/04/2016

Contact of the corresponding author:
Francisca Jessica Lima dos Santos Costa
Endereço: Cidade Universitária Paulo VI, s/n - Tiririca, São Luís - MA, 65055-000. Telefone: (98) 3244-0915