

## COUNTER-REFERRAL OF WOMEN WHO EXPERIENCED HIGH-RISK PREGNANCY TO FAMILY HEALTH UNITS IN CUIABÁ<sup>1</sup>

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### ABSTRACT

This is a descriptive study with a qualitative approach aimed to characterize the counter-referral process of high-risk pregnant women to the Family Health Strategy (FHS) of Cuiabá, State of Mato Grosso, Brazil. Seven women that received prenatal care in four FHS units and were referred at least once from a greater complexity unit to a family health unit of origin participated in this study. Data analysis pointed out that the counter-referral procedure was delegated to women when they returned from a unit of greater complexity, i.e., these women provided information between services at various levels of complexity. There is a need that professionals who provide prenatal care establish formal communication between the different health care levels, so that care provided to high-risk pregnant women happen in an integral way and with the necessary quality.

**Keywords:** Prenatal. Referral and consultation. Family health. Access to health services.

### INTRODUCTION

The current organization of the procedures of health care provided to women during the pregnant-puerperal cycle refers to the context of the health system prevailing in Brazil. In general terms, the access to these procedures has been historically characterized by inequalities and exclusion in the services provided by the Unified Health System (UHS). This fact has been observed in a research conducted with the aim to reflect on indicators that demonstrate inequalities in access to health services based on data from the National Household Sample Survey<sup>(1)</sup>.

The proposal of the Family Health Strategy (FHS) emerged with a view to reducing the inequities faced in health services. The FHS is within the context of the UHS as its main entry door. This happens in a hierarchical way with respect to the other health care levels, through the insertion of family health units (FHU) close to the community in order to facilitate users' access to basic health care and allow the recognition of health needs of the population registered<sup>(2)</sup>. FHS also aims at the reorganization of health care services based on a preventive/educational model and promotion, and no longer on the curative/medicalized

model, with a view to care for the greatest possible number of users through access facilitation<sup>(2-3)</sup>.

To this end, the local organization of the services should consider the health needs expressed by the population that uses these services. These needs are identified from epidemiological diagnosis and information expressed in the everyday life of the health care units. This way, users' access to quality services is facilitated. These services are based on the principles of comprehensiveness, with emphasis on sexual and reproductive rights, since, historically, there have been and still are difficulties in access to health services for women that are part of groups socially discriminated<sup>(4)</sup>.

As a consequence of the rationality that determines the organization of health services, favoring or not the access to different levels of complexity in the UHS, Brazil still faces difficulties in reducing maternal morbidity-mortality rates. With the goal to contribute to the resolution of this problem, the Cegonha Network was released by the Ministry of Health in 2011. This project ensures the right to reproductive planning and humanization of health care provided to women during pregnancy, childbirth and the puerperium. It

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extends to children aimed at appropriate and safe birth and growth through the expansion of access to prenatal care, specialized care, accessibility, and implementation of appropriate procedures during childbirth<sup>(5-6)</sup>. The non-completion of access to health services with different levels of complexity configures a problem that causes damage—sometimes irreparable—to pregnant women who receive prenatal care in FHUs.

With a view to facilitate/favor the access to services of greater complexity, the principles and guidelines of the UHS highlight the need of establishing the referral/counter-referral system (R/CR). This system is considered a management tool focused on service organization and the reduction of restrained demand. It aims to expedite the achievement of medium and high complexity services ensuring health care effectiveness at all levels.

However, for the R/CR system to be effective, it is essential that all health care levels have their well-defined functions, with availability of forms for recording procedures and/or referrals made. Thus, upon returning to the service of origin, the staff of the primary level may know what has been accomplished in other health care levels, making it possible to record the procedures in the medical chart<sup>(7)</sup>.

Specifically at the time of the R/CR, the difficulty or lack of access to FHS can result in weakening the bond between risk pregnant women with the primary health care unit. This will generate solution of continuity in health care provided, i.e., lack of comprehensive health care as stipulated.

High-risk pregnancies need specialized health care, ensuring pregnant women access to services that have hard and light-hard technologies to meet their health needs. It should be considered that pregnant women require more complexity for their health care at secondary and tertiary levels. However, it is essential to maintain the follow-up care provided by the FHU team, since these units are responsible for close and continuous monitoring of users.

Therefore, health care services need to reorganize the health care provided to women classified at high-risk during pregnancy, seeking

the integration of health services at different levels of complexity and implementation of integral health care<sup>(8)</sup>.

In view of the above, the following question arises: How does counter-referral of high-risk pregnant women to the FHS occurs in the city of Cuiabá, State of Mato Grosso? In order to answer such questions, this study aims to characterize the counter-referral process of high-risk pregnant women to the FHS in the city abovementioned.

## METHOD

A descriptive method with qualitative approach was used to conduct this study. It was developed with high-risk pregnant women who received prenatal care in FHS units of the city of Cuiabá, capital of the State of Mato Grosso, Brazil. These units belong to each one of the administrative regions; they are: Eastern, Western, Northern and Southern. A draw was carried out to choose the units where the study would be conducted. Four units were chosen, being one from each administrative region of the city.

There is a record book used to register pregnant women who receive prenatal care in the FHUs of the city of Cuiabá. In addition to pregnant women's names, dates of consultations, attainment of the tests recommended by the Program for Humanization of Prenatal Care and Childbirth (PHPC), probable date of birth, date of the last menstruation, and classification of pregnancy risk (present or not) are recorded in this book.

The record book of each of the four USF drawn was used for the identification of pregnant women that participated in this study. After the identification of the names of pregnant women classified at high-risk and that were receiving prenatal follow-up care at the FHUs where data were collected, the following criteria of inclusion was applied: women who were referred to units of greater complexity and counter-referred to the FHS of origin at least once during the prenatal period. This criterion allowed identifying eight high-risk pregnant women at risk. After the identification of these women, the nurses of the teams indicated the location of each one of them.

It was not possible to collect the data of one of the pregnant women identified because she was not found. This fact caused no prejudice to this research, since there was repetition of information supplied by women participating in the study, i.e., saturation of data. Data collection was carried out using the open interview technique with the following main questions: How did the return from the greater complexity health service to the FHU took place? What did you think of the access to prenatal care at that moment?

The information gathered during the interviews was collected only after the participants signed an informed consent form. The interviews were recorded using a digital recorder and subsequently transcribed in full. After the transcript of the interviews, the technique of content analysis was applied to the database obtained, as proposed by Gomes.<sup>(9)</sup> The interpretation of the data began simultaneously with the analysis process, since, according to this author, the two steps are contained in a single moment that is characterized by looking closely at the research data.

To conduct this study, ethical aspects were considered in order to meet the Resolution CNS/MS No. 196/96<sup>(10)</sup>. The matrix project was submitted and approved by the Research Ethics Committee of the Júlio Müller University Hospital, under protocol No. 880/CEP-HUJM/2010.

## RESULTS AND DISCUSSION

### HEALTH CARE CONTINUITY, TRANSFER OF INFORMATION: A PROCEDURE IMPLEMENTED BY THE SERVICE OF GREATER COMPLEXITY OR A PROCEDURE DELEGATED TO WOMEN?

According to Witt<sup>(7)</sup>, counter-referral is performed in the everyday life of health services by completing a specific form that consolidates relevant information. This procedure allows the health unit that referred the patient to understand which procedures were carried out in the unit of greater complexity, in order to provide completeness and continuity of health care provided in the unit of origin. This is a procedure

that must also be applied to pregnant women's health care.

In order to perform the R/CR process at any health care level, the Municipal Health Department of Cuiabá (MHD-Cuiabá) has defined a specific form that must be filled out in a standardized way for its execution. This form consists of two parts. At the top, there is a placeholder for recording personal information of pregnant women, the unit of origin and the unit to which the referrals are being held. Just below, there is a placeholder in which the professionals of the unit of origin record the clinical information concerning the high-risk pregnant women referred. This information allows the professionals of the unit of greater complexity to understand the reasons that determined the referral, in order to conduct their evaluation. At the bottom, there is a placeholder for the professionals that provided health care to these women in greater complexity units, where they inform the units of origin about the therapeutic procedures adopted and/or expected and the recommendations relating to follow-up care.

Such a form has been created with the goal of providing information to the service of greater complexity. These data are necessary to evaluate the users referred, in this case, high-risk pregnant women. It also offers the service of origin information obtained from health care provided in the service of greater complexity. The proper use of this form would favor health care provided to pregnant women in an integral and continuous way, offering the necessary subsidies to proceed with the health care to professionals involved in health care provided to high-risk users.

It is necessary to stress that the form standardized by the MHD-Cuiabá is not specific to pregnant women. The forms are used to refer and counter-refer all UHS users that require health care in units of greater complexity, without any specificity for pregnant women.

Within the context of the matrix project that originated this research, at the same time, another study was conducted on FHUs of Cuiabá. That study examined the perception of nurses about the process of referring and counter-referring pregnant women followed up

during prenatal care. It demonstrated that, according to nurses, the counter-referral of pregnant women did not happen in some units, highlighting the difficulties that those professionals faced to promote an integral health care to these women<sup>(11)</sup>.

We carry out the referral, but we don't get the counter-referral... It is a rarity. They don't send. Because the counter-referral that they have to send back, they don't send. Because when we refer, we don't lose the bond with them, we continue with the bond, they continue with us and continues there, but they don't send the counter-referral (E2). (Ipsis litteris)

The data collected in this study reinforce this finding. Pregnant women who were the subjects in this research reported that, after receiving health care from the health services of greater complexity and going back home, they did not receive the form with the counter-referral that they had taken when they were referred to the services of greater complexity.

No! This referral paper (R/CR form) they didn't give it back. At any time they gave me that paper so I could take it to the health unit. (G1) (Ipsis litteris)

Nobody said I had to go back to the health unit... they didn't give me any paper... If Someone (ACS) did not schedule an appointment for me, I didn't know I had to go back to the prenatal care of the health unit. (G3) (Ipsis litteris)

According to the excerpts presented, the users/pregnant women participants of this study stated that none of the R/CR forms were sent back to the FHUs of origin. Scholars on the subject consider that, when users of health services are referred with an R/CR form, it is possible that health care provided is more effective. This is due to the fact that it is possible to plan and organize the demand according to the needs identified, avoiding waste of public resources<sup>(12)</sup>.

A study conducted to assess the implementation of R/CR in specialized consultations held in the municipal health system of Alfenas, State of Minas Gerais, demonstrated the professionals' concern with the lack of effective R/CR<sup>(13)</sup>. This study also reports that due to its organization and articulation with all levels of complexity and specialty, the R/CR

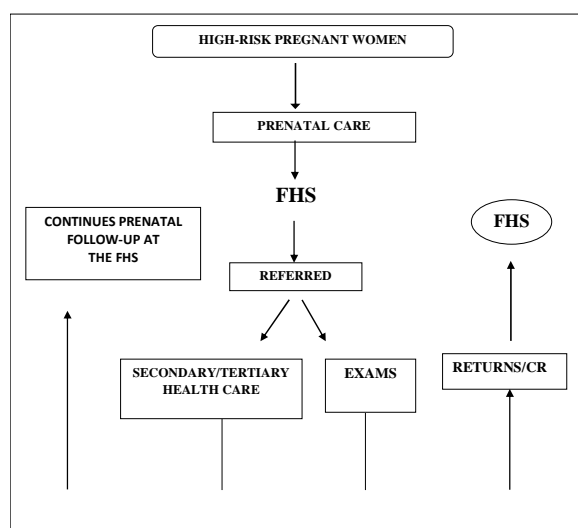
process promotes users' access to health services and strengthen the UHS.

Therefore, the non-completion of counter-referral causes losses not only to high-risk pregnant women—that even though they have the right to full and continuous access assured by law, they do not always achieve services with higher levels of complexity in the context of the UHS—but also to professionals working in primary health care. They are required to obtain information from the users regarding their state of health and therapy implemented, in order to meet the health needs of these women to promote quality health care.

In view of the above, it can be considered that the counter-referral reported by the participating women of this study took place in an informal way. The information was provided by high-risk pregnant women to primary care services. It is necessary to take into account that, although such information is valuable for the health service, and for this reason they cannot be disregarded, technical and health care information from medical services of greater complexity are critical for planning a qualified health care provided to high-risk pregnant women in the context of primary health care (PHC).

The search for enabling mechanisms of the R/CR process can be considered fundamental to the implementation of completeness<sup>(14)</sup>. However, it is necessary to implement municipal public policies that reaffirm the principles of the UHS in order to enable a techno-assistential model that enhances the R/CR system.

The counter-referral procedure, which should be achieved through the forms that must circulate between the services of different complexity levels, in order to enable the transfer of information for continuing health care provided by PHC, has apparently been performed by high-risk pregnant women. There seems to be delegation or intermediation of women when they come back to the unit of origin. Therefore, the trajectory of these women in the context of prenatal care in the health system of the city of Cuiabá can be represented with the following flowchart:



The flowchart presented demonstrates the possible trajectories of pregnant women users of the UHS in the city of Cuiabá when they go through all health care levels in the context of prenatal care in the FHS.

According to the Prenatal Manual of the Ministry of Health, prenatal care should be started preferably in FHS units located in the users' area of residence. According to the respondents of this study, this fact has been taking place.

I went to the health care unit. I found out that I was pregnant when I was about three to four months pregnant [...] She (nurse of FHS) asked me to confirm the pregnancy, to see whether I was pregnant. I was suspecting. [...] Because in my first pregnancy I had pre-eclampsia, then I get that [...] my blood pressure increases, decreases [...] then the doctor (doctor of FHS) though I should go to P. (unit of greater complexity) because there is easy and more [...] and controls better. They gave me just the referral and there everything was already scheduled. I did it there at the P. (unit of greater complexity) and here at the health care unit (FHU) as well. (G3) (Ipsis litteris)

There at the health care unit is a lot faster, so [...] The girls always [...] for me is a lot faster. I need anything, I go there go really fast and they care for me fast [...] they help me that way, a lot. It is that they already know my mother. My mother knows everybody there. It is a lot easier. (G4) (Ipsis litteris)

Pregnant women initially seek prenatal care at FHUs and only those who have risk pregnancy identified—classified as high-risk pregnant

women at any time—are referred to health care units of greater complexity, either to perform specialized consultations or examinations.

Even though users/pregnant women are referred to more complex services and, sometimes, they need to continue receiving health care from this service, high-risk pregnant women must keep their bond with FHUs of their area of residence. FHU becomes the unit of reference for their prenatal follow-up, so as to comply with the guidance of the PHPC, since the referral unit is responsible for continuous follow-up.

However, to return to the FHU of origin in order to continue prenatal follow-up and to plan health care with a view to the health needs detected regarding specificities of the risk pregnancy picture, users/pregnant women cared for in greater complexity services need to be counter-referred. This has been taking place informally, as described by the women who participated in this study.

The data collected show that referral forms had not been returned to the PHC units when high-risk users/pregnant women that participated in this study were counter-referred. This fact shows that counter-referral did not take place systematically, which determined that these women had to report to nurses and doctors the procedures performed in health care units of greater complexity.

No! The paper (R/CR form) that I took from the health care unit (FHU) to the H (unit of greater complexity) remained there. It is kept there with them (in the unit of greater complexity). (G4) (Ipsis litteris)

When I returned to the FHU they didn't give me any paper (R/CR form). But then I was talking, you know. She (doctor of the FHU) asked me (about the procedures performed in the unit greater complexity) and I talked. (G6) (Ipsis litteris)

Thus, it can be said that, at the time of counter-referral, pregnant women that participated in this study transferred the information between the service of greater complexity and the FHU of origin. This is a procedure that should be implemented by health professionals who work in these units with the appropriate use of the R/CR form, or using another management tool that is designed to

facilitate communication. This would make it possible to continue the service providing complete health care to high-risk pregnant women.

### FINAL CONSIDERATIONS

This study demonstrated that the process of referring and counter-referring high-risk pregnant women cared for at FHUs is of paramount importance in order to ensure that prenatal care is provided globally and based on these women's health needs. Such follow-up care would potentially contribute to ensure health care completeness with a view to reducing maternal and neonatal mortality.

The data collected suggest that, in the case of pregnant women that participated in this research, counter-referral was implemented by the users. They transferred the information between the services of greater complexity and

the FHUs, since they did not receive any formal submission to the health service of origin.

Communication between therapists and patients is crucial in the health care process. However, it can be considered insufficient for ensuring the transfer of technical information that is critical to continue the therapy, eventually, implemented in health services of greater complexity. Thus, such procedure can generate the discontinuity of health care provided due to lack of information, which may even cause the death of the fetus or the woman.

Therefore, it is evident that health professionals working at any level of prenatal care must seek/implement communication between the services that high-risk pregnant women go through during pregnancy. This way, it would be possible to promote women's access to health services in a complete way and with high quality, contributing to the reduction of maternal and neonatal morbimortality.

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## CONTRARREFERÊNCIA DE MULHERES QUE VIVENCIARAM GESTAÇÃO DE RISCO A UNIDADES DE SAÚDE DA FAMÍLIA EM CUIABÁ

### RESUMO

Este é um estudo descritivo, de natureza qualitativa, que objetivou caracterizar o processo de contrarreferência de gestantes de alto risco à Estratégia de Saúde da Família (ESF), de Cuiabá, Mato Grosso. Participaram deste estudo sete mulheres que fizeram o pré-natal em quatro unidades da ESF e que foram contrarreferenciadas, pelo menos uma vez, de uma unidade de maior complexidade para a unidade de saúde da família de origem. A análise dos dados apontou que a ação da contrarreferência era delegada às mulheres quando retornavam de uma unidade de maior complexidade, ou seja, eram as próprias mulheres que intermediavam as informações entre os serviços nos diversos níveis de complexidade. É evidente a necessidade de que os profissionais que atuam no pré-natal estabeleçam comunicação formal entre os diferentes níveis de atenção à saúde, a fim de que o atendimento prestado às gestantes de risco aconteça de maneira integral e com a necessária qualidade.

**Palavras-chave:** Pré-natal. Referência e consulta. Saúde da família. Acesso aos serviços de saúde.

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## CONTRARREFERENCIA DE MUJERES QUE EXPERIENCIARON EMBARAZO DE RIESGO A UNIDADES DE SALUD DE LA FAMILIA EN CUIABÁ

### RESUMEN

Este es un estudio descriptivo, de naturaleza cualitativa que tuvo como objetivo caracterizar el proceso de contrarreferencia de gestantes de alto riesgo a la Estrategia de Salud de la Familia (ESF) de Cuiabá, Estado de Mato Grosso, Brasil. Participaron de este estudio siete mujeres que hicieron el prenatal en cuatro unidades de la ESF y que fueron contrarreferenciadas, por lo menos una vez, de una unidad de mayor complejidad para la unidad de salud de la familia de origen. El análisis de los datos indicó que el procedimiento de contrarreferencia era delegado a las mujeres cuando regresaban de una unidad de mayor complejidad, es decir, eran las propias mujeres que intermediaban las informaciones entre los servicios en los diversos niveles de complejidad. Es evidente la necesidad de que los profesionales que actúan en el prenatal establezcan una comunicación formal entre los diferentes niveles de atención a la salud, para que la atención prestada a las gestantes de riesgo ocurra de manera integral y con la calidad necesaria.

**Palabras clave:** Prenatal. Referencia y consulta. Salud de la familia. Acceso a los servicios de salud.

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