SSOAR Open Access Repository
www.ssoar.info

Implementation of the user embracement module from the cegonha carioca program in the city of Rio de Janeiro

Sé, Carla Coutinho Sento; Progianti, Jane Márcia; Pereira, Adriana Lenho de Figueiredo

Veröffentlichungsversion / Published Version
Zeitschriftenartikel / journal article

Empfohlene Zitierung / Suggested Citation:
Sé, C. C. S., Progianti, J. M., & Pereira, A. L. d. F. (2016). Implementation of the user embracement module from the cegonha carioca program in the city of Rio de Janeiro. *Revista de Pesquisa: Cuidado é Fundamental Online*, *8*(1), 3935-3944. https://doi.org/10.9789/2175-5361.2016.v8i1.3935-3944

Nutzungsbedingungen:
Dieser Text wird unter einer CC BY-NC Lizenz (Namensnennung-Nicht-kommerziell) zur Verfügung gestellt. Nähere Auskünfte zu den CC-Lizenzen finden Sie hier:
https://creativecommons.org/licenses/by-nc/4.0/deed.de

Terms of use:
This document is made available under a CC BY-NC Licence (Attribution-NonCommercial). For more Information see:
https://creativecommons.org/licenses/by-nc/4.0

gesis Leibniz-Institut für Sozialwissenschaften

Mitglied der Leibniz-Gemeinschaft

Diese Version ist zitierbar unter / This version is citable under:
https://nbn-resolving.org/urn:nbn:de:0168-ssoar-53889-3

ISSN 2175-5361
DOI: 10.9789/2175-5361

RESEARCH

Implantação do módulo acolhimento do programa cegonha carioca no município do Rio de Janeiro

Implementation of the user embracement module from the cegonha carioca program in the city of Rio de Janeiro

Despliegue del módulo de acogida del programa cigüeñacarioca en el municipio de Rio de Janeiro

Carla Coutinho Sento Sé [1], Jane Márcia Progianti [2], Adriana Lenho de Figueiredo Pereira [3]

ABSTRACT

Objective: To describe the strategies from the public administration for the implementation of the user embracement module from the Cegonha Carioca Program. **Method:** Qualitative study. Semi-structured interviews happened in the period from January to March 2013 with three superintendents of Children's and Maternity Hospitals responsible for the creation and implementation of the Carioca Program. **Results:** The strategies adopted by the public administration for the implementation of the user embracement module were: linking the prenatal care to a reference Maternity Hospital; the reorganization of the City's obstetric emergencies and the insertion of the obstetrical nurse in the user embracement module. **Conclusion:** The obstetrical nurse was inserted into these emergencies in order to put the user embracement practices into action, being recognized by the superintendents as a technical authority on the humanized obstetrical care. **Descriptors:** Health policy, Women's health, Obstetrical nursing, User embracement.

RESUMO

Objetivo: Descrever as estratégias da gestão pública para a implantação do módulo acolhimento do Programa Cegonha Carioca. **Método:** Estudo qualitativo. Foram realizadas entrevistas semiestruturadas, no período de janeiro a março de 2013, com três gerentes da Superintendência de Hospitais Pediátricos e Maternidades, responsáveis pelo processo de elaboração e implantação do Programa Cegonha Carioca. **Resultados:** As estratégias utilizadas pela gestão pública para implantação do módulo acolhimento foram: a vinculação do pré-natal à maternidade de referência; a reorganização das emergências obstétricas municipais e a inserção da enfermeira obstétrica no módulo acolhimento. **Conclusão:** a enfermeira obstétrica foi inserida nessas emergências para implementar as ações de acolhimento, sendo reconhecida pelas gerentes como uma autoridade técnica no cuidado obstétrico humanizado. **Descritores:** Política de saúde, Saúde da mulher, Enfermagem obstétrica, Acolhimento.

RESUMEN

Objetivo: Describir las estrategias de la administración pública para implementar el módulo de acogidadel Programa Cigüeña Carioca. **Método:** Estudio cualitativo. Las entrevistas semi-estructuradas se llevaron a cabo en el período de enero a marzo de 2013, con tres gestores de la Supervisión de los Hospitales Pediátricos y Maternidades, responsables por el proceso de elaboración e implementación del Programa Cigüeña Carioca. **Resultados:** Las estrategias utilizadas por la administración pública a la implementación del módulo de acogidafueron:maternidad de referencia vinculante prenatal; la reorganización de las emergencias obstétricas municipales y la inserción de enfermera obstétrica en el módulo de acogida. **Conclusión:** La enfermera obstétrica fue insertada en estas emergencias para implementar acciones de acogida, siendo reconocidas por los administradorescomo una autoridad técnica en la atención obstétrica humanizada. **Descriptores:** Política de la salud, Salud de la mujer, Enfermería obstétrica, Acogida.

1 Master in nursing FACENF/UERJ (Line of research: Knowledge, Policy and Practice in Nursing and Health), 2012/2014. Obstetric Nurse (S Specialization Course in Obstetric Nursing in the residency program modality Nursing at SMSDC/RJ, linked to the School of Nursing UERJ), 2009-2011. Graduate in Nursing from the State University of Rio de Janeiro (- UNIRIO / 2008).
2 PhD in Nursing, Associate Professor in the Nursing Graduate Program at the State University of Rio de Janeiro. 3 PhD in Nursing, Assistant Professor in the Nursing Graduate Program at the State University of Rio de Janeiro.

INTRODUCTION

Since 2004, when the National Pact for the Reduction of Maternal and Neonatal Mortality was launched, stimulating the reference and cross-referenced formalization of pregnant women at delivery, it had already been presented as one of the government priorities, because they knew of the direct relationship of the maternal and infant morbidity and mortality indices with antepartum pilgrimage.[1]

The pilgrimage is a consequence of fragmented healthcare systems. According to the Pan American Health Organization (2010), this fragmentation manifests itself in several ways, such as the lack of coordination between the different levels and points of care in the duplication of services and infrastructure in idle capacity and healthcare services provided at less suitable locations, particularly in hospitals.[2]

Accordingly, in the municipality of Rio de Janeiro, in 2009, had a chronic problem of pilgrimage of pregnant women seeking care for childbirth, which culminated in a case of intrauterine fetal death reported in the media, and so even, had repercussions on the women's health policy.

With this context at the local level and with high maternal mortality in the country, in 2010, the Ministry of Health published the Organizational Network Guidelines for Health Care within the Unified Healthcare System (SUS). This legislation was the definition of health care network as organizational arrangements and actions of healthcare services, different technological densities, which should be integrated by means of technical, logistical and management support systems.[3]

This legislation was the definition of health care network as organizational arrangements and actions of healthcare services, different technological densities, which should be integrated by means of technical, logistical and management support systems The Stork Network (*Rede Cegonha*) consists of care that seeks to ensure women's right to reproductive planning and humanized care for pregnancy, childbirth and postpartum network well as the child, the right to safe birth, growth and healthy development.[4]

The Carioca Stork Program aims to expand and improve the care offered to pregnant women in the municipality of Rio de Janeiro. The objectives of this program: to humanize care of emergency care in maternity hospitals of Municipal Health Secretariat (SMS-RJ); describe the process of working in the emergency departments of hospitals in the SMS-RJ; sort by protocol, the risk of patients in the initial care setting the time limit for medical care; contribute to the effective and timely care of patients who seek care in maternity hospitals

of SMS-RJ, using the resources of her own motherhood or other units through coordination with the Internal Core Regulatory or Central Regulation of SMS-RJ; increase adherence of pregnant women to prenatal care; improve the network of reference and counter, linking primary care and hospital care responsible for the care in pregnancy, labor and birth.[5]

This program consists of three modules: prenatal care, reception and prenatal transport. The module enables the linking and prior knowledge of the reference maternity hospital for delivery care to pregnant women enrolled in the program.

In the module reception, the user is received and then her risk is stratified according to the guidelines adapted from the Manchester Protocol. Now the transport module, released in 2012, is characterized by the provision of mobile services for pregnant women to their referenced maternity hospital.

Given the above, this study aims to describe the strategies of municipal governance for the implementation of the Carioca Stork Program reception module. We believe that the discussion of the implementation of this program module process is a tool for planning and evaluation of health actions of women in the municipality of Rio de Janeiro, and may provide support to guide the deployment of new spaces.

METHOD

This is a qualitative research, which was to subject the three managers linked to the Superintendence of Pediatrics and Maternity Hospitals in the Municipal Health Secretariat of Rio de Janeiro, responsible for coordinating the hospital obstetric care in the municipality of Rio de Janeiro and the elaboration and implementation of the reception module.

The study was approved by the Ethics Committee in Research of the Municipal Health Secretariat of Rio de Janeiro, under No. 92/11, given the resolution 196/96 of the National Health Council, which protects research-involving humans.[6]

Data collection was conducted through semi-structured interview that consisted of a guiding question: *Tell me about the development and deployment of the Carioca Stork Program reception Module*. It is emphasized that the interviews were conducted at the location and the individuals defined as deponents, recorded by a *Media Player 4* (MP4). To preserve anonymity, the interviewees were identified by letters and numbers, according to the order of the interviews: Manager G1, Manager G2, and G3 Manager.

The statements followed the following steps: transcription of the interviews, data ordering, rereading the material, classification of data with horizontal and thorough reading of the texts, cross reading of each subset presented and final analysis.

Following this analytical course got the category entitled "Public Management Strategies deployment of the Carioca Stork Program reception Module", which was composed

of three sub-categories: linkage of the prenatal care to a reference maternity hospital, reorganization of municipal obstetric emergencies and the insertion of the obstetric nurse in the reception module.

RESULTS AND DISCUSSION

Linking the pre-natal the maternity reference hospital

The antepartum pilgrimage is historic in the municipality of Rio de Janeiro. This study concluded that the antepartum pilgrimage was related to the small number of available beds for the realization of low-risk deliveries, by the gap in the reference and contra-reference system between the basic and tertiary units and the difficulty of access for pregnant women to prenatal care.[7]

In the 1990s, there were insufficient obstetric beds for the population in the municipality of Rio de Janeiro, in addition to the migration of pregnant women from other municipalities, uneven geographical distribution of beds by programmatic areas and lack of integration of existing beds.

However, at the end of the first decade of the 21st century, there was a fall in the birth rate and stabilization of obstetric beds public in the municipality of Rio de Janeiro, a fact directly related to the expansion in the number of obstetric beds, in both the city and the Metropolitan Region. We emphasize that, in 1991, the gross birth rate was 18.7, and was maintained at 18.0 years in 2000, and having significant decrease to 13.7 in the year 2009.[8]

Thus, the facts mentioned above have helped to link the prenatal to the reference maternity hospital, which has arisen in the context of the reorganization of the perinatal system, having been possible through the mapping of obstetric beds existing and the consequent municipal network diagnostic obstetric care.

> This mapping was done, along with the Program Area Coordination, Superintendence and maternities, to evaluate our installed capacity. It was a scenario where there was an installed capacity that supplied the demand and the planning of new units that would be inaugurated. Then there was a big chart of the city of Rio de Janeiro. (G3)

As pointed out in the speech of the interviewee, this mapping was an important action to evaluate the capacity of prenatal care and the care of the pregnant women at the time of delivery, with the main purpose to reduce the antepartum pilgrimage.

Thus, with the municipal obstetric network diagnosis and aiming at linking pregnant women to the reference maternity hospital, in 2010, began the prenatal module of the Carioca Stork Program. This module has been instituted in all units under municipal

management. The other maternity hospitals located in the municipality, the Maternity Hospital School of the Federal University of Rio de Janeiro was the first to join the Program.

During this same year, there was the release of the proposal prenatal module in basic units and maternity hospitals were opened and the visits of pregnant women at the reference maternity hospitals. It is worth noting that the Federal Law No. 11634, of December 27, 2007, ensures the right of pregnant women to know in advance the location where delivery occurs and, if necessary, assistance in cases of complications.[9]

This linking of a prenatal referral maternity hospital highlighted the lack of care to women at the entrance doors of the municipal emergency hospitals.

> *We identified that the entrance door was undervalued and quality that people frequently questioned. We were then taking a pregnant woman to the maternity hospital, where they made a visit during pregnancy, which is part of the prenatal module. By the time they arrived to the maternity ward, they were not always received. (G1)*

Thus, this linking demonstrated the necessity of reorganizing the municipal obstetric emergencies, aimed at favoring access to childbirth, reducing the antepartum pilgrimage and the receiving of pregnant women in emergencies.

Reorganization of municipal obstetric emergencies

The reorganization of municipal obstetric emergencies, as evidenced by linking the reference prenatal maternity hospital, demonstrated the need to improve the care process at the obstetric care network hospital entrance doors.

Accordingly and in line with the goals for women's health pointed to by *More Health Program: Right of All (2008-2011)*[10], reception with credit rating was considered by the managers of the supervision of Pediatric Hospitals and maternity hospitals, an important technology for the improvement of the work process in obstetric emergencies in the municipal.

> *We recognize that the so-called emergency obstetric was a location where work processes were very poorly organized. They were at the mercy of the shift situation or the teams. Therefore, the technical team realized the need for a thorough review of obstetric admission work processes. The good evidence, good practice, good health systems showed that technologies in the reception and the risk rating were the answer to an improvement of the work process. (G2)*

The reception can be considered a trigger device of changes in the organization of the work process, to act with a focus on the user and their needs and based on the expanded concept of health, contributing to the strengthening of the perspective of law and for the qualification of the assistance.[11] Being understood as a technology meeting between the actors involved in the health work, the reception enables the qualification of listening, building bond, guaranteed access with accountability and problem solving services. As a technical-assistance device, allows reflection and switching modes to operate the service, which questions the clinical workplace relations in health care models and management relations and access to services.[12]

In the maternity hospitals of the city of Rio de Janeiro, the reception with risk classification was implemented initially in the Emergency Hospital Maternity Hospital Carmela

Dutra, presenting own nursing unit, only during the day, as a pilot project. Among all the maternity hospitals of the city, just the Fernando Magalhães Maternity Hospital had nurses in the emergency sector, for 24 hours. In other units, the presence of the nurse worked in day shifts or as a day laborer.

> *We had experiences in the [Maternity Hospital] Carmela Dutra, with its own chart. However, we only managed limit it there. Therefore, we knew it needed a new team; a new workforce at that time there was no prospect of the public contest. (G2)*

Thus, for the reorganization of emergencies was necessary to face the shortage of nursing human resources. Thus, the city opted for the contract management model with social organizations (SO) for the composition of the nursing board.

> *There was a political decision by a contract model with healthcare social organizations from experiments already carried out for many years in other capitals, in other Brazilian cities. Then a more recent experience, which the city itself was already having with the expansion of primary care, also through contracts with social organizations. Then, from these experiments, there was the decision that these new actions that the Secretariat was planning to increase would also be under contract with a social organization. (G2)*

Given the above context, the Notice of Public Notice for partnerships between social organizations was released and the SMS-RJ for operationalization of the Carioca Stork Program reception module. After the bidding process, it was decided that enabled social organization was the Center for Studies and Research of Ward 28 of the Santa Casa de Misericordia of Rio de Janeiro (CEP 28).

> *Then the basic project selection, organization is done and the selection process of the SO followed the procedures and the models of the Municipal Health Secretariat, at a public selection process. Then from March 2011, with the launch of the full program, we have the entry of teams' nurses in seven maternity hospitals. New workforce, new professionals, we have the availability of the trousseau and the early registration of pregnant women for the transport module. (G2)*

After bidding, Social Organization responsible for the operationalization of the Carioca Stork Program and aimed at reorganizing the work and qualifications of obstetric emergencies process launched the reception module. The Miguel Couto Municipal Hospital was the first unit to deploy officially this module in April 4, 2011, as municipal public management's response to the user population of this unit. In the course of 2011, this module was deployed in other municipal maternity hospitals.

> *Then the seven maternity hospitals that we were placed indirectly manages teams that is an obstetrician nurse, a generalist nurse and a nursing technician twenty-four hours to qualify this initial contact of pregnant women arriving at the maternity hospital. (G1)*

In view of managers, the agility of the hiring process, the possibility of replacement of licenses of contractors and specifying the profile of professionals to be hired were the key differentiators of this public-private partnership for the deployment of Carioca Stork Program.

> *The agility in hiring, in providing professionals that is used in the best services in the world. For example, [professional] joker. Joker is impossible to be operationalized in the direct administration. The same direct management, which gives a one-year license for the server, does not provide for someone their place. (G2)*

> *Having people available. Because today non-fixed statutory, we cannot do differential competition for the obstetric nurse. Over the past few years, attempts have been made, but the Class Council of Nurses itself did not allow us to do different obstetric nurse contest for nurses with experience in infant and maternal area and the management contract brought this facility. Why hire people qualified, trained, educated for a specific action. An area I think is the great differential of the management contract. (G3)*

This agility in the hiring process and replacement of workers and the possibility of better utilization of the human resources needs of the adhered population that services are related to the adoption of market mechanisms for hiring staff.

However, the appeal to the market tends to the conformation of greater instability in the functional framework, characterized by high turnover rates.[13]Moreover, this process based on the linked management model can result in a loss of position and obstetric nurses' autonomy in the exercise of their professional practice.[14] So, if on the one hand, the practice of these professionals may be interesting for this public administration model, on the other hand can cause the precarious work of nurse, with low pay, long hours and increasing the workday.[15]

Insertion of the obstetric nurse in the reception module

The third strategy of public administration for the implementation of the reception module of the Carioca Stork Program was the inclusion of obstetric nurses in the teams of this module.

The Notice of Public Call for Partnership with Social Organizations established that the reception team would be made up of at least of one nurse responsible for the care (necessarily being obstetric nurse with ongoing qualification and / or specialization degree), a generalist nurse and a technician nursing necessarily experienced in obstetric care.

> *The wording of the contract and project basis to speak at least two nurses, given the limitation of refusal, the availability of staff and the responsibility that you have to use in the public resource. However, that was the initial choice and we understand that there was a risk to derail the contract if we demanded two obstetric nurses from the outset. Then we thought that composition, at least two nurses for the management of these processes, at least one obstetric nurse, and a nursing technician. (G2)*

In the view of the managers interviewed, the amount of available obstetric nurses in the municipality of Rio de Janeiro, the accumulated experiences and care as the focus of the training of these professionals were facilitators for the establishment of teams of the reception module.

> *I think that one facilitator was the accumulation of obstetric nursing in Rio de Janeiro, accumulation in quantitative terms. We have this professional and accumulation of experience too. I think we had*

> *accumulated experience in the workspace, in the monitoring of low-risk childbirth. When an institution the size of a City Department of a city like Rio, recognizes that competence, I think this already brings a material impact to this professional category. Secondly, I think the impact of the capacity that we recognize in obstetric nursing to handle this task. (G2)*

It is noteworthy that the six maternity hospitals in the city of Rio de Janeiro where they were initially deployed reception module teams and classification of risk already had obstetric nurses working in the delivery room, which allowed this buildup of experienced practical experiences.

This accumulation of experience that gave the performance of the obstetric nurses in delivery rooms of maternity hospitals in the municipality of Rio de Janeiro. This insertion of obstetric nursing in delivery rooms began in 1988, the Fernando Magalhães Institute of Women, with the aim of reducing rates of perinatal asphyxia. Later, in 1994, aimed at reorienting the obstetric model, the SMS-RJ Maternity Hospital inaugurated Leila Diniz, where obstetric nurses were placed in the care of humanized birth.[16]

Continuing the actions of reorientation of obstetric model, in 1998, were the launch of Project Implementation of Nursing Assistance in Laboring Planning 3.3, which aimed to implement humane practices to prenatal and delivery care in Maternity Hospitals Herculano Pinheiro and Alexander Fleming. Allied to this, in 2004, opened the Birth Center David Capistrano Filho, with delivery care usual risk held exclusively by the obstetrics nurse.[17]

The training of the obstetrics nurse directed to the care, but also promotes skills and competencies aimed specifically for obstetric field was considered by managers a big difference for the presence of this professional on the team.

> *Nursing has a disciplinary field where the affection in caring is discussed. It is expected that in the formation. We understand that needed a new in this process and that no professional if use as well as the nursing professional. (G2)*

> *We thought it had to be a professional, qualified enabled, which could take decision, which could interact with the woman in the most correct possible quality for this woman. I think this is the great advantage of having an obstetric nurse. (G3)*

Thus, in the view of the managers, the insertion of obstetric nursing in team of the reception module has extended the performance spaces and brought a material impact to this professional category, since previously the obstetric nurses acted in maternity wards of the municipality, especially in delivery rooms and prenatal care.

CONCLUSION

In this study three public management strategies were found for the implementation of the reception module to the Carioca Stork Program. The first one, linking prenatal care to the reference maternity hospital reducing the pilgrimage of pregnant women in search of delivery care through municipal hospitals.

Through the deployment of the first strategy arose the need for reorganization of the municipal obstetric emergencies, both in regard to the modification of the care about the process of working with professionals in these spaces, inserting reception technology.

In this sense, the obstetrics nurse was inserted in such emergencies to implement the actions of reception, and is recognized by managers as a technical authority in humanized obstetric care.

In the process of reorganization of the emergencies, there was a public-private partnership, where the operationalization of the module studied was under the responsibility of a Social Organization, whose work is influenced by the process of productivity model imposed by market logic.

Given the above, this study points to the need for new research to address the changes in the practice of obstetric nurse on the reconfiguration of obstetric emergencies and the worker process from the insertion of public-private partnerships in the Healthcare System.

REFERENCES

1. Ministério da Saúde (Br). Departamento de Ações Programáticas Estratégicas. Pacto Nacional pela Redução da Mortalidade Materna e Neonatal. Brasília; 2004. [citado 2012 abril 22]. Disponível em URL: http://portal.saude.gov.br/portal/saude/odm_saude/visualizar_texto.cfm?idtxt=35197.
2. Organização Panamericana de Saúde (OPAS). Redes Integradas de Servicios de Salud: Conceptos, Opciones de Política y Hoja de Ruta para su Implementación em las Américas. Série: La Renovación de la Atención Primaria de Salud em las Américas. No.4. Washington, D.C.; 2010. [citado 2012 abril 22]. Disponível em URL: http://bvsms.saude.gov.br/bvs/publicacoes/redes_integradas_servicios_salud.pdf
3. Ministério da Saúde (Br). Portaria nº4279, de 30 de dezembro de 2010: Diretrizes para Organização da Rede de Atenção à Saúde do SUS. Diário Oficial da União; 251, Seção 1:88-93. Brasília (DF); 2010. [citado 2012 abril 22]. Disponível em URL: http://conselho.saude.gov.br/ultimas_noticias/2011/img/07_jan_portaria4279_301210.pdf
4. BRASIL. Ministério da Saúde. Portaria nº1459 de 24 de junho de 2011. Brasília (DF); 2011. [citado 2012 abril 22]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis../gm/2011/prt1459_24_06_2011.html
5. RIO DE JANEIRO (RJ). Secretaria Municipal de Saúde e Defesa Civil do Rio de Janeiro. Convocação pública para parcerias com organizações sociais: Programa Cegonha Carioca. Módulo Acolhimento. Rio de Janeiro; 2010.

[citado 2012 abril 20]. Disponível em URL: http://www.rio.rj.gov.br/web/smsdc/exibeconteudo?articleid=119495

6. Ministério da Saúde (Br). Conselho Nacional de Saúde. Diretrizes e normas reguladoras da pesquisa envolvendo seres humanos: Resolução nº 196/96. Brasília(DF); 1996.

7. Albuquerque VN, Oliveira QM, Rafael RMR, Teixeira RFC. Um olhar sobre a peregrinação anteparto: reflexões sobre o acesso ao pré-natal e ao parto. Revpesquicuid fundam[online], 2011 abr/jun;3(2):1935-46. Disponível em:www.seer.unirio.br/index.php/cuidadofundamental/article/.../659/1320

8. DATASUS [Internet]. Brasília (DF): Ministério da Saúde; 2011. [citado 2012 abril 26] Disponível em: http://tabnet.datasus.gov.br/cgi/idb2011/a07b.htm

9. BRASIL. Presidência da República. Casa Civil. Lei nº 11634 de 27 de dezembro de 2007. Dispõe sobre o direito da gestante ao conhecimento e a vinculação à maternidade onde receberá assistência no âmbito do Sistema Único de Saúde. Diário Oficial, Brasília (DF); 2007 dez 28. [citado 2012 abril 26] Disponível em: http://www.planalto.gov.br/ccivil_03/_Ato2007-2010/2007/Lei/L11634.htm

10. Ministério da Saúde (Br). Secretaria-Executiva. Mais saúde: direito de todos: 2008 – 2011. 2ª edição. Brasília (DF); 2008. [citado 2012 abril 26] Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/mais_saude_direito_todos_3ed.pdf

11. Barra SAR. O acolhimento no processo de trabalho em saúde. ServSoc Rev Londrina,2011 jan/jul; 13(2): 119-42.Disponível em: http://www.uel.br/revistas/uel/index.php/ssrevista/article/view/8828

12. Ministério da Saúde (Br). Secretaria de Atenção a Saúde. Núcleo Técnico da Política Nacional de Humanização. Acolhimento nas práticas de produção de saúde. 2. Ed. Brasília (DF); 2006. [citado 2012 abril 26]. Disponível em: http://portal.saude.gov.br/portal/arquivos/pdf/APPS_PNH.pdf

13. Barbosa NB, Elias PEM. As organizações sociais de saúde como forma de gestão público/privado. Ciênc Saúde Coletiva [online],Rio de Janeiro, 2010ago;15(5): 2483-95. Disponível em: http://www.scielo.br/pdf/csc/v15n5/v15n5a23.pdf

14. Prata JA,Progianti JM, Pereira ALF. O contexto brasileiro de inserção das enfermeiras na assistência ao parto humanizado. Revenferm UERJ, Rio de Janeiro, 2012 jan/mar; 20(1):105-10. Disponível em: http://www.facenf.uerj.br/v20n1/v20n1a18.pdf

15. Schmoeller R, Trindade LL, Neis MB, Gelbcke FL, Pires DEP. Cargas de trabalho e condições de trabalho da enfermagem: revisão integrativa. Rev Gaúcha Enferm [online], Porto Alegre, 2011 jun; 32(2): 368-77. Disponível em: http://www.scielo.br/scielo.php?pid=S1983-14472011000200022&script=sci_arttext

16. 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, Florianópolis, 2009 out/dez; 18(4): 731-40. Disponível em: http://www.scielo.br/scielo.php?pid=S0104-07072009000400015&script=sci_arttext

17. Porfirio AB. A atualização do habitus da enfermeira obstétrica no processo de implantação do modelo humanizado na maternidade Alexander Fleming (1998-2004) [dissertação]. Rio de Janeiro (RJ): Programa de Pós-graduação em Enfermagem, Universidade do Estado do Rio de Janeiro; 2011.

Received on: 04/01/2014
Required for review: No
Approved on: 31/07/2014
Published on: 07/01/2016

Contact of the corresponding author:
Adriana Lenho de Figueiredo Pereira
Boulevard 28 de Setembro, 157 / Vila Isabel, Rio de Janeiro – RJ.
E-mail: adrianalenho.uerj@gmail.com