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CARE PROVIDED TO PREGNANT WOMEN AND PUERPERAL MOTHERS BY THE MOBILE EMERGENCY CARE SERVICE

Natasha Valle Souza Gusmão*
Zannety Conceição Silva do Nascimento Souza**
Maria Cristina de Camargo Fonseca***

ABSTRACT
This article aimed to describe the profile of pre-hospital care provided to pregnant women and puerperal mothers by the Mobile Emergency Care Service (SAMU) in a municipality in Bahia, Brazil, in 2010. This is a descriptive, documentary, research with a quantitative approach, conducted by means of secondary data generated from 385 health care records; data collection took place through a form adapted from the health care records of this service, from December 2011 to April 2012. Data were tabulated by frequency distribution and analyzed by simple statistics. Out of the total number of health care records analyzed, 360 pregnant women (93.5%) were provided with care, and 78 became pregnant more than once (20.3%); 107 were at the age group from 20 to 24 years (27.8%); 95 were at a gestational age between 38 and 42 weeks (24.7%); and 208 were provided with care during labor (54.0%). Among the pregnant women, 337 underwent delivery at a hospital (87.5%) and 152 were referred to public maternity hospitals (39.5%); 99 patients were provided with care between 12:00 p.m. and 06:00 a.m. (25.7%). As for umbilical cord clamping, 13 procedures were registered (3.5%), as well as 11 deliverance cases (2.9%). It was concluded that the profile of pre-hospital care provided to pregnant women and puerperal mothers by the service focused on labor, delivery, and puerperium, something which may be related to the perception of ease, quickness, and safety.

Keywords: Emergency medical services. Obstetric nursing. Women's health.

INTRODUCTION

The Mobile Emergency Care Service (SAMU) provides urgency and emergency care at home, public routes, and workplaces, by sending qualified health professionals in mobile units. In this regard, users seek care by means of free phone calls through the number 192, answered by the Regulation Call Center, which through an analysis by the medical assessor, identifies the situation described and advises on the early actions to be taken until the arrival of the team in a particular ambulance. When the call is not regarded as appropriate, in addition to the guidelines, the physician indicates a health service that the user should seek[1].

This service is a part of the so-called Brazilian Urgency and Emergency Care Network, included in the Brazilian Health Care Networks (RAS), characterized by the relations between all health care settings, prioritizing the population's health needs, on a continued and comprehensive basis, through multiprofessional care[2].

Regarding the health needs among the female population at a childbearing age in the state of Bahia, Brazil, which involved urgency and emergency care procedures and resulted in hospitalization, pregnancy, childbirth, and puerperium stood out (65.5% in 2010), these are the main causes of hospitalization among women between 2001 and 2010[3].

The pregnancy and childbirth cycle also influences the rates of maternal morbidity and mortality. A recent study, conducted in a regional referral hospital in the state of Rio de Janeiro, showed there is a predominance of hypertensive disorders (severe pre-eclampsia), with 68.5% of the cases under analysis, followed by bleeding, with 19.1%, among the causes of severe maternal morbidity[4].

As for mortality of women due to maternal causes, there is a direct relation between a country's development and the mortality rate. In Canada and the U.S., for instance, the values are less than 11 maternal deaths per 100,000 live births (LBs); but in countries like Bolivia and

* Nurse. General Hospital "Clériston Andrade", Feira de Santana - BA, Brazil. Email: tashavalle@hotmail.com
** Obstetric Nurse. Master's degree. Assistant professor at the Bahia State University of Feira de Santana (UEFS). Researcher at the Center for University Outreach and Research in Women's Health (NEPEM). Feira de Santana - BA, Brazil. Email: zannetyenfermeira@gmail.com
*** Obstetric Nurse. Doctoral student at the Federal University of Bahia (UFBA). Assistant professor at the Bahia State University of Feira de Santana (UEFS). Feira de Santana - BA, Brazil. Email: mariacristinac77@gmail.com

Peru they reach more than 200 deaths. In Haiti, there is a maternal mortality ratio of 670 maternal deaths per 100,000 LBs. Throughout Latin America, around 15,000 women die each year due to complications during pregnancy, childbirth, or puerperium[5].

Concerning Brazil, studies show that: "more than 800 women die every year from complications during pregnancy, childbirth, and postpartum [...] In Bahia, the maternal mortality ratio by direct causes, in 2010, was 61.7 maternal deaths/100,000 [...] the state average is higher than the national average"[6:7].

Given the above, it is inferred that maternal mortality indicates the "quality of medical and health care provided to the population, reflects poverty, gender inequalities, poor socioeconomic conditions, low informational and educational level in a society"[6:7].

From the perspective of improving health care to women in the Brazilian National Health System (SUS), over the years various public policies have been implemented, among them stand out the Brazilian Program for Comprehensive Women's Health (PAISM), in 1984; the Brazilian Program for Humanization of Prenatal Care and Childbirth, in 2000; and the Brazilian National Policy for Comprehensive Women's Health (PNAISM), in 2004, which came to expand actions taken by the PAISM, pointing out relevant areas of care, such as climacteric period/menopause, assisted reproductive technology, mental health, adolescent health, gender and ethnicity perspectives in the activities undertaken. In addition to these policies, we may also mention the Pact for Reducing Maternal and Neonatal Mortality, in 2004; the Pact for Health, in its three dimensions, in 2006; and, in 2011, the conformation of networks, highlighting the Stork Network, the Stork SAMU, and the Urgency and Emergency Network.

For an effective implementation of these policies, it is crucial to face some difficulties and challenges, such as the process to access health services. Discussions related to access in the health sector need to gather managers, professionals, and users of the health care network, in order to establish new forms of care and management based on the reorientation of the health care model[7]. In urgency and emergency care to pregnant women and puerperal mothers, we still observe the need for implementing the policies mentioned above, since even with the existence of mobile pre-hospital care, often access to maternity hospitals and lack of beds in the maternal intensive care unit (ICU) undermine the effectiveness of care.

Given the difficulties exposed by the literature above and observed in daily health care, for further discussion on the subject, there was a need to ask which is the profile of pre-hospital care provided to pregnant women and puerperal mothers by the SAMU in a municipality in Bahia. Therefore, this article aims to describe the profile of pre-hospital care to pregnant women and puerperal mothers provided by the SAMU in 2010.

METHODOLOGY

This is a descriptive, documentary, research with a quantitative approach. Secondary data from health care records of the SAMU were used; the study was conducted in the central-eastern macro-region in the state of Bahia, in a municipality with a population estimated in 612,000 inhabitants in 2014[8].

Among the health services offered by this municipality, the SAMU was implemented in 2004 and it currently has 7 ambulances, 1 advanced life support unit (USA), or mobile ICU, 5 primary life support units (USBs), and 1 motorcycle ambulance. According to information gathered in the study field, there are no specific ambulances to provide pregnant women and puerperal mothers with care, however, the protocols in obstetric emergency situations are established. As for the existing mobile units and their teams in the municipality, the USA has a physician, a nurse, a nursing technician, and a driver; the USB has a nursing technician and a driver; and the motorcycle ambulance has a nurse or a nursing technician.

The inclusion criteria established for using documentary sources were: data from women aged at least 10 years, pregnant women or puerperal mothers, registered in health care records of the SAMU, in 2010. These exclusion criteria were adopted: illegible and/or smudged records and those that did not fall within the year, age, and gender proposed. Thus, it was

found that the total number of women provided with care by the SAMU in 2010 was 4,475 and out of these 385 were pregnant women and puerperal mothers, accounting for 8.6% of cases.

Data collection began after authorization by the Municipal Health Department (SMS) and research approval by the Research Ethics Committee (REC) of the Bahia State University of Feira de Santana (UEFS), under the Opinion 265/2011.

Between December 2011 and April 2012, we collected data from health care records of the service by using the collection instrument (form) adapted from the form used by the SAMU in the municipality under study. The independent variables were: age, pathological history, drug allergy, blood group, and Rh factor; in turn, the dependent variables were: working hours and main complaint; obstetric and puerperal causes; external causes; procedures performed; drugs/solutions; referrals; other observations.

Data were organized and tabulated by distributing class and frequency, using the software *Microsoft Excel*, version 7.0, with subsequent numerical description of data. This organization is named as tabular, because data were organized into occurrence classes or not in parallel with absolute and percentage frequencies. The analysis of variables followed the correlational proposal, i.e. there was no influence on their measurement, just relations/correlations between them after the description. We also used statistical sampling mode analysis, i.e. we wrote and interpreted, having the literature as a basis, the value found that occurred more frequently (unimodal distribution)[9].

RESULTS AND DISCUSSION

This study identified that the SAMU in the municipality under study provided with care, in 2010, women during labor, delivery, and puerperium in 8.6% of cases. Obstetric care was not considered as frequent as in other northeastern regions; a study on the evaluation of the SAMU indicators in Teresina, Piauí, Brazil, found that obstetric emergencies were the third most frequent occurrence observed[10].

Out of the population eligible for the study, 360 were pregnant (93.5%) and 107 were at the age group between 20 and 24 years (27.8%); in Brazil, that same year, the highest percentage of the female population fell within this age group (4.5%), totaling 8,614,963 women[8].

Among the women provided with care, 271 denied drug allergy (70.4%) and 149 did not know their blood type (38.7%). Among the records examined, 335 had no register of personal pathological history (87.0%), but 17 cases of hypertension were found (4.4%), as well as 5 cases of diabetes in the current pregnancy (1.3%).

The gestational age (GA) of 95 women (24.7%) was between 38 and 42 weeks; however, in the pre-hospital care records, there was underreporting of this variable in 267 occurrences (69.4%). Concerning prenatal care (PNC), underreporting of information was also found (69.4%); out of the total of 385 women, 97 underwent PNC (25.2%). Regarding PNC, this information should also be considered during the pre-hospital care provided to that pregnant woman or puerperal mother, because undergoing it may be correlated with the signs and symptoms of the problem that led the SAMU to provide care and the records on this information were not observed frequently. A study conducted in Recife, Pernambuco, Brazil, showed that "the failure to carry out prenatal care and the insufficient number of appointments are strongly associated with the risk of maternal death"[11:1982].

There was a predominance in the records examined of full-term pregnancy, a period indicating that the fetus is developed enough to adapt to life outside the womb. However, the highest percentage in pre-hospital care records did not register GA, auscultation of fetal heart rate (FHR), and uterine activity. The literature confirms that the identification of changes in FHR during labor supports the diagnosis of fetal hypoxia, and this procedure is included in the guidelines of care for the parturient woman; intermittent auscultation is recommended for low-risk pregnant women, in the dilation period every 15 to 30 minutes and in the expulsive period every 5 minutes[12].

If the data mentioned above were available in the records, they might support, more consistently, behaviors such as: in labor or full-term delivery, stimulus to breathing

exercises, guidance not to stress the pull, but let delivery go on; maintaining the left position during transport, making blood flow easier and preventing fetal distress; introduction of antibiotics if there is association with vaginal output of black or green amniotic fluid; preventive or assistive actions when faced with preterm labor (use of uterolytics, tocolytics, and analgesics, intravenous hydration, medications such as terbutaline, corticoids), justifying faster transport. In this regard, we stress that monitoring the uterine dynamics and accurate auscultation of FHR are important for ensuring fetal vitality and these procedures support a rapid delivery interruption if the fetus is at risk[13].

Regarding the number of pregnancies, 78 women (20.3%) were classified as those who became pregnant more than once, followed by 75 women (19.5%) undergoing their first pregnancy. Although the first group had already undergone many experiences during previous pregnancies, they sought pre-hospital emergency care more frequently. A recent survey conducted in a municipality in the state of São Paulo, with pregnant women who sought hospital care on an early basis, including through the SAMU, denoted that the reasons for this were: the presence of signs and symptoms different from those already experienced or known due to information received during prenatal care; confusion between false and real labor; fear of fetal complications; ease related to assistance by a health professional in the institution; fear of childbirth outside a hospital[14].

Thus, labor often encourages pregnant women to several comings and goings to the hospital, resorting to emergency services. This shows that not all women recognize the signs and symptoms indicating the right time to go to the maternity hospital, by observing their own bodies, something which indicates the importance of the approach to preparation for childbirth during prenatal care.

As for the causes to provide care, there was a predominance of 308 individuals (80.0%) due to obstetric causes, mainly labor, and natural childbirth among 208 pregnant women (54%).

Table 1. Causes to provide pregnant women and puerperal mothers with care by the SAMU. Bahia, Brazil, 2010.

Causes (N = 385)	N	%
Obstetric		
Childbirth	208	54
Abortion	17	4.4
Threatened abortion	27	7.0
Bleeding	5	1.3
Pre-eclampsia	8	2.1
Eclampsia	9	2.4
Others	33	8.6
Other non-obstetric causes	49	12.7
External		
Domestic violence	5	1.3
Accidents		5.97
Automobiles	6	1.6
Motorcycles	12	3.1
Automobiles + motorcycles	3	0.8
Running over	2	0.5

Source: Prepared by the authors.

As seen in Table 1, the hypertensive disorders of pregnancy are characterized as pre-eclampsia in 8 women (2.1%) and eclampsia in 9 (2.4%); these are problems that, despite the low frequency in this study, have an urgent and emergency nature in some situations, especially when prenatal care has not been conducted on an efficient and good quality basis, by identifying predictive signs and symptoms of these illnesses. The syndromes mentioned above are characterized as: gestational hypertension, when only an increase in blood pressure happens during pregnancy, not associated with proteinuria and stabilization of this value after the first gestational quarter; pre-eclampsia, characterized by acute hypertension after the 20th gestational week, with a sudden onset, and eclampsia, when this condition is associated with seizures, and vital functions may be affected[15]. Thus, the SAMU may be called when there is a severe hypertensive syndrome, because seizures are regarded by the community as factors that could lead the mother and fetus to die, if no emergency care is provided.

We identified in the records that pregnant women had a seizure in cases of eclampsia, which were described by family members as those occurring before the arrival of the SAMU ambulance. It is worth highlighting that eclampsia should be controlled through magnesium sulfate on a venous or intramuscular

basis with attack and maintenance doses[13] until admission to the referral hospital. However, there was no description of the occurrence of seizures in the route to the maternity hospital or the use of anticonvulsant medications. From this perspective, in a call for suspected eclampsia, the USA ambulance is the most suitable for transport and the team must consist in a physician, a nurse, and a nursing technician.

Bleeding, another cause cited in 5 health care records (1.3%), may happen during pregnancy, in addition to situations regarded as abortion or miscarriage threats. It was hard to define what kind of bleeding and its main cause in this research, because the bleeding features were not found in the description of the records. It is known that among the most common kinds of bleeding during pregnancy there are those caused by placenta previa (PP), characterized by live bleeding, painless, and self-limited in the end of the second and beginning of the third quarter; premature placental detachment (PPD), characterized by abdominal pain of varying intensity, which can reach the uterine hypertonia, dark-colored bleeding of varying amount, persistent pain between contractions, and a history of hypertension[16].

These specific kinds of bleeding during pregnancy should be known by professionals working in the SAMU 192, including the specific signs, because information on the features of blood loss and a patient's clinical condition will support behaviors with higher problem-solving potential for pregnant women, decreasing chances of complications and maternal and child mortality.

Other causes that lead to the occurrence of bleeding are the miscarriage threats and abortions observed in this study, respectively, with 27 (7.0%) and 17 cases (4.4%) (Table 1); abortions caused or induced by abortive medications amounted to 24%. They generate many consequences on women's health and emergency situations that require pre-hospital care. In abortion threats, we could not draw a conclusion about their consummation, because this information was not registeredor abortion itself took place within the hospital.

Provoked or induced abortion may become an emergency situation. A recent study conducted in Teresina with teenagers undergoing abortion showed there is a clandestine route pointed out by those who sell abortive substances, which includes seeking the hospital only in case of heavy vaginal bleeding[17]. Thus, in this situation, women are exposed to infections and severe bleeding, they are vulnerable to an increased risk of complications and the need for emergency pre-hospital care.

Within the category other obstetrical causes, there was a higher percentage related to complaints of uterine contractions, with 82 records (21.3%) and loss of amniotic fluid in 75 (19.4%). Among the records of external causes, 23 accidents (6.0%) and 5 cases of domestic violence (1.3%) were found. Women, including pregnant women, are increasingly inserted into the statistics of problems due to external causes; the increased number of women driving cars and riding motorcycles is a matter of concern for public health, because of the sequelae that an accident can bring, such as physical or mental disability or death. In a study conducted in Maringá, Paraná, Brazil, it was found that most women provided with care by the SAMU either drove vehicles (cars) or rode motorcycles[18]. Still regarding external causes, domestic violence during pregnancy was described in the records, and this is practiced by the victims' partners or relatives in their own households. A study with pregnant women who were victims of violence showed that 35.3% of the women have suffered physical violence by intimate partners[19] and this information corroborates the findings of this research, since, among all accounts on the type of violence committed against pregnant women described in the records of the SAMU examined, there was a predominance of physical assaults.

The records also contained vital signs measured during the provision of care, how the patient was transported, which medical procedures were performed, whether drugs and solutions were used. As for the vital signals, they are used as parameters to evaluate a patient's clinical condition, in cases of obstetric emergency.

Concerning the procedures performed with pregnant women and puerperal mothers, there was a predominance of venipuncture, with 128 registers in the obstetric area (33.2%), and in the neonatal area umbilical cord clamping occurred

in 13 newborn infants (3.5%); we also observed 11 deliverance cases (2.9%). It is noteworthy that these procedures were the most cited in the records when the SAMU team already found the newborn infant when arriving at the household; in these cases, transport was provided by the ambulance (USA) in 26 calls (6.8%). The drugs and solutions used were: physiological solution, glycosylate, and Ringer Lactate; antihypertensive (hydralazine and methyldopa) and analgesic medications (intravenous dipyrone).

We found in this study that the outcome of obstetric cases involving childbirth was 337 hospital births (87.5%), 41 home births (10.6%), and 7 births during the trip (1.9%). In this regard, referrals were made to 152 public maternity hospitals (39.5%) and 89 private maternity hospitals joined to the SUS (23.1%).

Regarding the units that provided care, 359 cases were addressed by a USB (93.2%). We noticed there are in the municipality public referral maternity hospitals specialized in women's care during the gravidic-puerperal cycle and a general hospital for women referred due to high-risk pregnancy and multiple trauma.

The referral of pregnant women and puerperal mothers is a part of a set of strategic actions named as Stork Network, launched by the Brazilian Ministry of Health in 2011[2], which aims to establish a network of care to ensure that a pregnant women undergoes humanized and good quality prenatal care, delivery, and puerperium, as well as to guarantee a child undergoes a humanized and safe birth, in addition to a healthy growth and development. To do this, the government is committed to pay for transport by bus to attend prenatal care appointments and transport by taxi for childbirth, as well as to increase the number of SAMU 192 ambulances to transport for childbirth, thus facilitating the connection between a pregnant woman and the maternity hospital and ensuring safe transport[2].

Also in relation to women's reality, in terms of social and economic conditions, public transport is the most frequently used by many of them, as they live on the outskirts of the town, far from maternity hospitals. So, when there is no affordable transport means during labor and delivery, they resort to the SAMU, which has no direct cost and it is regarded as rapid and effective and also relies on the safety of being along with a health professional if delivery occurs on the way. A study conducted in the SAMU of Natal, Rio Grande do Norte, Brazil, corroborates this finding, as it found that "due to the poor situation in which they live, many pregnant women call the 192 only for the purpose of being transported to a maternity hospital/hospital facility, overloading the phone lines and the ambulance fleet"[20:4838].

Referrals of high-risk pregnant women by the referral system are also a part of the Stork Network deployment strategy, which has a specific type of care aimed at women's health, with the purpose of prioritizing respect for the autonomy of SUS users, ensuring access to a comprehensive network of health services with suitable infrastructure, where the prevention of illnesses/diseases and health promotion should be highlighted[2]. It is worth mentioning that in the period when data were generated, in 2010, the Stork Network Policy was not implemented in the municipality.

FINAL REMARKS

This research showed that in the profile of pre-hospital care for pregnant women and puerperal mothers by the SAMU in this municipality there was a predominance of service provided to young adult women, due to obstetric causes, mainly in labor, delivery, and puerperium; women who became pregnant more than once, in late pregnancy, and those who underwent prenatal care.

It is inferred that fear as for getting closer to the date of delivery when faced with the clinical signs, difficulty related to access to transport, trust in the safety provided by the SAMU team and in its agility, associated with absence of costs in this transport, as well as social construction about the medicalization of childbirth, are factors that can stimulate women to seek the SAMU.

Considering the service involved, health professionals, and the scientific community devoted to nursing, this research brought as a contribution the reflection on the need for increased training in obstetric urgency and

emergency cases, their main signs and symptoms, and the behavior recommended for each case, in a continued way, according to the principles and guidelines of the Brazilian National Policy of Continued Health Education. Thus, it is possible to provide this woman with good quality care until her final destination, and there is also a need to raise awareness that detailed records demonstrate the actions undertaken and ensure not only the specific behavior, but professional safety on a legal basis.

ATENDIMENTO ÀS GESTANTES E PUÉRPERAS PELO SERVIÇO DE ATENDIMENTO MÓVEL DE URGÊNCIA

RESUMO

Este artigo objetivou descrever o perfil do atendimento pré-hospitalar às gestantes e puérperas pelo Serviço de Atendimento Móvel de Urgência (SAMU) em um município baiano em 2010. Trata-se de pesquisa descritiva, documental e de abordagem quantitativa, realizada a partir de dados secundários gerados de 385 fichas de atendimento; a coleta de dados ocorreu por meio de formulário adaptado da ficha de atendimento desse serviço, de dezembro de 2011 a abril de 2012. Os dados foram tabulados por meio da distribuição de frequências e analisados por meio da estatística simples. Do total de fichas analisadas, foram atendidas 360 gestantes (93,5%), sendo 78 multigestas (20,3%); 107 encontravam-se na faixa etária de 20 a 24 anos (27,8%); 95 tinham idade gestacional entre 38 e 42 semanas (24,7%); e 208 estavam em trabalho de parto (54,0%). Entre as gestantes, 337 tiveram parto hospitalar (87,5%) e 152 foram encaminhadas para maternidades públicas (39,5%); 99 atendimentos foram realizados entre 00:00 e 06:00 (25,7%). Quanto ao clampeamento de cordão, 13 procedimentos foram registrados (3,5%), bem como 11 delivramentos (2,9%). Concluiu-se que o perfil do atendimento pré-hospitalar às gestantes e puérperas pelo serviço esteve voltado ao trabalho de parto, parto e puerpério, o que pode estar relacionado à percepção de facilidade, rapidez e segurança.

Palavras-chave: Serviços médicos de emergência. Enfermagem obstétrica. Saúde da mulher.

ATENCIÓN PRESTADA A MUJERES EMBARAZADAS Y PUÉRPERAS POR EL SERVICIO DE ATENCIÓN MÓVIL DE URGENCIA

RESUMEN

Este artículo tuvo como objetivo describir el perfil de la atención pre-hospitalaria a las mujeres embarazadas y las puérperas por el Servicio de Atención Móvil de Urgencia (SAMU) en un municipio de Bahía, Brasil, en 2010. Se trata de una investigación descriptiva, documental, con abordaje cuantitativo, llevada a cabo por medio de datos secundarios generados desde 385 registros de atención a la salud; la recolección de datos ocurrió a través de formulario adaptado desde los registros de atención a la salud de este servicio, de diciembre de 2011 a abril de 2012. Los datos fueron tabulados por distribución de frecuencia y se analizaron mediante estadística simple. Del número total de registros analizados, 360 mujeres embarazadas recibieron cuidados (93,5%), entre estas, 78 quedaron embarazadas más de una vez (20,3%); 107 estaban en la franja etaria de 20 a 24 años (27,8%); 95 tenían una edad gestacional entre 38 y 42 semanas (24,7%); y 208 estaban en trabajo de parto (54,0%). Entre las mujeres embarazadas, 337 se sometieron a parto en un hospital (87,5%) y 152 fueron encaminadas a maternidades públicas (39,5%); 99 atenciones fueron realizadas entre 00:00 y 06:00 (25,7%). En cuanto al pinzamiento del cordón umbilical, 13 procedimientos fueron registrados (3,5%), así como 11 casos de liberación (2,9%). Se concluyó que el perfil de la atención pre-hospitalaria a las mujeres embarazadas y puérperas por el servicio se centró en el trabajo de parto, el parto y el puerperio, lo que puede estar relacionado con la percepción de facilidad, rapidez y seguridad.

Palabras clave: Servicios médicos de urgencia. Enfermería obstétrica. Salud de la mujer.

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Corresponding author: Zannety Conceição Silva do Nascimento Souza. Universidade Estadual de Feira de Santana, Campus Universitário. Av. Transnordestina, s/n, módulo 6, anexo ao MT. Novo Horizonte, CEP 44036-900. Feira de Santana/BA. Brasil. E-mail: zannetyenfermeira@gmail.com

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