http://dx.doi.org/10.1590/0104-0707201600003680013

PRENATAL CARE MODEL IN THE FAR SOUTH OF BRAZIL

Flávia Conceição Pohlmann[1], *Nalú Pereira da Costa Kerber*[2], *Marlene Teda Pelzer*[3], *Carmem Carballo Dominguez*[4], *Jéssica Medeiros Minasi*[5], *Vanessa Franco de Carvalho*[6]

[1] M.Sc. in Nursing. Rio Grande, Rio Grande do Sul, Brasil. E-mail: fcpohlmann@ibest.com.br
[2] Ph.D. in Nursing. Professor, *Escola de Enfermagem. Universidade Federal do Rio Grande* (FURG). Rio Grande, Rio Grande do Sul, Brazil. E-mail: nalu@vetorial.net
[3] Ph.D. in Nursing. Professor, *Escola de Enfermagem*, FURG. Rio Grande, Rio Grande do Sul, Brazil. E-mail: pmarleneteda@yahoo.com.br
[4] M.Sc. in Nursing. Rio Grande, Rio Grande do Sul, Brazil. E-mail: carmencdalmeida@gmail.com
[5] RN. Rio Grande, Rio Grande do Sul, Brasil. E-mail: jessica.minasi@hotmail.com
[6] Ph.D. student, Programa de *Pós-Graduação em Enfermagem*, FURG. Rio Grande, Rio Grande do Sul, Brazil. E-mail: va_carvalho@yahoo.com.br

ABSTRACT: This study's aim was to identify the health care model used in the prenatal care provided within the Family Health Strategy. This qualitative and exploratory study was conducted in three units of the Family Health Strategy in a city in southern Brazil. Data were collected through individual interviews with 10 pregnant women who were in the third trimester of pregnancy. The results were subjected to thematic analysis. Two thematic categories emerged: The perpetuation of the biomedical model in clinical and prenatal care and pregnant groups as an instrument to overcome the biomedical model. The conclusion is that the biomedical model is the most frequently occurring in prenatal care and health education developed through educational groups is confirmed as a strategy to overcome the biomedical model.

DESCRIPTORS: Delivery of health care. Prenatal care. Health education. Women's health. Nursing.

MODELO DE ASSISTÊNCIA PRÉ-NATAL NO EXTREMO SUL DO PAÍS

RESUMO: Este estudo se propôs a conhecer o modelo de atenção à saúde utilizado na assistência pré-natal em unidades de Estratégia de Saúde da Família. Apresenta abordagem qualitativa e exploratória e foi realizado em três unidades de Estratégia Saúde da Família de um município do sul do Brasil. A coleta de dados foi desenvolvida por meio de entrevista individual com 10 gestantes que se encontravam no terceiro trimestre gestacional e os resultados obtidos foram submetidos à análise temática. A partir dos dados, foram elaboradas duas categorias temáticas: a perpetuação do modelo biomédico nas consultas de pré-natal e grupos de gestante como instrumento capaz de ultrapassar o modelo biomédico. Foi evidenciado que o modelo biomédico permanece sendo o mais utilizado na assistência pré-natal e a educação em saúde desenvolvida por meio dos grupos educativos é reafirmada como estratégia para ultrapassar o modelo biomédico.

DESCRITORES: Assistência à saúde. Cuidado pré-natal. Educação em saúde. Saúde da mulher. Enfermagem.

MODELO DE ATENCIÓN PRENATAL EN EL EXTREMO SUR DE BRASIL

RESUMEN: Estudio tuvo como objetivo conocer el modelo de atención a la salud utilizado en el cuidado prenatal en unidades de la Estrategia Salud de la Familia. Presenta abordaje cualitativa y enfoque exploratorio y se llevó a cabo en tres unidades de la Estrategia Salud de la Familia en una ciudad del sur de Brasil. La recolección de datos se realizó a través de entrevistas individuales con 10 mujeres embarazadas que se encontraban en el tercer trimestre. Los resultados obtenidos se sometieron a análisis temático. Se elaboró dos categorías temáticas: la perpetuación del modelo biomédico en las consultas pre-natal y grupos de embarazadas como un instrumento para superar el modelo biomédico. Se ha demostrado que el modelo biomédico sigue siendo el más utilizado en la atención prenatal y la educación en salud desarrollado a través de grupos educativos se reafirma como una estrategia para superar el modelo biomédico.

DESCRIPTORES: Prestación de atención de salud. Atención prenatal. Educación en salud. Salud de la mujer. Enfermería.

INTRODUCTION

Historically, many healthcare models have been disseminated and implemented in the care provided to the Brazilian population. The practice of various actors responsible for health procedures is closely linked to the current care model guiding it, whether it may or may not be in accordance with these professionals' assumptions of what is right and wrong. This situation translates into submission, into automatically performed practices, without reflecting upon the way health is being produced.[1]

The concept of healthcare model refers to healthcare practices that are implemented, which can be multiple in nature and may not necessarily closely follow the model, since this model is based on the choices and experiences of each professional. The model represents the context experienced by individuals who seek healthcare, however, it can be criticized for not meeting the needs of these individuals. Hence, there is a need to replace the most frequently used models with other models capable of meeting the needs of individuals.[2]

The healthcare model most frequently used was developed in 1910, based on a report known as the Flexner Report, which was responsible for reform in medical teachings with profound changes in the way health was produced. The Flexner model, known as the biomedical model, gives priority to the disease and the hospital environment and is thus considered to be a reductionist model as it does not address social, psychological, or economic dimensions of one's health.[3]

The biomedical model is a conceptual framework for modern medicine, where the human body is separated into small parts and compared to a machine with mechanical functioning. The assumptions of this biomedical model have permeated diverse attempts to implement new care models, such as the Sanitary Model, which gave priority to the prevention of epidemics in the early 20th century, and the Social Security Model that ensured healthcare to workers.[2]

When the reference model prioritizes healing, it does not take the human being into its wholeness. Hence, it is necessary to rethink health and the way it is produced with systemic thinking. Systemic thinking means considering each individual's perception of health and his/her environment, and based on this relationship, to seek to meet the needs of each individual and implement a care model that is capable of overcoming the biomedical model.[4]

In this direction, it is evident that the biomedical model, characterized by reductionism – as it treats complex phenomena with simple primary principles – and also characterized by mind-body dualism, leaves social, economic and subjective aspects that determine the health-disease process aside.[5]

The production of health depends on various factors that interrelate, such as the construction of a system composed of networks capable of meeting the needs and demands of individuals and also depends on the relationship of network services that promote the continuity of health.[6] The work process of health providers is also important to transforming the reality of health production to qualify and humanize care and improve problem-solving capacity, to the extent it gives priority to attentive listening as a work tool, making the needs of each individual the core of their practice.[7]

Given the previous discussion, it is necessary to identify the care models currently used to reflect upon practices and the ways health is produced. Steering the discussion toward women's health, little has been discussed in the literature in regard to models that guide the practice of this specialty. Only one paper was found, "Hegemonic relationships and the cultural conflict of labor care models", which emphasizes a medicine- and hospital-centered practice based on the biomedical model. The authors of the paper suggest replacing the model evidenced in the study with one that is able to concretize humanized care to women and family members.[8]

Hence, in order to contribute to discussions regarding current healthcare models, this study proposes to answer the following question: what is the care model that has been reproduced by professionals – physicians and nurses – who provide prenatal care? To answer this question we aimed to identify the healthcare model that guides prenatal care in a city in the far south of Brazil.

METHOD

This qualitative and exploratory study aimed to understand the problem from the perspective of those experiencing it. The study setting included three Family Health (FHS) units in a city in the far south of Brazil. These units were intentionally chosen because they compose a field of practice

for the nursing program from the local University. This setting is justified given the high demand for prenatal procedures, such as nursing consultations, groups and training provided to pregnant women that surpass the biomedical model.

The study participants were pregnant women in the third trimester of pregnancy because we believe that the time elapsed favors the woman's completed report regarding the care received, as she will have already experienced almost the entire process. Access to women was possible by consulting the records available at the care units. All the pregnant women who met the inclusion criteria were included, which were 16 women. Data saturation was verified when nine individuals had been interviewed; that is, their responses became similar. Hence, another interview was conducted in the unit with the easiest access to verify whether new themes would emerge and the conclusion was that no more data would be collected given the similarity of findings and collection ceased.

Data were collected in the women's homes through individual interviews, which were guided by a script containing questions that addressed guidance the women had received during prenatal consultations in regard to their rights during pregnancy and childbirth. Based on the reports, we sought to understand the prenatal care model developed given the content that was part of the prenatal care providers' work processes.

The interviews were initiated in September 2011 and ended in December 2011, when data saturation was verified; interviews were recorded with the consent of the participants.

The results were submitted to thematic analysis from which thematic cores, related to the care model used in prenatal care, emerged, i.e., according to the importance given to content during reports. The analysis stages were: "reading and immersion into data; tabulation and organization; interpretation and grouping findings".[9:209] Immersion into data enabled the researchers to step into the context of the participants' experiences and a less complex interpretation of data was possible. Analysis was concomitant with data collection, that is, when the researcher made the transcriptions of interviews, she considered and reflected on their meanings at that time. Tabulation and organization of data was performed according to meanings discovered.

After data tabulation, the findings were grouped into categories based on similarity, in which 'meaning cores' were more frequently found and met the study's objective.[9] Thematic analysis showed the issues that are most significant in the context of the interviewees and that stood out as being indicative of the healthcare model developed in prenatal care.

The study was approved by the Institutional Review Board at the *Universidade Federal do Rio Grande* (FURG), Report n.. 95/2011 and complied with Resolution n. 466/2012. The participants signed free and informed consent forms to ensure confidentiality. The reports are identified by the letter G, followed by a number representing the order in which the interviews were held.

RESULTS

After analysis of results, two thematic categories emerged: The Perpetuation of the biomedical model in prenatal consultations and Groups of pregnant women as an instrument to overcome the biomedical model, which are presented and discussed as follows.

The perpetuation of the biomedical model in prenatal consultations

We sought to identify in the participants' reports the content of prenatal consultations, verifying what guidance was provided to women in regard to their rights during pregnancy and labor; whether the consultations were restricted to physical examination, laboratorial exams and orientation regarding diet. This context was exposed in the following reports: [...] *I never heard anything about my rights in the consultations, only about eating, exams, these things related to consultation really, this other stuff she didn't say anything about* [...] (G1); *They never said anything about it during consultations, only asked me how I was and assessed me* (G8); *Neither in my previous pregnancy nor in this one, they never talked about rights, I don't even know whether these are things you discuss in a consultation* (G10); *No, she only assessed me and sometimes asked me to undergo exams; about my rights, they never told me about it in the consultations* (G7).

Only one woman mentioned having received instruction during prenatal consultations about having priority preference in healthcare: [...] *yes, she told me during consultation about me having priority. Only this one, if there are any other rights, I don't know* (G5).

The same woman had had a prior experience of receiving prenatal care outside the city's public

health care network, and based on this experience, she reported that the consultations within the FHS provided more health education than those performed within private services. [...] *In my other pregnancies, nobody told me anything, I was cared for in a private service and they would only make physical assessments. Here they talk more and they told me about this priority* (G5).

The fact that women are not aware of their rights because they did not receive clarification during consultations and did not even show interest in asking the professionals becomes apparent in the next report: [...] *they never said anything during consultations. And I never asked. Like I told you before, this is something I don't know how to address, I've never asked, because you have to be able to ask these things, ask about your rights. So, I guess you end up forgetting, if I had asked, they'd have told me, I guess. At least, I've never raised the issue, and they didn't say anything, either* (G2).

Additionally, it seems that, in some cases, guidance was provided but the women were not able to report them: [...] *we talked a lot, he told me some stuff, only I can't recall right now. I received a lot of guidance, they were great, but this thing about rights, I don't remember it* (G6).

Groups of pregnant women as instrument to overcome the biomedical model

Even though the biomedical model predominated in prenatal consultations, there were units in which nurses promoted groups of pregnant women to provide guidance together: [...] *they never said what were my rights, only during the training, really* (G3); [...] *They didn't say anything during consultations. It was only in the group that they talked about having a companion and maternity leave for those who work. That's what I remember* (G9).

Another element that emerged in the reports refers to a lack of information concerning rights during pregnancy and childbirth in the woman's previous pregnancies. The women who took part in a pregnant women group reported not having received clarification regarding their rights in previous pregnancies. These orientations were only provided in the latest pregnancy, when they participated in the group: [...] *I got this information during this last pregnancy, I didn't have this kind of information in any of the other pregnancies* (G9); [...] *No, I only attended the group this time and they never talked about this issue in the consultations before* (G3).

DISCUSSION

This study's limitations include the number of health units included in the study, because only those with practices developed by students from the nursing program of the local university were selected. Further studies addressing a larger number of units are needed to investigate whether these findings are confirmed in other contexts. There is a growing need to assess the services, especially in Primary Health Care, and the challenges inherent to the assessment process can be identified when we take into account the complexity of actions and practices involved. There is also the subjectivity of assessments and the need for results to support decision-making to be considered, reaffirming a process that demands effort.[10]

That the reports of the women reveal a lack of guidance regarding women's rights during pregnancy and childbirth is of concern because the consultations seem to be based on the implementation of the biomedical model. Care practices based on this model are not more efficacious because they only treat the woman's biological aspects and put aside other educational needs involving all spheres of a woman's life.

Taking as a point of reference the idea of integral care, a guiding principle of the Brazilian Health System (SUS), criticisms regarding the way in which the health care model is applied are largely known, because the way care is provided involves a segmented view in which the patient is not seen in her/his wholeness and care is not included in the individual's context. Thus, care is centered on the disease, which is a result of the biomedical model. Hence, interactions and relationships between health care providers and patients are poor and there is a weak commitment to the well-being of patients.[11]

Only one of the women who participated in the study reported she was instructed, during consultation, that she had a priority in the provision of healthcare. Based on the universe under study, the number of individuals receiving guidance was small; at the same time, the guidance provided did not encompass all the rights a woman is entitled to as a pregnant woman and mother.

Healthcare systems need to change to be able to respond to patients' conditions, to their rights and duties in an effective, efficient and safe way by addressing situations that are present in the context

of patients so that effective healthcare models can be developed.[12]

Mentioning that health education provided during consultations performed within the FHS are more effective than those provided by private services does not seem to ensure care is actually appropriate, since it is still focused on the biomedical model. This seems to indicate that additional information or care is not or does not need to be routinely provided.

In regard to prenatal care provided in the private sector, we verify that the concern of pregnant women is based on how they are treated and how the gestational process is conducted. Women focus on seeking bonds and a relationship of trust with the healthcare provider, which favors growing levels of autonomy, so that the greatest different between care provided in the public and private sectors is based on use of technology.[12] This situation shows that the context experienced by the women addressed in this study is not in agreement with the study previously described.

There is a differentiated approach in the care provided within the private sector; however, the decisions of pregnant women, when asked about some aspect of pregnancy, are a result of a lack of knowledge combined with trust in her physician. Normally, this trust is characterized by a relationship based on dialog, on having her needs met. In this case, however, it is through a hierarchical relationship of power centered on the figure of the physician and on the model used.[13]

Usually, users of the FHS identify it as a place to attend consultations, gain therapeutic control, and of continuity of care, a conceptualization very much limited to the biomedical model.[14] Therefore, it is necessary that individuals become the center of health care delivery, implying they have the power to express their opinions and transform their own contexts.[15] This process refers to the quality and nature of listening, welcoming and response to the demands of healthcare. It is essential to develop sensitivity and an ability to respond to needs that are not restricted to prevention, correction and recovery of the body's morphological or from functional disorders. It does not mean, however, that these needs should be disregarded, rather that care should also include the rights of these women.[11]

The report of one of the women draws attention because she blames herself for not having more information, explaining that she did not take the initiative to ask the professionals. Therefore, she is an example of the idea that the health service performs its role when its users present needs and doubts and not on its own initiative, based on the work processes of professionals responsible for providing prenatal care. When an individual does not know about a given subject, s/he will probably not ask about such a subject, and for this reason health education is an essential element because it enables the production of knowledge and leads individuals to indicate changes necessary to their care and develop critical and reflective behavior in regard to their health.[16]

In the field of obstetrical care, decisions of professionals concerning the health of women have always been based on limiting the knowledge of women, who should accept what is imposed on them. Nurses have an important role in recovering the rights of women when they adopt a humanistic approach based on interrelationships with women, giving them a voice and information that safely supports their choices. When actions are based on authoritarianism, however, women remain alienated and uninformed.[17]

In regard to the guidance provided and effectiveness of understanding or importance of this information to pregnant women, we verify that the methods used to provide such guidance were not efficacious because the women did not remember having received such guidance. The participants also reported they were only addressed with "consultation information", showing that women are not bothered by the care model they received because they do not perceive health education as being part of the work process of healthcare providers.

Prenatal care is a singular opportunity to perform educational actions, which can be done through a pregnant women's group, in the waiting room, or individually. This work strategy permits integrating providers and pregnant women and can be a time to share experiences, strengthen knowledge and clarify doubts.[18] It is the role of professionals, however, to constantly assess this process in order to compare instances effective service in which guidance is provided to women because the focus should be quality healthcare delivery.

Health education is a strategy that can enhance nursing care because it is a means to promote measures that benefit maternal-infant health, including the active participation of women in

healthcare, in addition to favoring a bond with healthcare providers.[19]

Pregnant women groups are important spaces where topics not addressed during consultations can be discussed. In this context, it is important to perceive the quality and nature of inter-subjective interactions in the routine of healthcare delivery. Motivation leads to the development of dialogical conditions among the individuals participating in meetings addressing healthcare, be it from person to person, or from the perspective of staff/communities.[11]

Some women who participated in the pregnant women group were multiparous, but even though they had attended prenatal care in their previous pregnancies, they had never been educated concerning their rights; such guidance was only provided in the group meetings. This shows the importance of health actions to give priority to a holistic view of healthcare as a way to assess/meet the needs of women as a whole, seeing women as active agents in the process of monitoring their own health.

It is necessary to empower women concerning issues that refer to their rights, their bodies, conduct and procedures, so that they have an active voice and seek dignified care. Additionally, other models should be added to the biomedical model, such as the promotion of health and prevention of diseases.

It is important that public spaces enable the empowerment of women, since the right to health is acquired through the construction of citizenship; for the construction of citizenship to happen, social awareness is key. Knowledge and opportunity to provide healthcare are essential tools to construct knowledge of health and rights to which the population is entitled.[14] It is worth noting that all stages of the pregnant-childbirth cycle, and even in other moments of a woman life cycle, should be used to provide health education to contribute to their autonomy and ensure that their rights are respected.

But do we overcome the biomedical model, so present in the lives of individuals? One solution that seems to be decisive and which could be used by nurses is health education as they can exchange experiences and knowledge with individuals, enriching ideas and enabling citizens to criticize the health process and promote proper interpersonal relationship, opening opportunities to women and other patients to express and expose their doubts, concerns, and fears. The idea of care comes from trying to reconstruct, based on problems and tensions, providing integral care to individuals and communities, seeking to recompose competencies, relationships, and implications that are sometimes fragments, impoverished, and/or disconnected.[11,20]

We highlight the importance of valuing the bond established between patients and health staff. When bonds are established, satisfaction is achieved, as the patients understand they are being cared by professionals committed to humanized care.[21] Hence, pregnant women feel safe to expose their doubts and desires, as well as demand professionals to provide guidance concerning the process of being a mother.

While healthcare teams do not adopt a new care model, the practice of the biomedical model focused on disease and based on physical assessment and exams will not be transformed. Members of the health staff themselves need to assimilate strategies directed to innovative practice that restructures health actions with an enlarged view of the health-disease continuum and of the relationships among the health staff members.

It is expected that, through empowering women, spaces for providing knowledge and assimilating rights will be disseminated, to change their behavior of accepting poor healthcare quality, consequently changing the behavior of professionals that are resistant to providing care within a model other than the biomedical model. Therefore, the autonomy of women and their quality of life during the process of being a mother will be improved.[22]

FINAL CONSIDERATIONS

This study achieved its objective, which was to identify the care model that directs the prenatal care actions in a city in the far south of Brazil. The predominant model identified was the biomedical model. This finding was possible when women reported they were not aware of their rights in the pregnancy-childbirth cycle and, based on this result, we sought to identify the content of prenatal consultations, in which physical assessment, laboratorial exams and guidance concerning diet prevailed. The reports of these women revealed that there is a predominance of technical actions during prenatal care and a perpetuation of the biomedical model in this modality of care.

We verified that identifying and deepening knowledge concerning the model used in the practice of healthcare workers in the field of women's

health was one of the positive aspects of this study. While it is clear that the biomedical model is neither the only nor the best method to provide holistic care to women, we verified that it is still the method used. It is characterized as extremely important to providing quality care when combined with other models, but not when performed with a restricted, merely biologistic view.

Through this study's results, it is possible to sensitize healthcare professionals providing care to women in the pregnancy-childbirth cycle in regard to the importance of providing guidance concerning women's rights. This guidance is to empower them in relation to self-care, as well as for nurses to reassess and reflect upon the model they adopt in their professional practice. In this way, in addition to guiding health professionals to improve their practice, this study also supports nurses in the development of further studies in the field, to deepen and enrich already existing knowledge.

REFERENCES

1. Faria HP, Coelho IB, Werneck MAF, Santos MA. Modelo assistencial e atenção básica à saúde. 2ª ed. Belo Horizonte (MG): Nescon/UFMG; 2010.
2. Paim JS. Modelos de Atenção à Saúde no Brasil. In: Giovanella L, organizadora. Políticas e Sistema de Saúde no Brasil. Rio de Janeiro (RJ): Fiocruz; 2008 p.547-73.
3. Pegliosa FL, Ros MA. O Relatório Flexner: para o bem e para o mal. Rev Bras Educ. Med. 2008; 32(4):492-9.
4. Capra F. O modelo biomédico. In: Capra F. O ponto de mutação. São Paulo (SP): Cultrix, 2004.p.116-55.
5. Mouta RJO, Progianti JM. Estratégias de luta das enfermeiras da Maternidade Leila Diniz para implantação de um modelo humanizado de assistência ao parto. Texto Contexto Enferm [online]. 2009 [acesso 2015 jun 16] Out-Dez; 18(4):731-40. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-07072009000400015
6. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Política Nacional de Humanização da Atenção e Gestão do SUS. Redes de produção de saúde. Brasília (DF): MS; 2009.
7. Cecílio LCO. As necessidades de saúde como conceito estruturante na luta pela integralidade e eqüidade na atenção em saúde. In: Pinheiro R, Mattos RA, organizadores. Os sentidos da integralidade na atenção e no cuidado à saúde. Rio de Janeiro (RJ): IMS, UERJ; 2001.
8. Pereira ALF, Moura MAV. Relações de hegemonia e o conflito cultural de modelos na assistência ao parto. Rev Enferm UERJ. 2008; 16(1):119-24.
9. Minayo MCS. O desafio do conhecimento-pesquisa qualitativa em saúde, São Paulo (SP): Hucitec; 2004.
10. Gomes ML, Moura MAV, Souza IEO. A prática obstétrica da enfermeira no parto institucionalizado: uma possibilidade de conhecimento emancipatório. Texto Contexto Enferm [online]. 2013 [acesso 2015 jun 13]; 22(3):763-71. Disponível em: http://www.scielo.br/scielo.php?pid=S0104-07072013000300024&script=sci_arttext
11. Ayres JRCM. Organização das ações de atenção à saúde: modelos e práticas. Saúde Soc. 2009; 18(2):11-23.
12. Mendes EV. As redes de atenção à saúde. Ciênc Saúde Coletiva. 2010; 15(5):2297-305.
13. Gama AS, Giffin KM, Tuesta AA, Barbosa, GP, Orsi E. Representações e experiências das mulheres sobre a assistência ao parto vaginal e cesárea em maternidades públicas. Cad Saúde Pública. 2009; 25(11):2480-8.
14. Martins PC, Cotta RMM, Mendes FF, Priore SE, Franceschini SCC, Cazal MM, et al. De quem é o SUS? Sobre as representações sociais dos usuários do Programa Saúde da Família. Ciênc Saúde Colet**.** 2011; 16(3):1933-42.
15. Bernardes ACF, Silva RA, Coimbra LC, Alves MTSSB, Queiroz RCS, Batista RFL, et al. Inadequate prenatal care utilization and associated factors in São Luís, Brazil. BMC Pregnancy Childbirth [online]. 2014 Aug 10[acesso 2015 Jun 13]; 14:266. Disponível em: http://www.biomedcentral.com/1471-2393/14/266
16. Santo R, Penna CM. A educação em saúde como estratégia para o cuidado à gestante, puérpera e ao recém-nascido. Texto Contexto Enferm. 2009 Out-Dez; 18(4):652-60.
17. Busanello J, Lunardi Filho WD, Kerber NPC, Lunardi VL, Santos SS. Participação da mulher no processo decisório no ciclo gravídico-puerperal: revisão integrativa do cuidado de enfermagem. Rev Gaúcha Enferm. 2011 Dez; 32(4):807-14.
18. Anversa ETR, Nunes LN, Dal Pizzol TS, Bastos GAN, 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. 2012; 28(4):789-800.
19. Diaz CMG, Hoffman IC, Costenaro RGS, Soares RS, Silva BR, Lavall, BC. Vivências educativas da equipe de saúde em unidade gineco-obstétrica. Cogitare Enferm. 2010;15(2):364-7.
20. Dowswell T, Carroli G, Duley L, Gates S, Gulmezoglu AM, Khan-Neelofur D, et al. Alternative versus standard packages of antenatal care for low-risk pregnancy. Cochrane Database Syst Rev [online]. 2010 Oct 6 [acesso 2015 jun 13]; (10):CD000934. Disponível em: http://www.ncbi.nlm.nih.gov/pubmed/20927721
21. Kerber NPC, Kirchhof ALC, Cezar-Vaz MR. Atenção domiciliária e direito à saúde: uma experiência na rede pública brasileira. Acta Paul Enferm. 2010; 23(2):244-50.

22. Lathrop B. A systematic review comparing group prenatal care to traditional prenatal care. Nursing for Women's Health [online] 2013 [acesso 2015 jun 13]; 17(2):118-30. Disponível em: http://www.ncbi.nlm.nih.gov/pubmed/23594324

Correspondence: Flávia Conceição Pohlmann
Rua I, 430
96200-000 - Parque São Pedro, Rio Grande, RS, Brasil
E-mail: fcpohlmann@ibest.com.br

Received: December 12,02013
Approved July 11, 2014