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Pregnant-puerperal care in Network: the experience of nurses, doctors and administrators

Cuidado gravídico-puerperal em Rede: o vivido de enfermeiros, médicos e gestores

Cuidado gravídico-puerperal en Red: el vivido de enfermeros, médicos y gestores

Renata Andrade Teixeira[I]
ORCID: 0000-0002-2438-2520

Rosângela Aparecida Pimenta Ferrari[I]
ORCID: 0000-0003-0157-7461

Sebastião Caldeira[II]
ORCID: 0000-0003-2827-1833

Mauren Teresa Grubisich Mendes Tacla[I]
ORCID: 0000-0001-8928-3366

Adriana Valongo Zani[I]
ORCID: 0000-0002-6656-8155

[I] *Universidade Estadual de Londrina. Londrina, Paraná, Brazil.*
[II] *Universidade Estadual do Oeste do Paraná. Cascavel, Paraná, Brazil.*

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Corresponding Author:
Rosângela Aparecida Pimenta Ferrari
E-mail: ropimentaferrari@uel.br

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ABSTRACT

Objective: Understand the experience of nurses, doctors and administrators of pregnancy-puerperal cycle care to women in the Rede Mãe Paranaense (Freely translated as Paranaense Mother Network). **Method:** Qualitative research according to social phenomena with 44 professionals from 10 municipalities of the Regional of Health, in Paraná State, Brazil. The testimonies were recorded until converge and were analyzed following the steps established from the background. **Results:** It was understood a content of meaning experienced among different professional classes. The "motives why" in which the Network was a reasoned proposal to improve the mother care quality, although there is disarticulation in the planning and application. The expectation for "motives for" proved fragility and challenges to reach the goals and aims of the Network in the Primary Health Care practice. **Final Considerations:** The Network reorganization was carried out, but there are gaps in the reference and counter-reference system, especially for the pregnancy and high risky childbirth and puerperal cycle.
Descriptors: Women's Health; Health Programs and Projects Assessment; Prenatal Care; Health Personnel; Primary Health Care.

RESUMO

Objetivo: Compreender a vivência de enfermeiros, médicos e gestores no cuidado à mulher no ciclo gravídico-puerperal na Rede Mãe Paranaense. **Método:** Pesquisa qualitativa à luz da Fenomenologia Social com 44 profissionais de 10 municípios de Regional de Saúde, no Paraná, Brasil. Os depoimentos foram gravados até alcançar a convergência e analisados cumprindo os passos estabelecidos do referencial. **Resultados:** Apreendeu-se um contexto de significados vivenciados entre as diferentes classes profissionais. Os "motivos por que" em que a Rede veio como uma proposta fundamentada para melhorar a qualidade do cuidado materno, embora haja desarticulação no planejamento e implementação. A expectativa dos "motivos para" evidenciou fragilidades e desafios para o alcance dos objetivos e metas da Rede no serviço de Atenção Primária à Saúde. **Considerações finais:** A reestruturação da Rede ocorreu, mas ainda há lacunas no sistema de referência e contrarreferência, em especial para a gestação e o parto de alto risco e seguimento puerperal.
Descritores: Saúde da Mulher; Avaliação de Programas e Projetos de Saúde; Cuidado Pré-Natal; Pessoal de Saúde; Atenção Primária à Saúde.

RESUMEN

Objetivo: Comprender la vivencia de enfermeros, médicos y gestores en el cuidado para la mujer en el ciclo gravídico-puerperal en la Red Madre del estado Paraná (*Rede Mãe Paranaense*). **Método:** Investigación cualitativa bajo la luz de la Fenomenología Social con 44 profesionales de 10 municipios de Regional de Salud, Paraná, Brasil. Los testimonios fueron grabados hasta alcanzar la convergencia y analizados cumpliendo los pasos establecidos del referencial. **Resultados:** Se captó un contexto de significados vivenciados entre las diferentes clases profesionales. Los "motivos por qué" en que la Red vino como una propuesta fundamentada para mejorar la calidad del cuidado materno, aunque haya desarticulación en la planificación e implementación. La expectativa de los "motivos para" evidenció fragilidades y desafíos para el logro de los objetivos y metas de la Red en el servicio de Atención Primaria en Salud. **Consideraciones finales:** La reestructuración de la red ocurrió, pero todavía hay lagunas en el sistema de referencia y contrarreferencia, en especial para la gestación y parto de alto riesgo y seguimiento puerperal.
Descriptores: Salud de la Mujer; Evaluación de Programas y Proyectos de Salud; Atención Prenatal; Personal de Salud; Atención Primaria de Salud.

INTRODUCTION

The most recent proposal of the Health Ministry toward to strengthen maternal and child care was the Rede Cegonha (freely translated as Stork Network), established in 2011 in Brazilian States and, in 2012, in Paraná its implementation was by mean of the Paranaense Mother Network[1].

In addition to unquestionable importance of Network's institutionalization in the country, it is necessary to consider that the Health System is very complex, the relation between health problems and interventions susceptible to solve them are constantly surrounded by uncertainties and rules to economical allocations of resources that does not apply. So, the assessment is one of the best mechanism to meet the administrators and professionals' needs for information that put it in place and need to justify their choices to a public more and more strict[2].

Assessment of maternal health care programs has been done with the main concern of increasing availability and access. However, there are few studies about the implementation, especially, in the perspective of Primary Health Care professionals. In this context, this study aimed to understand the experience of nurses, doctors and administrators of pregnancy-puerperal cycle care to women in the Paranaense Mother Network.

The choice to work together with these professionals was due the understanding that what each one has experienced is directly related to the programs, care, assistance, management, planning and assessment in health. Also, because internal and external assessment of the actions and programs are limited and, for some authors, the tools to evaluate the effectiveness of the processes of the Primary Health Care are rare[3].

OBJECTIVE

Understand the experience of nurses, doctors and administrators of pregnancy-puerperal cycle care to women in the Paranaense Mother Network.

METHOD

Ethical aspects

The study met the ethical and legal issues bound to research with human beings. By looking at a multicenter study, it was requested authorization from the State Health Office and the Regional Health Management. After being approved by the Research Ethics Committee of the Universidade Estadual do Oeste do Paraná, telephone contacts with the nurses, doctors and municipal administrators were started to schedule the interview according to the availability of each one. Before the interviews, all the participants were read and signed an informed consent form. The meeting took place at the Health Unit, privately and reserved.

Type of Study

It is a research with qualitative approach based on the theoretical-methodological background of the Social Phenomenology of Alfred Schütz[4].

Theoretical-methodological background

Social Phenomenology is defined as an interactive process that, when experienced by two or more people, has meaning for the individuals involved in this social action. Thus, administrators or secretary of health, nurses and doctors have own interests and that led them toward care actions in health sectors[4-6]. However, the health actions of these professionals demand technical competence, attitude, empathy, respect, commitment, consideration and expectations about their actions, which just become possible from the knowledge background available by each of them[5].

It is theoretical and/or methodological background of research that aim to understand the human view based on their whole experience, as well as the form in the world and in its complete life, by means of description of its experience and the meanings given to it. In Nursing, it is considered the individual that experiences certain phenomenon, allowing the researcher to understand its real meaning[7].

The Social Phenomenology of Alfred Schütz, also called Phenomenological Sociology or Understanding Sociology, make use of concepts as life world, intersubjectivity, knowledge collection, biographical situation, mutual perspective, social action and typification[5,8].

From the professionals' practice experience in the health care, they acquire experiences that constitute the typification of their specific professional social group – that what is typical[4]. The everyday world is presented in the typifications, it means, in the representations created by the own social actors according to their relevance, which includes the universe and the stable, the specific and the mutable. Thus, the social actor typifies the world to be able to understand it and to communicate with its fellow creature[4]. Typicity allows the understanding among people in social interaction, and it becomes stable to the point of led them to recognize the characteristics of certain action as social roles[9-10].

Human actions can be understood through subjects' motivation, in which the individual perform by means of existential motives handed down from our predecessors and is realized by utter actions, basis of communication a social relationship driven by the "motives why" and "motives for", to interpret the behavior of the man in the social world[4,7]. The social action is understood as a conduct directed to a specific purpose and, this action, the "motives why" are the reasons based on previous experiences, related to done actions and inherited knowledge background[4-5,10]. The "motives for" guide future action (anticipated action, imagined, subjective meaning of action), which is a category basically subjective, because it still didn't happen[4-5,10]. This category is just revealed to the researcher when the respondent is asked about the meaning he/she gives to a certain action.

Methodological procedure

Study Scenario

Study carried out among acting professionals in the Primary Health care of 10 municipalities of a Regional of Health of Paraná State, consisted of 21 municipalities and 884,039 inhabitants.

The municipality of the Regional of Health were selected based on the size (small, medium and large), the interest of administrators

of health and the availability of the three social groups (nurses, doctors and health Secretary) from the same city to understand the implementation experience of the Network in different professional classes and way of acting in the Primary Health Care.

Data source

Data was collected by means of the technique of semi-structured individual technique among 44 professionals, consisting of 12 nurses, 22 doctors (10 pediatrician, 7 gynecologist and 5 general practitioner) and 10 administrators. Testimonies were given between October of 2014 and February of 2015.

Collection and organization of data

The guiding questions to the semi-structured interview among professionals were created based on the matrix of the Guideline of the Paranaense Mother Network to answer to the following issues: What is the knowledge/understanding about the Network?; Was there training of professionals?; How is prenatal care in the municipality?; How is the linkage of pregnant women to secondary and tertiary care?; Has the Network's objectives been met?; What do you expect for the service, for the professionals themselves and for the pregnant women with the Network establishment?

The testimonies were recorded in audio and closed when there was convergence of the "motives why" and "motives for", being the kind of experience in the health care of the woman from the perspective of the professionals[4]. Interviews with nurses, doctors and administrators totaled 197 minutes of recording and were transcribed *ipsis litteris*. For identification, the professional class, Arabic number and interview order were considered: nurses "E"nº; doctors «M"nº (Mnº-Ped, pediatrician; Mnº-GO, gynecologist; Mnº-CG, general practitioner) and «G"nº administrators.

Data analysis

For the organization and analysis of the qualitative material the following steps have been followed[5-6]: 1°- attentive and careful reading of each testimony in full to understand the global meaning of social action; 2°- re-reading of each testimony to identify common aspects expressing the contents related to "motives for" and "motives for"; 3°- grouping of common aspects according to the convergence of contents for the composition of concrete categories; 4°- analysis of categories for understanding social action; 5°- built of the king of experience from the set of "motives why" and "motives for" expressed in the analysis of categories; 6°- discussion of the kind of experience in the light of the Social Phenomenology and other references in the subject.

From the analysis, two thematic units emerged, the first one, "Experiencing the reality of the Paranaense Mother Network (motives why)", which resulted in two subcategories, "Planning and implementation: (des)articulation of woman care" and "Woman care during prenatal, childbirth and puerperium after the Paranaense Mother Network" The second unit, "What to expect from the Paranaense Mother Network (motives for)", regarding the "Achievement of goals and aims: fragilities and challenges for the woman care".

RESULTS

The biographical characteristics of the professionals included age between 25 and 65 years and working time in the primary care from five to twenty years. The training of the administrators was diversified with practicing in Nursing (nurse and nurse technician), geography and accounting.

The testimonies resulted in a context of meanings, experienced by the professionals from different professional classes in their daily life and showed, from a complex structural and care plot, the "motives why" and the expectations of the "motives for" regarding the implementation of the Network in the Primary Health Care service.

Experiencing the reality of the Paranaense Mother Network (motives why)

Planning and implementation: (des)articulation of woman care

Among the "motives why", the concrete experience of professionals was perceived, although they considered that the planning and implementation of the Network in the municipalities had been came apart, the purpose was to reorganize the services offered in prenatal and childbirth, especially in small municipalities that do not have gynecologists and obstetricians, as well as to reduce the rates of caesarean section and maternal death.

> [...] *there is no obstetrician, no anesthetist in small hospitals, so the childbirths were performed by the general practitioner!* [...] *sometimes the childbirths went from normal to Cesarean section and had run after another doctor and assist who was on call, now is safety for the mother and the baby. The childbirth is humanized*. (G10)

> [...] *I am a general practitioner and this program gives support, especially in the countryside.* [...] *it makes us to act in rearwards, when I am conducting a prenatal I observe that has the risks: the common, the intermediate and the high risk*. (M10-CG)

> [...] *there was a very large concern about three things* [...]. *First, maternal death, second, problem with the fetus, and third, high level of Cesarean section in the whole country*. (M16-GO)

For the implementation of the Network in the municipalities, not all professionals participated in meetings or training workshops, mainly doctors, so that the assistance in the units was maintained, and the little that they knew about the Network was individual.

> [...] *it had. The first meeting was the Health Secretary, the doctor, me and an ACS*. [...] *it involved everybody*. (E10)

> [...] *I participated but was related to maternity and it is a childbirth improvement course. I was learning by my own* [...] *the test of the "mommy"* [...] *I didn't have this flow, so I didn't know what to do* [...]. *One month earlier it came to me a copy of the flow, what I was supposed to do, they gave me and said: "Read! Work it out for yourself"* [...]. (M14-GO)

> [...] *I was invited, didn't participated they prefer that we follow the schedule because there is full up*[...]. (M22-GO)

In the implementation of the Network there was also a re-adaptation of the pregnant woman's health card, but there was rejection of the professionals due to lack of functionality, difficult handling and data duplication, discouraging registration.

> [...] *we made another card for the municipality, we were able to discuss in the committee of infant mortality and with other places of assistance, including in private (G1);* [...] *she is very extensive, repetitive* [...]. (E6)

> [...] *mix urine test with blood test, the other card was more practical, it used to fit in any female purse. This one is a book, despite the beautiful bag*. (M19-GO)

> [...] *awful! Whoever created it is because never did prenatal*[...]. (M22-GO)

The laboratory tests in prenatal by the Network, when not available in the origin municipalities, are forwarded to other cities and, when they do, there is a delay to release the results. Not everyone performs quick tests because of infrastructure problems or due to lack of resources and another stop requesting them.

> [...] *got to be waiting about three months* [...]. (G7)

> [...] *syphilis test? Perform it before the childbirth, it is according to medical conduct* [...] *are performed in the hospital [quick tests], the units don't perform it.* (E6)

> [...] *hemoglobin electrophoresis? It's routine, it's has no value! At my office, I don't request* [...] *toxoplasmosis I wouldn't request three times during pregnancy* [...] *HIV if the patient is married, has HIV negative from the beginning of pregnancy, I will request three times during pregnancy? I see no reason to perform the quick test for HIV* [...] *three tests are too much* [...] *Glycemia in the third trimester doesn't need, GTT I request between twenty four and twenty eight weeks* [...]. (M17-GO)

The risk stratification proposed by the Network introduce the intermediary risk, but some professionals state that women don't understand this criterion. Doctors and nurses are adapting to this new classification and engaging in conducts according to the risk.

> [...] *who lives in the countryside already is an intermediary risk, we internally classify because we don't consider that all be intermediary risk but those aged more than 40 years, very needy* [...]. (E7)

> [...] *it was well defined, now we know how to classify, forward properly* [...] *to explain to them is a little bit complicated, black pregnant woman has automatically.* (E10)

> [...] *it is intermediary risk because includes somethings, like age, what we can handle here* [...]. (M13-CG)

Woman care during prenatal, childbirth and puerperium after the Paranaense Mother Network

The start points to classify prenatal care is the early collection to start the appointments and the registering is SISPRENATAL as the quick tests results are obtained, causing integration among professionals of the health team.

> [...] *the community agent that goes in the home, approach the pregnant woman in the street, knows her region and brings her to the Basic Unit in Health.* [...] *they spontaneously seek it and perform the quick test of pregnancy.* (E1)

> [...] *they* (ACS) *do active search, don't wait the pregnant woman to visit the Basic Units* [...]. *Also, the assistant does active search in the appointment, the nurse* [...]. (E4)

> [...] *follow-up in the notebook, take note to identify who didn't attend to prenatal and do active search with the Community Agents.* (M13-CG)

Prenatal care present different realities in the studied municipalities. In some municipalities, the nurse performs the first visit registering in the system, requesting tests and prescribing medication. The next visit is performed by the doctor.

> [...] *the first visit is with the nurse, do anamnesis, filling up this form and card. The pregnant woman goes with "Teste da Mãezinha"* [Freely translated as "Mommy Test"], *the first ultrasonography, the nurse prescribes at least folic acid until the next visit with the general practitioner bringing all the test results, monthly follow-up up to 27 weeks, then biweekly and weekly, average of eight to ten visits, all with the doctor* [...]. (G6)

> [...] *here the prenatal is carried out by the nurse, it is a cruelty! Our gynecologists like to do it, we just open the prenatal* [...]. (E5)

> [...] *opening of SISPRENATAL with the nurse, before pass with me, she conducts all the interview, risk identification, request the initial tests and the first ultrasonography.* [...] *here is all with me* [the visits] *it is a thing that didn't use to happen, and I prioritized, after 37 weeks the return visit is weekly* [...]. (M14-GO)

Regarding to pregnancy stratification some professionals report that it is performed in all visits both by the doctor and the nurse and, the visits, happen according to risk identification, with medical record registration and partially in the pregnant card.

> [...] *who performs stratification is the nurse in the first visit, after the doctor* [...]. (G6)

> [...] *I do in the first visit and the risk can change in the second visit, I always register in the medical record and the card. The doctor usually takes note if there is any risk, because she needs to know where the baby will born, then I change the name of maternity, the phone number* [...]. (E5)

> [...] *we do it by visit, the risk of each one, because the high-risk ones are not assisted here* [...]. (M13)

> [...] *in every visit, in the first I already have an overview, I take note in the card. When it comes from nursing, they add everything into the medical record* [...]. (M14-GO)

The high risk pregnant must be assisted in a specialized outpatient car, but not always the municipality obtain vacancy to forward. On the other hand, when there is attendance it is not done counter-reference leading to duplication of tests and conducts due to lack of communication and register in the pregnant card.

> [...] *for high risk we are facing difficulties, the number of visits is still insufficient, those with higher risk can get it even in the week or two to three months.* (G1)

> [...] *We sent the reference and the counter-reference didn't come, who brought was the own pregnant to the doctor, now it will be needing to do the pregnant release, post-release and all follow-up, has this document and the pregnant will take the reference to the Hospital das Clínicas and come back with the counter-reference.* (G5)

> [...] *the pregnant end up doing the tests twice, with no access! They don't even register in the card* [...]. (E10)

> [...] *counter-reference? It takes a lot by intern hand, resident still take notes, intern don't, I see she is well educated I trust her, but there is those that are not, if scape something I ask and do.* (M14-GO)

The entailment of pregnant women to high risk childbirth assistance, according to Network's proposal does not happen, because there is no vacancy to prompt routing to the reference hospital, making the waiting time longer than it should be.

> [...] *high risk pregnant keep kind of lost, she must request a doctor's letter to know where she will give birth, not always the University Hospital (UH) take.* (E10)

> [...] *a great difficult of the Network was to centralize a lot the childbirth in Network* [...]. (M7-Ped)

> [...] *just came to the hospital here, so it draws back, even calling the SAMU* [Mobile Emergency Care Service]*, she is being a high-risk patient, I can't get the ambulance and take her*[...]. (M22-GO)

After the childbirth, the assistance for the puerperium follow-up, in some municipalities, is immediate through the interlocution between the services; but in others, the hospital takes over. There is also just visits by spontaneous search of the puerperal women.

> [...] *the Regional that made it possible, the hospital already types in who are born and the employee call to the units every day that gets the email.* [...] *the puerperal return is scheduled at the beginning and one to forty days.* (G2)

> [...] *The maternity that conduct the visits of puerperium review that we used to do in the unit, inserts IUD and prescribes contraceptive, it didn't exist before, it changed after the Network and the puerperal visit we can't do, but it's the residents who has gone and assisted.* (E1)

> [...] *they just seek when has any pain or episiotomy or caesarian section* [...]. (E5)

What to expect for the Paranaense Mother Network (motives for)

Fragility and challenges

It was understood that there is fragility and challenges for the goals and aims to be reached to improve the women's care in the municipality. In this point for the professionals, was made slow progress and not all administrators joined the Network, what made the work difficult. It is also difficult to identify the high-risk pregnancy for the childbirth.

> [...] *we reached a point that, to improve the levels, or we improve a lot our actions in Health or it is the situation of the population that must improve* [...]. (G1)

> [...] *there is still a lot of things to be solved, but I think the major goal has been reached and the routing of the high risk pregnant at the childbirth moment is complicated.* (E10)

> [...] *it is entitled to the administrators to establish what the Network calls for, if it demands the test it must be introduced, now if it is not established, it is not the Network's fault, it is the administrator's fault* [...]. (M19-GO)

The studied individuals state that the Rede was established with no evaluation of the process' limitations and work conditions in the primary care–that is complex and do not assist only pregnant –, because there is a lack of physical resources, basic material, protocols and actions resolution. On the other hand, the administrators have been investing more in medical specialties.

> [...] *it needs to have a protocol from Paraná based on the guideline, but it was not finished due to change of administrators, so I gave up on waiting for the State we are adapting ours.* (G1)

> [...] *we don't just assist women, there is a high complexity here in the unit, we can't have resolution because there is still a lack of physical structure, material a human resource. We try to improve but has never the support that we need to have. The major focus of the administration is on urgency and emergency, it is the specialty and the primary care that remains the same* [...]. (E11)

> [...] *the main is human resource because I am subdivided in other units. if I had just one unit, even the flow was so intense, I could have a group of pregnant once a month, have a better follow-up, don't take so long to return* [...]. (M14-GO)

Although the primary care focus on health prevention and promotion, some professionals want to ensure the puerperal return in the hospital range and with specialists, as in the private sector. For others, the expectation is that the prenatal do not be exclusive to the nurse, but there is a lack of doctors and cannot obtain a specialized routing.

> [...] *the mother should have at least one more assessment by the obstetrician* [...] *in the maternity where the childbirth was performed because not every private, every health plan has its return, one week, from seven to ten days must remove the stitches, an evaluation and we don't have.* (G10)

> [...] *the nurse take control by himself of almost 100% of the prenatal, it cannot happen, must take advantage of the doctor even if it was the general practitioner to do the low risk prenatal.* [...] *must intercalate one appointment of the nurse and one of the doctors.* [...] *even use the people of the high risk municipal outpatient care.* [...] *unlikely to happen, but would be valid* (E1)

The SISPRENATAL must be improved, aiming to make it useful to write trustful reports, as well as to plan health actions, because

there are still some obstacles that make the everyday work difficult and affects the quality of care. There was also the creation of intermediary risk in the Network that is not in the system.

> [...] *the system could propose active search, provide a list of people without las month attendance, a list of pending tests.* [...] *the Network doesn't take body mass index into account, overweight, as a risk factor, but the Stork Network does. Black pregnant women are intermediary risk, he imports from SUS card the race, but he doesn't consider as a risk, this is something specific from Paraná State. The indigenous women, he will consider as intermediary risk, when insert the risk gives the alert "follow the protocol" and doesn't give the protocol.* (G1)

However, the Network's actions for the professionals has had mobilized some changes in women's health care, still to be effective as policy for advance e qualification in the public system and the compliance with the Guideline goals, the permanent education of the team must be merged to the municipality's planning, as well as human resource investments to decrease the work's overweight.

> [...] *keep a permanent education, continued in the municipalities a little bit smaller, that has no permanent and continued permanent education, it is more complicated than the other places* [...]. (G4)

> [...] *there is a lack of a lot of things that are still on paper, sometimes the reality ends up changing a little, many doctors don't like to comply with the Guideline* [...] *have our workshop, but there are periods that we don't do it because I am with few professional.* (E4)

> [...] *when you know you must assist 20 pregnant women in two hours, you already come stressed out in the place, you won't perform a good assistance, so we wait for a more humanized assistance.* (M22-GO)

DISCUSSION

The understanding of the professional regarding the Network was partially acquired and had a new meaning (motives why) from the moment they participated in training phases before the establishment. But during the establishment these professionals experienced difficulties to perform many changes in everyday work, both in management and assistance. The implementation of health services in networks establishes a continuous and full care through unique mission, common goals and planning[11]. However, according to the interviews, these goals were not actually established during the Network implementation due to incompatibility between what was defined and what can be practiced. This incompatibility still exists due to lack or incorrect use of health services evaluation to plan and implement programs[2].

In this set of (re)construction and changes, the human being lives in a world of intersubjectivity, of different social relations and in a universe of meanings that are interpreted and guide them to act[5]. Therefore, if the health actions be directed considering the diversity of each reality, it will be obtained higher adherence to the Network. Because, to improve the capacity of professional development, is essential for the implementation of assistance strategies and articulations, making the flows, routines and technical-scientific knowledge possible[12].

Among changes in the Network, is the pregnant card, what did not reflect the real needs of professionals that perform prenatal follow-ups. Such difficulties also were proved in other studies[13-14].

With the interviews also was understood that the SISPRENATAL, although has the function as monitoring, assessment and identification of pregnancy risk factors, is under used due to problems since internet network access until data entering. However, this is not just a local or regional issue, it is also global. Most countries do not have a trustful information system regarding maternal health[15-17].

The early approach to women for prenatal follow-up happens due to previous relation between the woman and the health team in the community. This face -to-face contact established in the primary care context é very important to create a bond between pregnant and team. It refers to the most authentic social relation, because allows the exposure of the intentional acts of others and the everyday situations understanding[4].

It is highlighted that the proper start for the prenatal make it easier the access to diagnostic and therapeutic methods for many diseases that can influence directly in health of the mother and fetus[18]. However, studies point out how difficult the early approach to the pregnant, what negatively impacts the number of appointments and quality of care[19-20]. Consequently, it impacts the increase of diseases, in special to high risk pregnant, that need specialized services and hospitals – that not always are accessible –, reality understood based on the professionals' speech of this study, even if the reference and counter-reference are established in the Network's guideline and contractualization between the municipalities.

Results of the research carried out in many regions of the country identified that the lack of counter-reference was an obstacle to do a prenatal of quality, especially among black and brown-skinned women; and responsible for interrupt the pregnant care[19,21]. This interruption was showed in the professionals' interviews, what gave a feeling of frustration due to lack of institutional support, even higher for the high risk pregnant. Those who, in turn, frequently presents fetal and maternal complications due to lower access to specialized services, as well as peregrination and procrastinations of childbirth care[22].

After the childbirth and maternity release, the puerperium and the baby return to primary care service, because both may be exposed to diseases. The Rede's Guideline establishes that the health team will carry out the home visit until the fifth day after childbirth to identify risks and early intervention, as well as the inclusion of women in reproductive planning and of child in the program of immunization and monitoring of development and growth. Few studies analyze the puerperal return and authors points out the need to increase the number of appointments, given the importance for the improvement of indicators of maternal morbidity and mortality[23].

In the Rede's management and assistance context, it was perceived in the professionals' speeches that the expectations of changes (motives for) were greater than those actually implemented and that there is still much progress to be made regarding the qualification of women's care, although they are trying to overcome the structural, operational and human resource obstacles that have not been solved even before the implementation of

this Rede. These obstacles were also evidenced by users of the primary health care service in Brazilian metropolises, as well as the difficulty of continuing the treatment[24].

For this Rede to offer qualified assistance to the woman, the professionals also point out that administrators must include in the planning the permanent education in health to all the individuals involved directly and indirectly. The building of knowledge is the result of the baggage of knowledge of everyone, which is related to the subject rank in the social world[4]. The world of life is the scenario of human interaction, in which the person uses his previous knowledge, which is imparted to predecessors and successors, thus giving meaning to his experiences that constitute the classification of his respective professional social group[4].

Study limitations

The investigation was carried out in sixteen municipalities, of the twenty one of one of the state's regional of health. These follow the routine care chart for women of common and intermediate risk and have reference to the high risk in specialized service of the Unified Health System. However, it may mean a reality that does not reflect the conditions characteristic of most of the state's regional. In addition, the investigation was carried out about three years after the implementation of the Network and may have more time to evaluate the service.

From study results, it is necessary to observe other research, since new looks can be launched on the same subject and phenomenon with the subjects of these same professional categories and, in other scenarios, contexts and programs like this one searched to add to the results reached

Contributions to Nursing, health and public policy

The Network assessment, through the professionals' perspective, is enriching, since this interpretation shows how much they can contribute to the care qualification, although there are new traditional models and implantations, without considering the way in which they act in daily life of care. The implementation of the Network depends, mainly, on the nurses and doctors, as well as all the health staff. The personal view of each one and is practiced in daily women care reflects directly on the women's health.

FINAL CONSIDERATIONS

It was understood that the reorganization and (re)structuring of the Network brought positive propositions for the support system. However, failures in the logistic system (reference and counter-reference) still need to be solved. Through the approach of the administrators, nurses, doctors and the way in which they interact in the world of life, it could be their typical actions regarding the women care in the pregnancy-puerperal cycle evidencing their needs and expectations. In view of the constant rearrangement of flows, it is incumbent upon administrators to immerse themselves in the reality of assistance so that they can plan and seek local and regional strategies that are applicable and feasible to the structural reality and human resources of their municipalities.

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