



REFLECTIONS ON THE NURSE'S ROLE IN THE REDE CEGONHA (STORK NETWORK)

REFLEXÕES ACERCA DA ATUAÇÃO DO ENFERMEIRO NA REDE CEGONHA REFLEXIONES RESPECTO AL EJERCICIO DEL ENFERMERO EN LA REDE CEGONHA

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ABSTRACT

Objective: to submit a reflection about the role of the professional nurse given the implementation of a new care model for delivery and childbirth, established as in the Rede Cegonha (Stork Network). **Method:** reflective study conducted from specialized literature, indexed articles in online journals, resolutions, and standards relating to the subject in question. After reading and critical analysis of the material found, we proceeded with the discussion of the results through the elaboration of distinct thematic axes. **Results:** along with this evolution, the role of nurse has been modifying, as it initially focused on prenatal care and with new Rede Cegonha (Stork Network) proposal, we have as an important performance the assistance to delivery without complications. **Conclusion:** Such being the case, for executing the model, the nurse will have a key role ensuring the principles of humanization, good practices, and safety in delivery and childbirth in the country. **Descriptors:** Public Policies; Women's Health; Nursing; Humanization of Care.

RESUMO

Objetivo: apresentar uma reflexão acerca da atuação do profissional enfermeiro perante a implementação de um novo modelo de atenção ao parto e nascimento, estabelecido como Rede Cegonha. **Método:** estudo reflexivo realizado a partir da literatura especializada, artigos indexados em periódicos on-line, resoluções e normativas referentes à temática em questão. Após leitura e análise crítica do material encontrado, procedeu-se com a discussão dos resultados mediante a elaboração de eixos temáticos distintos. **Resultados:** juntamente com esta evolução, a atuação do enfermeiro vem se modificando, pois inicialmente focava-se na assistência ao pré-natal e agora, com a nova proposta da Rede Cegonha, também tem como atuação importante à assistência ao parto sem complicações. **Conclusão:** para a efetivação do modelo, o enfermeiro terá papel fundamental ao assegurar os princípios da humanização, das boas práticas e da segurança no parto e nascimento no país. **Descritores:** Políticas Públicas; Saúde da Mulher; Enfermagem; Humanização da Assistência.

RESUMEN

Objetivo: presentar una reflexión respecto al ejercicio del profesional enfermero, ante la implementación de un nuevo modelo de atención al parto y nacimiento, establecido como Rede Cegonha. **Método:** estudio reflexivo realizado a partir de bibliografías específicas, artículos indexados en diarios on-line, resoluciones y normativas referentes a la temática en cuestión. Luego de la lectura y del análisis crítico del material investigado, se procedió a la discusión de los resultados mediante la elaboración de diversos ejes temáticos. **Resultados:** junto con estos acontecimientos, el ejercicio del enfermero está cambiando, dado que, en un principio, se enfocaba en la atención del prenatal y ahora, con la nueva propuesta de la Rede Cegonha, también actúa de forma importante en la atención al parto sin riesgos. **Conclusión:** para poner en marcha este modelo, el enfermero debe tener un papel fundamental al asegurar los principios de humanización, de las buenas prácticas y de la seguridad en el parto y nacimiento en el país. **Descriptores:** Políticas Públicas; Salud de la Mujer; Enfermería; Humanización de la Atención.

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INTRODUCTION

Attention to women's health was incorporated into national health policies in the early 20th century, and its focus limited to demands related to pregnancy and delivery. Based on the biological specificities, the actions directed to maternal and child care were elaborated in the 30, 50, and 70 decades. They translated a restricted view on women, focusing on their social role of mother, domestic activity, and family caregiver. Over time, the actions aimed at *Comprehensive Care to Women's Health* have demonstrated, in a certain way, as priorities in the different administrative government levels.¹

From this moment, various policies and actions were deployed and implemented in order to encourage attention to women's health in an integrated manner and with respect for their individuality.

In 1983, the Ministry of Health/MS, given the claims of women's movements, elaborated the Woman Integral Health Assistance Program (WIHAP), which was widely disclosed only in 1984. As a precursor of the current model, the WIHAP has already demonstrated changes in the actions, in addition to the election of differentiated priorities in this care line. In this way, there was a paradigmatic break with the guiding ideals of women's health policies previously in force. It was an innovative model for the time, because its contents had already included the definition of reproductive health adopted by the World Health Organization in 1988, expanded and consolidated in Cairo in 1994 and in Beijing in 1995.²

The Ministry of Health, in the year of 2000, created the Program of Humanization in Prenatal and Birth/PHPN (Brazil, 2002), seeking to improve the quality of Prenatal Care and, consequently, decreasing morbidity and mortality indicators tied to pregnancy, delivery and puerperium. The PHPN is structured on the principles that every pregnant woman has the following rights: decent access to care and with quality in the course of pregnancy, delivery and puerperium; knowing which organization and safety in which maternity ward they will have their baby; delivery and puerperium assistance held in humane and safe form; and that mother and fetus may receive adequate and safe perinatal assistance.³

Discussions began in 2003 for the construction of the National Policy of Comprehensive Care to Women's Health, just released in 2004 and built from the principles

of the Unified Health System, respecting the characteristics of the new health policy. The National Policy of Comprehensive Care to Women's health - NPCCWH (2004) prioritized closer actions in relation to the comprehensive care for the female needs. It approached themes regarding maternal mortality, precarious obstetric care, abortion under risk conditions, precariousness of assistance with contraception, STD/HIV/AIDS, domestic and sexual violence, health of women, teenager women's health, women's health in climacterium/menopause, mental and gender health, chronic diseases and gynecological cancer, women's health, health of homo-affective women, Afro-Brazilian women's health, indigenous women's health, health of women residing and working in rural areas, and women's health in prison.¹

From this context, several actions were implemented in order to promote better assistance to women and newborn babies. Along with this evolution, the role of nurse has been modifying, as it initially focused on prenatal assistance and with the new proposal of the Rede Cegonha (Stork Network), we have as an important performance the assistance to delivery without complications. Such being the case, it is justified to better understanding this performance given the new program under implementation.

In this article we aim at submitting a reflection on the role of the professional nurse given the implementation of a new care model for delivery and childbirth, established as in the Rede Cegonha (Stork Network).

MÉTODO

A reflective study conducted from specialized literature, indexed articles in online journals, resolutions, and standards relating to the subject in question. After reading and critical analysis of the material found, we proceeded with the discussion of the results through the elaboration of distinct thematic axes.

It is understood that, with the propositions of this network, the role of the nurse has fundamental importance, not only in assistance, but also for its operationalization.

RESULTS AND DISCUSSION

♦ Contextualizing the new model - Rede Cegonha (Stork Network)

Rede Cegonha (Stork Network) - RC is a strategy of the Ministry of Health - MOH, nationwide, operationalized by the Unified Health System and instituted by Article 1 of

Ordinance No. 1.459/GM/MS, dated June 24 2011.⁴

It consists of a network of cares that aims to assure the women their rights for reproductive planning and humanized care during pregnancy, delivery, and puerperium. And ensure the right to safe delivery and healthy development for the child.⁴

This strategy is based on the principles of humanization and care. In this way, the rights granted to women, the newborn and child focus: the increase in access, welcome process and prenatal care quality; the aid to urgency and emergency transport; conducting pregnant binding to a reference institution for delivery assistance; the realization of safe delivery and childbirth insurance, by using good care practices; the presence of an escort under choice of the women during delivery ; access to reproductive planning; and the child from zero to 24 months of life, access to quality care and with efficaciousness (Brazil, 2011a, Brazil, 2011b).^{4,5}

To promote these warranties, Rede Cegonha (Stork Network) brings in its goals propositions that go beyond the structural issues and care financing, referred to in the previous policies. Such being the case, it comes to promote the implementation of a new health care model for women and children, in addition to organizing the Maternal and Child Health Care Network, so that it may ensure access, welcome process and efficaciousness in meeting the needs of that group. Other goals are to reduce maternal and child mortality, with a focus on neonatal care.⁵

In order to ensure its operation and achievement of goals, RC must be organized in such a way as to enable the continuous supply, for the population of a given territory, of actions of attention to maternal and child health, through the actions of health care services, the support system, logistic system and governance of the health care network.⁴

Its implementation will occur throughout the country, gradually and according to epidemiological criteria, such as child mortality rate, maternal mortality ratio and population density.^{4,5} Such being the case, the regions most in need receive the early financial incentives, which will be disseminated to other regions, according to the goals.

This investment is organized using four components: Prenatal; Delivery and childbirth; Puerperal e Comprehensive Care to Child's Health; as well as the Logistical System.⁴

The first two are crucial in the discussion of maternal mortality rates and are not, undoubtedly, based on scientific evidence. Such an investment demonstrates the pursuit of changing the model of hospital-centric care. On the other hand, the Comprehensive Care to Child's Health is addressed with more emphasis on child's care, because for years this care policy was related under secondary form to women's care policies.

But the aid for the operation of the system is brought in encouraging and financing sanitary health, and in regulation and physical structure. Along with the change in the care model, financial incentives are offered, like those applied to improving service structure, creation of Maternity Homes and Natural Delivery Centers, for increasing the number of beds in the Intensive Care Unit - ICU neonatal and adult, and improvement in the associated clinical transport services so that the network may work.⁴

The MS will finance the components under a differentiated form, in accordance with the joined necessities. Consequently, we foresee the 100% funding for the expenses of prenatal care examinations, in addition to the supply of consumption material kits, such as chairs, examination desks, scales for the Basic Health Units - SUS, in order to improve care to pregnant women. As for the transport of pregnant women and newborns at risk, it will be carried out through the Urgency Mobile Service Care - SAMU Cegonha, through properly-equipped enhanced support ambulances.

In relation to the total funding per year, an investment for constructing a Normal Delivery Center - NDC (CPN) and Home of pregnant woman, baby, and puerperium - CGB. There is also funding for the ambience at the places of delivery. These investments will take place in the first two years of the agreement between RC and the municipalities.^{4,5}

Part of the funding (80%) will be allocated for expansion and qualification of ICU beds and Intermediate Care Unit - ICU, and among them are predicted beds for the Kangaroo Method. The Kangaroo Method is a public policy that currently has been expanding and strengthening actions in Brazil, from its incorporation to the actions of the Pact to Reduce Maternal and Neonatal Mortality. Such a policy is configured in a model of perinatal assistance intended for the humanized care, combining biopsychosocial intervention strategies.⁶

The adhesion and the agreement of the municipalities can happen under a fractional form, in accordance with the organization of its health services. Thus, they can adhere to specific RC components, since there is a differentiation on the ability of municipalities to be of full management or basic management as for the health services.⁴

In relation to the advances in the Network, the current Health Care Secretary of MS, Helvécio Martins Magalhães Júnior, in the 13th National Shows Of Successful Experiences in Epidemiology, Prevention and Control of Diseases in October 2013, in Brasília - DF, with the participation of managers and professionals in the Unified Health System, submitted the balance of 2011-2013 actions with results of RC implementation.⁷ On the occasion, the 27 federative units had already adhered to RC.

Among 435 health regions in Brazil, 183 (42%) had published action plans and with transferred resources, including 428 services that perform delivery and/or newborn assistance, with resources from the RC. Among 5570 Brazilian municipalities, according to IBGE, 5488 municipalities (98.53%) have joined the basic care component, with resources transferred to new prenatal examinations.⁷

Within the Rede Cegonha (Stork Network) Regional Action Plans - RAP (PAR), the resources were intended for high risk pregnancy beds (HRP), Neonatal INTENSIVE CARE UNIT, Conventional Intermediate Care Unit - ICU in 428 services that care for reference delivery for high-risk pregnancy and/or care to newborn baby under risk. To this end, there was a mutual involvement in the preliminary contractualization process of RC's goals with monitoring of indicators that determine the maintenance of fund transfer. Perinatal Forums in the states and capitals were also built up within RAP (PAR), in order to constitute a space for action discussion and favoring social control. There was also encouraging to strengthening surveillance of maternal, fetal and child related death and the Maternal Death Prevention Committees.⁷

In relation to increments that are happening in relation to performed delivery and childbirth care, according to the report of the Health Care Secretary (2013), the investments for adapting the ambience of the maternity wards in order to favor delivery physiology are already on course, increasing access and qualification of care realized for the women and their newborn. Thus, reforms were held in obstetric centers of maternity

wards; construction and expansion of Pre-delivery , Delivery Puerperium - PPP rooms; implementation of Natural Delivery Centers; implementation of Maternity Homes, Babies and Puerperium; construction of new maternity wards; reform of neonatal units under new progressive care model, from the ICU to the insertion in the ICU Kangaroo.⁴⁻⁷

Some advances occurred in relation to the type of care, according to Ordinance GM 904, dated May 30, 2013, establishing within UBS (SUS) deployment guidelines for implementing and enabling a Normal Delivery Center (NDC), for care to women and newborn baby in delivery and childbirth. This resolution is in accordance with Rede Cegonha (Stork Network) Delivery and Childbirth Component.⁸

The Ordinance GM1020/2013 also potentiates these changes when setting up guidelines for the organization of High Risk Pregnancy Health Care, defining criteria for establishing and qualifying reference services, including Maternity, Baby, and Puerperium Home (CGBP), in accordance with the proposed by RC.⁹

It also includes the Ordinance GM 930/2012, which sets up the guidelines and objectives for the organization of comprehensive and humanized care to the severe newborn baby, or potentially severe, and the criteria for classification and qualification of Neonatal Unit beds.¹⁰ In this context, R\$ 290,502,921.46 were invested in proposal for structural adjustments in the years 2011 and 2012. These resources were used to address 89 proposals of ambience in maternity wards, 43 proposals for Natural Delivery Centers, 30 proposals for Maternity, Baby and Puerperium Homes, and constructing 12 new maternity wards.⁷

Some actions are described in the report on the component Delivery and Childbirth, such as: the incentive to good practices of care to delivery and childbirth and abortion; programs of qualification in the services for the teams in the involved maternity wards; technical visits to Hospital Sofia Feldman, which is the national support center for dissemination of good care practices for delivery and birth; construction of forums and seminars for discussing the Natural Delivery Homes; setting good indicators for good practices in contractualization of maternity wards; distribution of 175,000 copies of the High Risk Pregnancy Manual; and establishment of Regional Support Centers, which are in the process of qualification in six hospitals.⁷

For operating and evaluating the care network proposed by RC, seven strategic

indicators were constituted for monitoring and implementation, especially in relation to the Regional Action Plan. Thus, we have the following indicators: Prenatal/Sisprenatal web information system, deployed in the municipalities; deploying pregnancy, syphilis and HIV rapid test in the services of women's health care; updating the map for binding of pregnant women; strengthening the Perinatal Forum; contractualization of maternity wards; presence of full-time escort and free choice deployed; and carrying out a welcome process with risk classification deployed. As a vehicle for monitoring, the Ombudsman of RC was created in the municipalities, aiming to assess network implementation, by means of telephone surveys from the telephone number obtained by the AIH, with women who gave birth in maternity wards of the Unified Health System.²⁻⁷

Defining the role of the nurse in the current policies

Advances in knowledge of obstetric phenomena have provided for the nurse roles, and favoring their professional performance in prenatal care, delivery and birth, generating positive indicators for women's care, in addition to greater confidence of society. Nurses can go beyond physical determinations, increasing understanding of psychological processes that pervade the gravid-puerperal period.¹¹

Included in the care to women's health, prenatal care is highlighted, since it has a fundamental role, both in monitoring pregnancy, with reflections on indicators such as maternal and neonatal mortality, and in achieving the goals. Thus, care provided in prenatal must be carried out by a multidisciplinary health team, being medical professionals or nurses responsible for prenatal and puerperium care appointments. According to Decree No. 94.406/87 laying down the Professional Nursing Practice Law, low-risk prenatal care may be accompanied by a nurse.¹²⁻¹⁶

The Technical Manual of Prenatal and Puerperium Care: Qualified and Humanized Care (2006) highlights that it falls to the nurse during the prenatal monitoring, to run educational activities for women and their families; performing prenatal consultation for low-risk pregnant women; requesting routine exams and guiding treatment according to service protocol; detecting and referring high-risk pregnant women; performing group activities with pregnant women; conducting home visits when necessary; properly registering the maternity card in each

appointment; In addition to collecting citopathologic exam.¹³

The nurse should be able to discuss aspects regarding prenatal monitoring routine related to appointments, vaccines, symptoms presented by pregnant women and others, as well as individual aspects related to the meaning of pregnancy, family relations and with the companion.¹³

In relation to the delivery service, the resolution of the Federal Council of Nursing, no. 223, dated 1999, in its first article states that "[...] carrying out natural delivery without dystocia is the competence of nurses, and the holders of obstetrician diploma, certificate, or an obstetric nurse, as well as specialists in obstetric nursing and in women's health".¹⁴

The natural delivery without dystocia may be assisted by an obstetric nurse in any health service in which it may occur. Concerning the high-risk pregnancy, it is clear that for a better monitoring of pregnant women it is necessary to have care by a multidisciplinary team, consisting of experts from various fields, including doctors and nurses, so that a joined and planned work may occur. The integration of the multidisciplinary team is essential, especially for the early diagnosis regarding the pathological conditions.¹³

In monitoring and care to high-risk pregnant women, the services must have availability of nurses and other professionals from the nursing staff to conduct monitoring of mother and fetus against the complications that may come to occur during pregnancy.¹³

As for the new care model under implementation in the country, Rede Cegonha (Stork Network) had a strong support from and partnership with the class bodies and associations that represent nursing with the Ministry of Health. You can highlight the Brazilian Nursing Association (ABEN), Brazilian Association of Midwives and Obstetric Nurses (ABENFO), besides the Brazilian Association for Graduate Studies in Collective Health (ABRASCO), Network for Humanization of Childbirth and Delivery (REHUNA), among other social movements that count with nurse participation.⁵

This new humanistic care model focuses on the well-being of the pregnant women and their baby, seeking to reduce the use of invasive procedures, understanding delivery as a physiological process, respecting the psychological dimension and the social-cultural context of the pregnant women.⁴

To this end, this model determines the use of appropriate technology, featuring the care by the ongoing monitoring of the parturition process. In this way, in addition to hospitals, it proposes the care to delivery in Delivery Homes or outpatients, getting booked to the hospital environment situations of obstetric complications.⁵

The presence of the escort under the choice of the mother was established, in addition to their free choice for the parturition position, according to the guidelines of good practice from the World Health Organization.¹⁵ In RC's papers, the Intra and Peri-hospital Natural Delivery Centers are units of care to delivery and childbirth/delivery and birth, which carry out the humanized service and quality. This service is given exclusively to natural delivery without dystocia, favoring women's privacy, dignity and autonomy to give birth in a warm and comfortable environment.⁴

These centers are fields for practice of obstetric nurses and nursing technicians. We highlight the role of the nurse as the person in charge both for monitoring the process of delivery and the early detection of dystocias or clinical interurrences, and may refer for removing the pregnant woman to a specialized reference service after providing appropriate conditions for such.^{4,5}

According to National Demographic Health Research, between 1996 and 2006, the percentage of hospital delivery rose from 96% to 98%, with regional variations, being 92% in the North region and 99.5% in the Southeast region. In many regions of the country, especially in the rural areas, riverside localities and more distant places, the sole existing option is the home delivery assisted by traditional midwives.⁵

However, there are challenges to overcome. Among them, we may highlight that 2006 data showed that from the total number of births occurring in Brazil, 76% were carried out through SUS, and of these, only 8.3% were done by nurses, and, it is observed that appropriate practices such as using a partogram, that would work for a good delivery monitoring, are little used in the Brazilian reality.⁵

As an increment to the delivery and puerperium care, the new policy ensures the user's transport, mainly among network's services, according to the severity of the case, by means of a Basic Support Unit (SAMU) or Advanced Life Support Unit (SAMU), properly equipped, especially for the newborn baby care. The professionals involved should

be properly qualified for the high-complexity care, especially of severe and premature Newborn Baby, having the nurse as a team member. 4

To potentiate these actions, having the nurse as fundamental piece for the functioning of these services, various training and improvement strategies were proposed by the MS. Such being the case, according to the report of the Secretary for Health Care, the establishment of residence in obstetric nursing programs was provided, with 142 vacancies filled up in 2013; obstetric nurses enhancement programs, with 64 vacancies in 2013; qualification of traditional midwives and delivery of basic material kits for parturition care, such as scissors, tweezers, cardio-fetal rate auscultation apparel, including 346 midwives in 2013; and specialization courses in obstetric nursing, with commencement planned for 2014.⁷

Remote Education courses in surveillance to maternal fetal and infant death, will also be provided , as an incentive to the performance of the respective committees; training in advanced life support in obstetrics - ALSO, professional improvement course for obstetrical care professionals; Kangaroo Method course, to raise awareness of hospital-level professionals, including training of multipliers in six teaching hospitals; qualifying new reviewers for New Initiative - Child Friendly Hospital (Nova Iniciativa Hospital Amigo da Criança), with "Friendly women's care" and assuring the presence of the parents with the newborn baby.⁷ The hospitals are recognized by meeting the recommendations of the practices advocated by the Ministry of Health with respect to quality care for the woman and child.

It is essential that the nurse carries out the monitoring of strategic indicators, through actions such as Sis prenatal web, which moreover qualify the activities of these professionals, demonstrating their relevance in implementing this new policy of care to women and child health.⁴⁻⁷

FINAL REMARKS

In this context of change towards a new care model for women's health/Rede Cegonha (Stork Network), we may observe that work's organization of the health teams does not favor interdisciplinary work. On the one hand, there is dependence on the medical professional action in care to the hospital delivery, and in another perspective, the excessive performance of nurses and nursing technicians occur in Natural Delivery Centers.

Among the total of births that occur in Brazil by the public network, the portion of normal deliveries assisted exclusively by nurses is still small. Consequently, a need for even greater participation on the part of nurses is suggested, being encouraged and guided by the proposals coming from Rede Cegonha (Stork Network), and in respect of deliveries assisted by doctors, it is necessary to pay greater attention to some of the best practices recommended by the World Health Organization for assistance to delivery, as an example, using a partogram.

These situations are present as important difficulties for the proper functioning of the care model to the woman advocated by the current health policy in Brazil. Gradually, states and municipalities are adhering to the recommendations of Rede Cegonha (Stork Network), and receiving financial incentives for adjusting the physical structure and care processes. In this way, the services targeted under the new delivery care model, intended by the Government, also need even more skilled medical and nursing professionals. The role of the obstetric nurses, because the deployment of Normal Delivery Centers extends their attributions and responsibilities within the new perspective of care to delivery and childbirth, which require broader skills and autonomy.

Based on scientific evidences, the continuous presence of a nurse or obstetric nurse favors the promotion of emotional, psychological and physical comfort, being a key element in carrying out the delivery through, good practices both in Delivery Care Centers, as well as in hospitals.

The ideal would be that assistance to natural delivery without dystocia, in the public network, might be conducted by obstetric nurses, leaving to the doctors the care to delivery with complications and caesarean.

For executing the model, one needs to broaden actions such as investments in the training of professionals, especially obstetric nurses, and in experimenting and monitoring other methods of monitoring the pregnant woman, such as Normal Delivery Centers, which have been proposed by Rede Cegonha (Stork Network). Such being the case, the nurse will have a key role ensuring the principles of humanization, good practices and safety in delivery and childbirth in the country.

REFERENCES

1. Ministério da Saúde (BR). Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. Política Nacional de Atenção Integral à Saúde da Mulher: plano de ação 2004-2007 [Internet]. Brasília: Ministério da Saúde, 2004 [cited 2014 Jan 24]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/politica_nac_atencao_mulher2.pdf
2. Osís MJMD. Pásm: um marco na abordagem da saúde reprodutiva no Brasil. Cad Saúde Pública [Internet]. 1998 [cited 2014 Jan 14];14(1):[about 5 screens]. Available from: <http://dx.doi.org/10.1590/S0102-311X1998000500011>
3. Ministério da Saúde (BR). Secretaria de Políticas de Saúde. Área Técnica da Mulher. Programa de humanização no pré-natal e nascimento [Internet]. Brasília; 2002 [cited 2014 Feb 02]. Available from: <http://bvsms.saude.gov.br/bvs/publicacoes/parto.pdf>
4. Ministério da Saúde (BR). Portaria nº 1459 de 24 de junho de 2011: Institui no âmbito do SUS a Rede Cegonha [Internet]. Brasília: Gabinete do Ministério, 2011 [cited 2014 Feb 02]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt1459_24_06_2011.html
5. Ministério da Saúde (BR). Secretaria de Políticas de Saúde. Manual Prático para Implementação da Rede Cegonha [Internet]. Brasília, 2011[cited 2014 Out 10]. Available from: http://www.saude.ba.gov.br/images/arquivos/rede_cegonha/manuais/1.manual_pratico_ms.pdf
6. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Atenção humanizada ao recém-nascido de baixo peso: Método Canguru [Internet]. Brasília: Ministério da Saúde, 2011 [cited 2014 Feb 20]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/metodo_canguru_manual_tecnico_2ed.pdf
7. Ministério da Saúde (BR). Relatório final. 13ª Expoepi: Mostra Nacional de Experiências Bem-sucedidas em Epidemiologia, Prevenção e Controle de Doenças. Ministério de Estado da Saúde [Internet]. Brasília: Ministério da Saúde, 2013 [cited 2013 Nov 13]. Available from: <http://www.expoepi.com.br/images/Anais%2013%20EXPOEPI%20divulga%C3%A7ao.pdf>
8. Ministério da Saúde (BR). Portaria nº 904, de 29 de maio de 2013: Estabelecem diretrizes para a implantação e habilitação de centro de parto normal (CPN), no âmbito do

Oliveira FAM de, Leal GC, Wolff LDG et al.

Reflections on the nurse's role in the Rede...

Sistema Único de Saúde (SUS) [Internet]. Brasília: Gabinete do Ministério, 2013 [cited 2013 Nov 11]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2013/prt0904_29_05_2013.html

9. Ministério da Saúde (BR). Portaria nº 1020, de 29 de maio de 2013: Institui as diretrizes para a organização da atenção à saúde na gestação de alto risco [Internet]. Brasília: Gabinete do Ministério, 2013 [cited 2013 Nov 20]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2013/prt1020_29_05_2013.html

10. Ministério da Saúde (BR). Portaria nº 930, de 10 de maio de 2012: Define as diretrizes e objetivos para a organização da atenção integral e humanizada ao recém-nascido grave ou potencialmente grave [Internet]. Brasília: Gabinete do Ministério, 2012 [cited 2013 Nov 20]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2012/prt0930_10_05_2012.html

11. Ministério da Saúde (BR). Secretaria de Atenção à Saúde Pré-natal e puerpério - Atenção qualificada e humanizada [Internet]. Brasília: Ministério da Saúde; 2006 [cited 2013 Nov 20]. Available from: <file:///C:/Users/Giseli-pc/Downloads/Manual20Puerperio202006.pdf>

12. Ministério da Saúde (BR). Decreto Nº 94.406/87: Dispõe sobre o exercício da Enfermagem [Internet]. Brasília: Gabinete do Ministério, 1987 [cited 2013 Nov 20]. Available from: http://www.coren-ro.org.br/decreto-n-9440687-dispoe-sobre-o-exercicio-da-enfermagem-e-da-outras-providencias_767.html

13. Ministério da Saúde (BR). Secretaria de Atenção a Saúde. Gestação de alto risco: manual técnico [Internet]. Brasília: Ministério da Saúde, 2010 [cited 2013 Nov 22]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/gestacao_alto_risco.pdf

14. Ministério da saúde (RJ). Resolução nº 223 de 03 de dezembro de 1999: Dispõe sobre a atuação de enfermeiros na assistência a mulher no clico gravídico puerperal [Internet]. Rio de Janeiro: Conselho Federal de Enfermagem - COFEN, 1999 [cited 2013 Nov 22]. Available from: <http://abenfo.redesindical.com.br/arqs/outr os/resolucao2.pdf>

15. World Health Organization, Maternal and Newborn Health/Safe Motherhood Unit. Care in normal birth: a practical guide [Internet]. 1996 [cited 2013 Oct 13]. Available from: http://whqlibdoc.who.int/hq/1996/WHO_FRH_MSM_96.24.pdf?ua=1

16. Melo AS, Santos AG dos, Nery IS, Santos SEG, Santiago AKC. Diagnósticos de enfermagem na saúde da mulher: parturientes na primeira fase do trabalho de parto. J Nurs UFPE on line [Internet]. 2014 June [cited 2013 Dec 27];8(6):1467-73. Available from: <http://www.revista.ufpe.br/revistaenfermage m/index.php/revista/article/download/5911/9214>.

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