OBSTETRIC OCCURRENCES TREATED BY THE MOBILE EMERGENCY CARE SERVICE

OCORRÊNCIAS OBSTÉTRICAS ATENDIDAS PELO SERVIÇO DE ATENDIMENTO MÓVEL DE URGÊNCIA

OCURRENCIAS OBSTÉTRICAS ATENDIDAS POR EL SERVICIO DE ATENCIÓN MÓVIL DE URGENCIA

Jéssica Gomes da Silva¹, Suzel Regina Ribeiro Chavaglia², Mariana Torreglosa Ruiz³, Maria Carolina Belo da Cunha⁴, Kleiton Gonçalves do Nascimento⁵, Eliana Maria Scarelli Amaral⁶

ABSTRACT

Objective: to describe the profile of the obstetric occurrences attended by the Mobile Emergency Care Service. **Method:** this is a quantitative, descriptive, exploratory study with retrospective data. The data were collected through the SAMU service records. The sample consisted of the analysis of 301 service records, and the results presented through statistical data. **Results:** it is reported that obstetric calls accounted for 0.40% of the SAMU services; the mean age of pregnant women was 25.08 years; the majority were primigravida, were in the third trimester, performed prenatal care and the main complaints were related to labor (91.3%). There was statistical significance between the activation of the SAMU by complaints regarding labor and the third gestational trimester indicating the relevance of the calls. **Conclusion:** it is concluded that knowing the needs of women seeking care in the pre-hospital service and drawing the profile of care are essential information to subsidize public actions and policies that enable quality care and reduce maternal and child morbidity and mortality. neonatal. **Descriptors:** Obstetric Nursing; Prehospital Care; Emergencies; Pregnant Women; Emergency Nursing; Emergency Medical Services.

RESUMO

Objetivo: descrever o perfil das ocorrências obstétricas atendidas pelo Serviço de Atendimento Móvel de Urgência. **Método:** trata-se de um estudo quantitativo, descritivo, exploratório, com dados retrospectivos. Coletaram-se os dados por meio das fichas de atendimento do SAMU. A amostra foi composta pela análise de 301 fichas de atendimento, e os resultados apresentados por meio de dados estatísticos. **Resultados:** informa-se que os chamados por causas obstétricas representaram 0,40% dos atendimentos do SAMU; a idade média das gestantes foi de 25,08 anos; a maioria era primigesta, estava no terceiro trimestre gestacional, realizou pré-natal e as principais queixas foram relacionadas ao trabalho de parto (91,3%). Houve significância estatística entre o acionamento do SAMU por queixas referentes ao trabalho de parto e o terceiro trimestre gestacional indicando a pertinência dos chamados. **Conclusão:** conclui-se, que ao conhecer as necessidades das mulheres que buscam atendimento no serviço pré-hospitalar e traçar o perfil de atendimentos são informações essenciais para subsidiar as ações e as políticas públicas que possibilitem oferecer assistência de qualidade e reduzir a morbimortalidade materna e neonatal. **Descritores:** Enfermagem Obstétrica; Assistência Pré-Hospitalar; Emergências; Gestante; Enfermagem em Emergência; Serviços Médicos de Emergência.

RESUMEN

Objetivo: describir el perfil de las ocurrencias obstétricas atendidas por el Servicio de Atención Móvil de Urgencia. **Método:** se trata de un estudio cuantitativo, descriptivo, exploratorio, con datos retrospectivos. Se recogen los datos por medio de las fichas de atención del SAMU. La muestra fue compuesta por el análisis de 301 fichas de atención, y los resultados presentados por medio de datos estadísticos. **Resultados:** se informa que los llamados por causas obstétricas representaron el 0,40% de las atenciones del SAMU; la edad media de las gestantes fue de 25,08 años; la mayoría era la primera gestación, estaba en el tercer trimestre gestacional, realizó prenatal y las principales quejas fueron relacionadas al trabajo de parto (91,3%). Hubo significancia estadística entre el accionamiento del SAMU por quejas referentes al trabajo de parto y el tercer trimestre gestacional indicando la pertinencia de los llamados. **Conclusión:** se concluye que al conocer las necesidades de las mujeres que buscan atención en el servicio pre-hospitalario y trazar el perfil de atención son informaciones esenciales para subsidiar las acciones y las políticas públicas que posibiliten ofrecer asistencia de calidad y reducir la morbimortalidad materna y neonatal. **Descriptor:** Enfermería Obstétrica; Atención Pre-Hospitalaria; Urgencias Médicas; Mujeres Embarazadas; Enfermería de Urgencia; Servicios Médicos de Urgencia.

¹Nurse, Federal University of the Triângulo Mineiro / UFTM. Uberaba (MG), Brazil. E-mail: jessicagomes36@hotmail.com ORCID iD: <https://orcid.org/0000-0002-9969-0579>; ^{2,3,6} PhD, Federal University of the Triângulo Mineiro / UFTM. Uberaba (MG), Brazil. E-mail: suzel.ribeiro@yahoo.com.br ORCID iD: <https://orcid.org/0000-0001-7033-0185>; E-mail: marianatorreglosa@hotmail.com ORCID iD: <https://orcid.org/0000-0002-5199-7328>; E-mail: enfermagemcampinas@unip.br ORCID iD: <https://orcid.org/0000-0002-6174-6821>; ⁴ Master (Doctorate student), Federal University of the Triângulo Mineiro / UFTM. Uberaba (MG), Brazil. E-mail: carolindabelo@hotmail.com ORCID iD: <https://orcid.org/0000-0003-2288-8103>; ⁵Master (Doctorate student), Federal University of the Triângulo Mineiro / UFTM. Uberaba (MG), Brasil. E-mail: kleitton_uniube@yahoo.com.br ORCID iD: <https://orcid.org/0000-0002-2717-6837>

INTRODUCTION

It is emphasized that maternal mortality is a public health problem faced worldwide. It was estimated that in 2013, there were approximately 292 thousand deaths.¹ There were 82,790 deaths of women of childbearing age (10-49 years) in the State of Minas Gerais / MG, Brazil, from 2000 to 2011, 1,219 were classified as maternal deaths.²

Maternal death is defined by the World Health Organization (WHO) as: "death of a woman during pregnancy or within a period of 42 days after termination of pregnancy due to or related to pregnancy related cause, but not due to accidental or incidental causes".³

Maternal deaths can be classified as direct when they occur due to obstetric complications during pregnancy, delivery or puerperium, and indirect when caused by diseases that existed before pregnancy and were aggravated by the physiological effects of pregnancy.⁴

It is known that most maternal deaths are preventable. Hemorrhages are considered to be the leading causes of maternal mortality in the world followed by complications arising from: infections, increased blood pressure during pregnancy, complications of childbirth, and clandestine abortions.⁵⁻⁶

Eight Millennium Development Goals (MDGs) were established by the United Nations (UN) in 2000, and the fifth objective refers to improving maternal health.⁷ The following targets were set for this goal: to reduce by 75 % maternal mortality in the period 2000 to 2015; gestation and delivery by qualified personnel; improving access to reproductive health services (including prenatal care and family planning); reduce teenage pregnancy rates and improve the quality of information and records on births and deaths.⁶

According to the report of the millennium goals released by the UN in 2015, the progress was significant, but far short of the goals and targets set, and great inequalities were identified among the different regions of the world.⁶ It is noted that the overall rate of reduction in maternal mortality reached was 45%, however, it has been noted that the index has been declining in all countries since 2000. However, improvement in regions with worse indices such as Southeast Asia (64 per cent) and Sub-Saharan Africa (49 per cent), although rates are still 14 times higher in developing regions.⁶ The maternal mortality rate declined in only 21%.⁸

In order to improve the quality of health care in general, the Ministry of Health launched in 2003 the National Emergency and Urgency Policy with the purpose of structuring and organizing the emergency and emergency network in the country, interconnecting the pre-hospital fixed, pre-hospital, mobile, hospital and post-hospital components.⁹

It is also added that mobile pre-service was also under the responsibility of the Mobile Emergency Care Service (MECS), regulated by Administrative Rule No. 1864 / GM. It should be emphasized that it has, as a function, the rescue and rescue carried out in homes, workplaces and public roads throughout the national territory through access by the Central de Regulation 192.⁹

It is evidenced that MECS has, as its main focus, emergency and emergency care for users with clinical, pediatric, psychiatric, surgical and gynecological-obstetric demands. It is shown in this last area, which is essential in the rapid care and transportation of pregnant women in labor where there is a risk of death for the mother and / or fetus, that is, it is an important tool to reduce the number of deaths due to delay access and minimize sequelae due to late care.¹⁰

It is revealed that, as in Brazil, the goal of reducing maternal mortality was not achieved, some initiatives were created to improve the quality of care for pregnant women, such as the "Stork Network" (2011) and "Health Near You "(2013). These initiatives focus on improving the four components: prenatal care; birth; puerperium and integral attention to children's health, in addition to the logistic system, linked to MECS, which includes the transportation and regulation components.⁸

Thus, it is indicated to reduce maternal mortality and make possible new advances, that it is necessary to first understand the causes of death, to know the main complaints of the users of the health service and to identify the access of these pregnant women to the service, justifying the accomplishment of this study.

OBJECTIVE

- To describe the profile of the obstetric occurrences attended by the Mobile Emergency Care Service.

METHOD

It is a quantitative, descriptive, exploratory study with the use of retrospective data.

It is noticed that the scientific evidences for the practice of Nursing depend on

descriptive researches. It should be noted that there is a logical progression of knowledge expansion, and descriptive studies documenting the prevalence, nature and intensity of conditions and behaviors are of great importance for the health area.¹¹ Retrospective exploratory studies with a database that can support more rigorous prospective studies.¹¹

The study was approved and approved by the Research Ethics Committee (REC) of the Federal University of the Triângulo Mineiro (UFMT), under opinion No. 1,777,162, in strict compliance with the Resolution of the National Health Council (NHC) n ° 466/2012 and the Operational Norm n ° 001/2013 of the NHC.

Data was collected through the analysis of MECS / Uberaba data sheets from January 2014 to June 2016. The sample was determined for convenience. All the records of attendance where obstetric causes were included as a reason for occurrence. During this period, 403 obstetric referrals were requested, however, the final sample consisted of the analysis of 301 tokens. They were excluded from the files not found and with incomplete information, which resulted in a loss percentage of 34%.

For the collection of data, an instrument was structured by the researchers themselves based on the data described in the data sheets. The data sheets contained the following information / variables: the age of the pregnant woman; gestational age; main complaint; prenatal care; number of pregnancies; number of previous deliveries and types (normal or cesarean section), number of abortions and place of referral of the pregnant woman.

The data was stored after collection in an Excel® worksheet and transported to the Statistical Package for the Social Sciences (SPSS), version 20, and analyzed by simple descriptive statistics with the presentation of the results in tables.

RESULTS

It is shown, from January 2014 to June 2016, that 102,002 calls were answered by MECS from Uberaba - MG, with an average of 3400.0 ± 1254 calls / monthly, varying from 2,401 calls (November / 2015) to 9,550 called (April / 2015). The number of obstetric causes was 403 in this period, with an average of 13.4 ± 8.6 monthly calls, ranging from one (October / 2014) to 33 (December / 2014). 0.40% of the MECS's referred to as obstetrical causes were represented. It should be

emphasized that the data presented below represent the analysis of the 301 tokens for obstetric reasons found and with complete information on the occurrence.

It is reported that the age of pregnant women ranged from 13 to 42, with an average of 25.1 ± 6.6 years, of which 15.3% were adolescents and 10.6% were older than 35 years. Gestational age ranged from four to 42 weeks, with a mean of 33.8 ± 8.4 gestational weeks, and the majority of the pregnant women were in the third gestational trimester - 243 (80.7%).

It is noteworthy, as far as the previous obstetric history is concerned, that the majority, 193 (64.1%), reported being the first or third gestation; 86 (28.6%) had four to six pregnancies; 21 (7%), seven to ten pregnancies and only one (0.3%) had 11 to 13 previous pregnancies. Regarding previous deliveries, 115 (38.2%) had already had one to three normal deliveries; 35 (11.6%), four to six and four (1.3%), from seven to ten. The cesarean section was the previous outcome of 96 (31.9%) pregnant women with one to three deliveries and seven (2.3%) had four to six operative deliveries. Only 4.3% of pregnant women had a history of previous abortion.

It is reported that almost all pregnant women attended (281 - 93.4%) underwent prenatal care and 20 (6.6%) reported having not had any prenatal visits.

It should be noted that, when analyzed, the main complaints of pregnant women on presentation of the call were: 133 (44.2%) had labor characteristics such as uterine contractions (69 - 22.9%) and lower belly pain 64 - 21.3%); rupture of amniotic membranes was the second most frequent cause (102 - 33.9%) followed by vaginal bleeding (36 - 12%).

The calls were still motivated by: convulsive crisis (five); loss of mucus buffer (four); hypoglycemia and pre-eclampsia (both with three calls); and exogenous intoxication, fainting, vomiting and general malaise (two calls in each category) and complaints automobile trauma, weakness, chest pain, vertigo, falling from the height itself and scorpion sting received a call because of this.

The pregnant women were referred mainly to the two reference maternity hospitals of the municipality that provide care for the Unified Health System (UHS), according to municipal agreement - public teaching hospital, 148 (49.2%), and private teaching hospital, 140 (46.5%). Three (1.0%) were referred to the Emergency Care Unit (ECU)

and ten (3.3%) refused service after the call and remained at home.

It is demonstrated that the pregnant women referred to the Emergency Care Unit had the following profile: two had eight weeks of gestation and one, 34 weeks. The main complaint was pain in the lower belly (67%) and an eight-week pregnant woman had a broken bag complaint. The pregnant women who refused treatment had between 18 and 40 weeks of gestation and the main complaints were: low belly pain (40%); uterine contractions (20%); hypoglycemia (20%); (10%) and vaginal bleeding (10%). Hypoglycaemic complaints were made by pregnant women at

18 and 24 weeks, respectively, and the other complaints were made by pregnant women in the third gestational trimester.

The results of Pearson's correlation between the relevance of the complaint and the gestational trimester are presented in the table below (Table 1). It can be verified that the pertinence between the gestational trimester and the complaint was significant ($p < 0.001$): pregnant women in the third gestational trimester triggered the MECS more because of complaints about labor (lower belly pain, contractions, ruptured pocket, bleeding vaginal bleeding and loss of mucus).

Table 1. Pearson's correlation between the relevance of the complaint (labor complaint and other complaints) with the gestational trimester between the so-called registered in the MECS. Uberaba (MG), Brazil, 2016.

Labor and Delivery		Other complaints	Total	p
3rd trimester	230	13	243	<0.001
1st and 2nd trimester	45	13	58	
Total	275	26	301	

DISCUSSION

It is characterized the number of obstetric calls received by the MECS in the analyzed period (30 months) as inferior to data from other Brazilian municipalities. In the city of Botucatu (SP), in one year, 358 calls were made for obstetric causes.¹² It was seen that when analyzing the percentages of calls in relation to total calls, this figure was also lower than in other Brazilian municipalities where the percentage ranged from 2.5 to 8.6% of total visits.¹³⁻⁵

It is reported that the mean age of the pregnant women (25.1 ± 6.6 years) who performed the call was higher than the data found in the literature in which the majority of pregnant women were between the ages of 15 and 24 years.¹²⁻⁶ In a Chilean study, the average age of women was equal to or greater than 29 years.¹⁷

It is also considered, when analyzing the age of pregnant women, in this study, a high percentage of adolescent pregnant women, aged between 13 and 18 years (15.3%). It is characterized the gestation in the adolescence with a public health problem. It was observed that, according to a study conducted in Botucatu / SP with 220 adolescents, 73 had pregnancies at an early age (13 to 16 years) and 147, late (17 to 19 years). It was shown in the study that the profile of adolescents with gestation at early ages, mostly worked, had no partner, was

primigravida, had lower income and performed the birth in the UHS.¹⁸

The Brazilian Institute of Geography and Statistics (IBGE) complements the profile of pregnant women aged 15 to 19 years, with a predominance of residence in the Northeast region (35.8%); 69% are black or brown; have an average year of study of 7.7 years; only 20.1% were still studying at the time of gestation and 59.7% did not study and did not work.¹⁹

It is warned that this group of pregnant women deserves special attention from health professionals due to the physical, emotional and social lack of preparation that gestation causes in the maternal organism. This group is more likely to present complications such as abortion, hypertensive gestational disease, hemorrhagic syndromes, urinary infections and premature rupture of membranes.²⁰ It is considered among newborns of adolescent mothers, a higher prevalence of prematurity and low birth weight.²¹

It was pointed out that there was a predominance of calls for pregnant women in the third gestational trimester (80.7%), as well as in a study that analyzed the obstetric calls of the MECS in a municipality of Bahia. However, 69% of the records did not contain information on gestational age,¹⁵ which may compromise the evaluation and quality of care.

It is explained that, contrary to the results of other studies,^{12,15} the majority of the pregnant women attended by the MECS were

primigravida, and, among those who had previous deliveries, previous normal delivery (38.2%). A study in an emergency service at the border between the United States and Mexico showed that, among the pregnant women who already had children, 84.6% had a history of normal delivery and 15.4% had previously had a cesarean section.¹⁶

It should be noted that the World Health Organization (WHO) recommends that the cesarean section rate should not exceed 15%⁽²²⁾, however, in the declaration published in 2015, it is suggested that these rates should not exceed 10% and that the classification be adopted of Robson to detect the profile of women undergoing caesarean section.²³ Caesarean section is reported to be an effective life-saving intervention when indicated for justifiable reasons, however, rates above 10% were not associated with reduced mortality and increased rates complications.²³

It is shown that a national study entitled "Birth in Brazil" indicated that 51.9% of births occurred through cesarean deliveries.²⁴ It was found that in 2015 the Information System on Live Births (SINASC) registered 3,017. 668 births, with a predominance of cesarean deliveries (55.5%).²⁵

It is observed that almost all the pregnant women attended by the SAMU (93.4%) performed the prenatal follow-up. It is seen that this trend towards greater prenatal adherence has been observed in Brazil with percentages above 90% of adherence.^{19,26} They observed that in studies that interviewed pregnant women, they show that they recognize the benefits of prenatal care for the birth of a healthy baby.^{20,27}

It is known that the adequate follow-up in pregnancy allows the identification of problems and risks in a timely manner for interventions and, thus, avoids complications and reduces damages. The percentage of adherence to the seven consultations recommended by the Ministry of Health (six during pregnancy and one in the puerperium) has increased over the years from 46% in 2000 to 61% in 2010.²²

In the national and international studies on emergency obstetric care performed by the MECS, the same characteristics of the sample callings were presented, that is, the majority of pregnant women presented signs of labor, with more frequent complaints of uterine contractions, loss of vaginal tamponade, loss of amniotic fluid, vaginal bleeding and lower belly pain.^{12,14-7,28}

It is understood, in relation to the relevance of the calls, that there was statistical significance between the activation of the MECS by complaints concerning labor and the third gestational trimester. It should be pointed out that the obstetric care of the MECS has, by focus, the rapid care and transportation of pregnant women in labor.¹⁰ It was identified in a study on the pertinence, according to the Risk Classification for Pregnant Women in the Ministry of That 93.3% of the so-called obstetricians were.¹²

This study was limited by the inadequate completion of the records, with incomplete data, making it difficult to trace the profile of all occurrences attended with a high percentage of losses (34%). In this sense, the United Nations has also identified the quality of information as a component that needs attention and intense improvements in the reduction of maternal and neonatal morbidity and mortality.⁶ In this process, manual annotations are cited as obstacles. , since if this data were computerized, containing a checklist, it would facilitate greater ease and agility at the time of filling.

CONCLUSION

Based on data from this study, the following profile can be outlined: obstetric referrals accounted for 0.40% of MECS care; the mean age of pregnant women was 25.08 years; the majority were primigravida, were in the third trimester, performed prenatal and the main complaints were related to labor. There was statistical significance between the activation of the MECS by complaints regarding labor and the third gestational trimester indicating the pertinence of the so-called.

However, it was identified a high percentage of incomplete fulfillment records, demonstrating the need to improve information on care.

It is concluded that the data of this study is fundamental for the Secretary of Health to propose advances and to plan new projects and strategies of public health. It is imperative to know the needs of women who seek care in the pre-hospital service, as well as to draw the profile of care to subsidize actions and public policies that allow to offer quality care and reduce maternal and neonatal morbidity and mortality.

REFERENCES

1. Kassebaum NJ, Bertozzi-Villa A, Coggeshall MS, Shackelford KA, Steiner C, Heuton KR, et al. Global, regional, and

national levels and causes of maternal mortality during 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet*. 2014 Sept;384(9947):980-1004. Doi: [10.1016/S0140-6736\(14\)60696-6](https://doi.org/10.1016/S0140-6736(14)60696-6)

2. Martins EF, Almeida PFB, Paixão CO, Bicalho PG, Errico LSP. Multiple causes of maternal mortality related to abortion in Minas Gerais State, Brazil, 2000-2011. *Cad Saúde Pública*. 2017;33(1):1-11. Doi: <http://dx.doi.org/10.1590/0102-311x00133116>.

3. Ministério da Saúde (BR), Secretaria de Políticas de Saúde, Área Técnica de Saúde da Mulher. Manual dos comitês de mortalidade materna [Internet]. Brasília: Ministério da Saúde; 2002 [cited 2018 June 18]. Available from:

http://bvsmms.saude.gov.br/bvs/publicacoes/cd07_13.pdf

4. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. Manual dos comitês de mortalidade materna [Internet]. 3rd ed. Brasília: Ministério da Saúde; 2009 [cited 2018 June 15]. Available from: http://bvsmms.saude.gov.br/bvs/publicacoes/manual_comites_mortalidade_materna.pdf

5. Say L, Chou D, Gemmill A, Tunçalp O, Moller AB, Daniels J, et al. Global causes of maternal death: a WHO systematic analysis. *Lancet Glob Health*. 2014 June;2(6):e323-33. Doi: [10.1016/S2214-109X\(14\)70227-X](https://doi.org/10.1016/S2214-109X(14)70227-X)

6. United Nations. The millennium development goals report [Internet]. New York: United Nations; 2015 [cited 2018 May 28]. Available from: http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20%28July%201%29.pdf

7. Instituto de Pesquisa Econômica Aplicada e Secretaria de Planejamento e Investimentos Estratégicos, Grupo Técnico para o acompanhamento dos ODM. Objetivos de desenvolvimento do milênio: relatório nacional de acompanhamento [Internet]. Brasília: Ipea; 2014 [cited 2018 May 12]. Available from: http://www.ipea.gov.br/portal/images/stories/PDFs/140523_relatorioodm.pdf

8. Objetivos de Desenvolvimento do Milênio (BR). Os objetivos de desenvolvimento do milênio [Internet]. Brasília: Governo Federal; 2017 [cited 2018 Apr 18]. Available from: <http://www.odmbrasil.gov.br/os-objetivos-de-desenvolvimento-do-milenio>

9. Ministério da Saúde (BR), Política nacional de atenção às urgências [Internet]. 3rd ed. Brasília: Ministério da Saúde; 2006 [cited 2018

Apr 17]. Available from: http://bvsmms.saude.gov.br/bvs/publicacoes/politica_nacional_atencao_urgencias_3ed.pdf

10. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Atenção Especializada. Manual instrutivo da rede de atenção às urgências e emergências no Sistema Único de Saúde (SUS) [Internet]. Brasília: Ministério da Saúde; 2013 [cited 2018 Mar 18]. Available from: http://bvsmms.saude.gov.br/bvs/publicacoes/manual_instrutivo_rede_atencao_urgencias.pdf

11. Polit DF, Beck CT. Fundamentos de pesquisa em enfermagem: avaliação de evidências para a prática da enfermagem. 7th ed. Porto Alegre: Artmed; 2016.

12. Michilin NS, Jensen R, Jamas MT, Palvequeires S, Parada CMGL. Analysis of obstetric care provided by the Mobile Emergency Care Service. *Rev Bras Enferm*. 2016 July/Aug; 69(4):669-75. Doi: <http://dx.doi.org/10.1590/0034-7167.2016690408i>

13. Dias JMC, Lima MSM, Dantas RAN, Costa IKF, Leite JEL, Dantas DV. Profile of state prehospital mobile emergency care service. *Cogitare Enferm*. 2016 Jan/Mar; 21(1): 01-9. Doi:

<http://dx.doi.org/10.5380/ce.v21i1.42470>

14. Monteiro MM, Sá GGM, Oliveira Neto JG, Lopes KDCL, Carvalho DA, Martins MCC. Emergency obstetric: case features served in mobile service urgente. *R Interd* [Internet]. 2016 Apr/June [cited 2018 Apr 21]; 9(2):136-44.

https://revistainterdisciplinar.uninovafapi.edu.br/index.php/revinter/article/view/948/pdf_320

15. Gusmão NVS, Souza ZCSN, Fonseca MCC. Care provided to pregnant women and puerperal mothers by the mobile emergency care service. *Ciênc Cuid Saúde*. 2016; 15(1):11-8. Doi: <http://dx.doi.org/10.4025/ciencucuidsaude.v15i1.2376>

16. McDonald JA, Riskel K, Escobedo MA, Arellano DE, Cunningham TJ. Obstetric emergencies at the United States-Mexico border crossing in El Pano, Texas. *Rev Panam Salud Publica*. 2015; 37 (2): 76-82. PMID: [25915011](https://pubmed.ncbi.nlm.nih.gov/25915011/)

17. Portiño MC, Novoa DG, González-Burboa A, Aguilera CL, Fernández NP, Astorga PV. Evaluación de la categorización de las urgências gineco-obstétricas en un hospital der sur de Chile. *Rev Chil Obstet Ginecol*. 2016 Apr;81(2):105-12. Doi:

<http://dx.doi.org/10.4067/S0717-75262016000200004>

18. Costa CC, Carnevalheira APP, Gomes CB, Duarte MTC, Borgato MH, Parada CMGL. Early and late pregnant adolescents and neonatal results: a cohort study. Online braz j nurs [Internet]. 2013 [cited 2017 May 9];12(4):773-81. Available from:

http://www.objnursing.uff.br/index.php/nursing/article/view/4269/html_64

19. Governo do Brasil. Cidadania e Justiça. Taxa de fecundidade caiu 18,6% em 10 anos no País. [Internet]. Brasília: Governo Federal; 2015 [cited 2018 May 19]. Available from: <http://www.brasil.gov.br/cidadania-e-justica/2015/12/taxa-de-fecundidade-caiu-18-6-em-10-anos-no-pais>

20. Azevedo WF, Diniz MB, Fonseca ESVB, Azevedo LMR, Evangelista CB. Complications in adolescent pregnancy: systematic review of the literature. Einstein (São Paulo). 2015 Oct/Dec;13(4):618-26. Doi:

<http://dx.doi.org/10.1590/S1679-45082015RW3127>

21. Queiroz MVO, Brasil EGM, Alcântara CM, Carneiro MGO. Profile of pregnancy in adolescence and related clinical-obstetric occurrences. Rev RENE. 2014;15(3):455-62. Doi: [10.15253/2175-6783.2014000300010](https://doi.org/10.15253/2175-6783.2014000300010)

22. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. Atenção à saúde do recém-nascido: guia para os profissionais de saúde: cuidados gerais [Internet]. 2nd ed. Brasília: Ministério da Saúde; 2014 [cited 2018 Mar 25]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/atencao_saude_recem_nascido_v1.pdf

23. Betran AP, Torloni MR, Zhang J, Ye J, Mikolajczyk R, Deneux-Tharaux C, et al. What is the optimal rate of caesarean section at population level? A systematic review of ecologic studies. Reprod Health. 2015 June;12(1):57. Doi: [10.1186/s12978-015-0043-6](https://doi.org/10.1186/s12978-015-0043-6)

24. Leal MC, Pereira APE, Domingues RMSM, Theme Filha MM, Dias MAB, Nakamura-Pereira M, et al. Obstetric interventions during labor and childbirth in Brazilian low-risk women. Cad Saúde Pública. 2014; 30 (Suppl 1): S17-S32. Doi: <http://dx.doi.org/10.1590/0102-311X00151513>

25. Ministério da Saúde (BR), Departamento de Informática do Sistema Único de Saúde. Informações de Saúde. Nascidos Vivos Brasil 2016 [Internet]. Brasília: Ministério da Saúde; 2017 [cited 2018 May 22] Available from: <http://tabnet.datasus.gov.br/cgi/tabcgi.exe?sinasc/cnv/nvuf.def>

26. Silva EP, Lima RT, Ferreira NLS, Costa MJC. Prenatal primary care in the municipality of João Pessoa, in the Brazilian State of Paraíba: characterization of services and users. Rev Bras Saúde Matern Infant. 2013 Jan/Mar; 13(1):29-37. Doi:

<http://dx.doi.org/10.1590/S1519-38292013000100004>

27. Ceron MI, Barbieri A, Fonseca LM, Fedosse E. Prenatal care in the perception of postpartum women from different health services. Rev CEFAC. 2013 May/June; 15 (3): 653-62. Doi:

<http://dx.doi.org/10.1590/S1516-18462012005000081>

28. Dantas AKC, Castro GLT, Silva HC, Davim RMB, Carvalho JBL. Characterization of obstetrical service attended by occurrences of Mobile Service of Urgency/Samu. J Nurs UFPE on line [Internet]. 2013 [cited 2017 June 8];7(10):6156-61. Available from: <https://periodicos.ufpe.br/revistas/revistaenfermagem/article/view/12251/14877>

Submission: 2018/08/28

Accepted: 2018/09/12

Publishing: 2018/12/01

Corresponding Address

Suzel Regina Ribeiro Chavaglia
Curso de Graduação em Enfermagem
Universidade Federal do Triângulo Mineiro
Praça Manoel Terra, 330
Bairro Abadia
CEP: 38025-015 - Uberaba (MG), Brazil