

Production of comprehensive prenatal care: a pregnant woman's route at a primary family healthcare unitⁱ

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Abstract

This study aims to understand the production of comprehensive care in prenatal care in a Basic Unity of Family Health in Fortaleza. To this end, we conducted semi-structured interviews with a user, whose prenatal care was provided by a Basic Unity of Family Health, as well as systematic observations of her prenatal care appointments. Data analysis, conducted according to Merhy's analytic flowchart, revealed that bureaucratization of reception at the entrance, a sequence of violated rights in the team-user relationship and the little access by the user of information on childbirth and *puerperal* period. It was concluded that embracement, attachment and responsabilization are still non-institutionalized devices in family health team. Health care is based on individual values of each professional, which by themselves do not provide comprehensive prenatal care.

Key words: Prenatal care. Family health. Women health.

INTRODUCTION

Health care involves considering the subject's experience, listening to his/her life project and being open to really be with the other. In the production of care there should be attentive listening which will result in understanding the situation experienced by the user, including understanding of why the user does not adhere to a treatment or is not interested in preventive orientations. This attentive listening can even help the professional to find out the subject's detachment to his/her own life (Ayres, 2006).

Listening is understood to consist of an active process that makes the subject produce his/her own replies to his/her suffering as it recognizes that, as a human being, the subject has the ability to be autonomous. Therefore, the health professional can induce the subject to question his/her own actions and fantasies, without prompting answers to his/her inquiries.

For this listening to take place, it is essential to share responsibilities and perceive the other as someone who has alterity. This alterity is characterized by the autonomy to decide what is best for his/her life or for his/her project of happiness (Ayres, 2006).

It is possible to notice that the definition of care highlighted by this author shares the perception proposed here, that is, to search for co-responsible care which enables the user to become autonomous. This view is also in harmony with the concept of light technology of health care proposed by Merhy (2002).

Light technology of health care is understood as the one that allows the production of relationships that take place at the unique moment the meeting takes place. Although hard materiality is present while low technology is used, this technology does not depend on it since it prioritizes meeting, conversation and the subject who looks for help. This type of technology emerges from “attachment, embracement and responsabilization”.

In his discussion on this topic, Merhy (1997) defines “attachment, embracement and responsabilization”. According to this author, embracement is a humanized relationship that health workers as a whole have to establish with users, which involves changing the dominant impersonality in the daily routine of health services.

As far as attachment is concerned, the author suggests that health professional should have clear and close relationships with users, get integrated in the community in his/her area, and become reference for its actions.

On responsabilisation, the researcher says: “the professional takes the responsibility to orient and guarantee the paths to be taken to solve the problem, and is also in charge of bureaucratic transfer to either other decision making authority or level of care” (Merhy, 1997, p.138).

Thus, in Merhy’s perspective (Merhy, 2002), the production of care takes place when we promote the meeting between the user and his/her world of necessities based on his “way of walking through life”. This can only happen when embracement, attachment and responsabilization are possible to be established in health care, since, this way, each user’s necessities, which are present in his/her project of happiness, will be appropriately attached and articulated in his/her therapeutic project (Ayres, 2006). As we can notice, Merhy e Ayres agree when the theme is the importance of singularity as a priority in health care. For both, articulation between this singularity and the scientific knowledge of the health professionals should be searched.

With the implementation of the Family Health Program (FHP – PSF, in Brazil), it is possible to glimpse a possibility of renewal in health care, since this program requires a new way of meeting the health needs of the subject in which he/she must be seen in a holistic way. For this to take place, teams

shall rethink the health work process, adopting new methodologies and technologies. According to Vasconcelos (1998), actions of the FHP aim to provide minorities that have difficulty to get access to health treatment with good quality service and to promote greater integrality of this care.

It is possible to establish a parallel with Ayres (2006) when we highlight the need to subvert technification or objectivity of human work into “live intersubjectivity of the moment of care”, in which it is important to go beyond the technological aspects and establish sharing. In this circumstance, according to Ayres (2006), one can think of the FHP proposal as a relationship among subjects who perceive one another as having alterity.

In general terms, the Family Health Program contributes to the organization of basic attention as a regulator of the entrance door of the health system. It also aims at basic health care, avoiding mother-child mortality through pregnant care in prenatal period. Besides considering biological procedures, the prenatal care provided by the FHP must refer to an analysis of the pregnant woman’s subjectivity, including psychic and social aspects. Some initiatives reinforce this proposal, for instance: in 2000, the Brazilian Health Department launched the Prenatal Care Humanization Program, which emphasizes the recognition of the need to establish attachment between the health team and the pregnant woman, including subjective aspects present in prenatal care (Brasil, 2000).

To make it possible to grow attention to those aspects, user-centered care that contrasts with procedure-centered care is demanded. Focus on the user must be based on light technologies directed to health, grounded on an interrelation that involves attachment, embracement and responsabilization.

In this perspective, this study aims to understand the production of health care during prenatal care in a Basic Health Unit (UBS, in Brazil) in Fortaleza – CE through the analysis of a user’s case in order to learn how care embracement, attachment and responsabilization were provided in this context.

METHOD

This study took place in Fortaleza-CE, in a Basic Health Unit of the IV Regional Executive Office, considered to be reference for a population of 31.653 inhabitants, although it only attends 198 inhabitants (Fortaleza, 2008). Only one health team was working at the unit at the time this study was conducted. This team was composed by a medical doctor, a nurse, a dentist and a community health agent. There were other health professionals who did not belong to the family health team. In order to understand this specific reality, the qualitative approach was used.

As far as data collection techniques are concerned, semi structured interviews and systematic observation were used. There were four interviews in total. Three of them were carried out monthly, every time the pregnant woman went to the unit for prenatal care; one of the interviews was made in the puerperal period. Meanwhile, observations of doctor

appointments were made. We chose a reserved place in the BHU for the interviews where there were only the researcher and the user.

The subject in this study was a pregnant woman who met the inclusion criteria: to be cared by a family health team and to be more than 18 years old. The choice of this user's case resulted from the peculiarity of her prenatal care, which followed two models of health care available at the BHU. In this study, we adopted the concept of "analyzer", i.e., "what makes it possible to reveal the structure of the institution, to challenge it, and to force it to speak" (Lourau, 1996, p. 284). In this sense, the criterion for choosing the sample for this study would be having a case with such a degree of complexity that stresses the healthcare network, and, in this tension, reveals its actual way of operating.

The techniques used to collect data were guided by a script which contained information on the subject involved in the study and on comprehensive care during prenatal care, based on the following items: (1) embracement (entrance door, type of demand, healthcare system), (2) relationship between health team and user (attachment) and (3) orientation to other services (responsibilization).

Data analysis was based on Merhy's analyzer flowchart (2002, 1997). This author proposes a critical analysis of the work process using a flowchart that enables a new understanding of the interaction among the subjects in health practice. This flowchart allows us to analyze the healthcare model created by the team, besides making it easier to visualize the information gathered in empirical research.

Complying with some research requirements, the research project was submitted to the Research Ethics Committee of the State University of Ceará, and was approved. Also as required, the pregnant woman interviewed in this study signed a consent form and received all the necessary information to participate in the study.

ANALYSIS AND DISCUSSION

Flora (fictitious name, suggested by the user) is a 20 year-old married maid, with low financial status, who lives in her mother-in-law's house in Fortaleza. When the first interview was conducted, she was six months pregnant of her third child. This interview is about the period in which the child was gestated, to which this study is restricted.

Before knowing about her pregnancy, Flora had tuberculosis and was being cared by the FHP team of that unit. During this period, the drug used to treat tuberculosis made her contraceptive medicine ineffective, and this, as she reported, was the reason why she became pregnant. As stated by Souza (2006), some medicines used to treat tuberculosis promote the acceleration of hepatic metabolism, decreasing the levels of hormones and making oral contraceptives ineffective. In that case other contraceptive means are recommended. However, Flora had not been advised about the risks of the treatment to minimize the effects of oral hormonal contraceptives by the family health team. There was, thus, violation of the right to get information.

For Barata (1990), in the Brazilian society, health authorities assume a technocratic attitude in which health information is believed to belong only to professionals in the area. These authoritarian attitudes in health may vary from the simple decision not to give information to the attempt to confuse the population with technical discussions, reducing the ability of the user to understand the problem.

As Moura and Rodrigues (2003) appropriately highlight, in a new perspective of health care, particularly during prenatal care, information exchange and experience sharing should be privileged in order to promote understanding of pregnancy through communication activities and health information.

When she knew she was pregnant, Flora was advised to abort by her husband and mother. She tried to do that three times using drugs, but she was not successful. When she realized she would not abort, she was already five months pregnant, and decided to seek for the basic health unit for prenatal care, even having an unwanted pregnancy.

Starting Moment: embracement at the reception of the Basic Health Unit

The amount of health care provided in this unit is large. As mentioned before, there is only a FHP team in a unit that covers 29.05% of the territory (Fortaleza, 2008). This team is reference in the area because, although there are other health professionals in the unit, they do not share this model of health care.

In this initial stage, the space of reception is in focus. This space should serve to welcome the subject who seeks for health care. It is a place for conversation, listening and involvement with the need revealed by the user. That's when the health professional perceives such a need and becomes responsible for it.

According to what was observed in Flora's testimonies, there are conflicting situations in relation to reception. As the user reported, when she arrived at the unit, she was very nervous, and looked for reception service. The professional just scheduled the dates of her prenatal care. There was no attempt to provide the woman with a more comfortable situation, despite of her visible fragility.

The type of care provided at the reception was bureaucratized, focusing on scheduling appointments exclusively. In this case, the appointment was made with a doctor that was not a member of the FHP team. The process of embracement, however, should have been carried out by a team of different professionals and should have aimed at listening and appropriate orienting the user in response to her demand (Merhy, 1994).

At Flora's first doctor appointment, a nursing assistant checked her vital signs and left her waiting for care for about 1 hour and 30 minutes in an uncomfortable room, inappropriate for users and professionals. At that unit there was not enough space to accommodate users either at the reception or in the waiting room. The waiting room was actually a corridor, located across from the treatment rooms, where everyone who entered the unit went

through. Thus, it was uncomfortable to be there as it was a narrow and very hot place, with no ventilation. As noticed, the discomfort was prolonged in the benches, built solely of masonry and insufficient to accommodate everyone who was waiting for care.

Moment of prenatal appointments: individual relationship in medical practice (attachment establishing)

As remarked, the first doctor to meet Flora was not a member of the family health team. As reported by the user, this care was provided by a doctor who did not give her the opportunity to say what was happening. He simply prescribed drugs and performed procedures, as shown in the subject's talk below:

"There is a terrible doctor here, I was attended by him a few times ... never more... he did not even look at me ... he simply prescribed medicines and I couldn't get better ... Later, I told him straight ... if he had been in charge of my whole prenatal care, I would have died "(Flora).

In contrast with the need for a comprehensive care that respects the uniqueness of the subject, Flora found a mechanized care that only worked with explicit demands (prenatal prevention care). This service was performed using hard technologies and excluded the possible responses to psychosocial health needs fully present in that situation.

Unsatisfied, Flora searched for another doctor for prenatal care, and decided to seek for care of the family health team, the same team that took care of her when she had tuberculosis.

With this attitude, it is possible to notice the initiative and the protagonist role of the user in her case. She demanded the right to choose the professional by whom she wanted to be taken care of. The user's relationship with the professionals in the family health team is pointed out, since it enabled the search for a particular care based on trust and attachment, which had been previously established with the team that had already embraced her.

Flora's attitude confirms the essential elements of primary care presented by Trad (2006): trust and longitudinality. Based on these elements, Flora acknowledged in the work of the FHP team the possibility of willingness to help and permanence of a reliable source of attention for her suffering.

Through the prenatal care provided by the family health team, it is possible to notice the willingness to open space for a listening network that connects the health professionals and the user. Straight in our first meeting, she explained the various problems in her life, and highlighted the embracement she had from the health care.

This first embracing contact provided by the health family team led to the construction of an initial connection between Flora and the professionals. At that moment, they articulated some health work that linked the technical and subjective interventions. This allowed the beginning of talks and served as

support for the suffering experienced by the pregnant woman at home. This finding matches what Merhy and Franco (2003) defend in relation to resolute intervention. According to these authors, it occurs in a user-centered health production process in which the importance of embracing and attaching is recognized.

Differently from what is discussed above, however, the work process of the first doctor while attending Flora exploited the symptoms of pregnancy. There was no listening neither recognition of the user's anguish and anxiety, and there was a failure to perceive and interpret the factors that actually made Flora suffer.

The doctor and the nurse of the family health team, on the other hand, tried to overcome the difficulties and develop a user-centered care using the available tools. Thus, even with existing structural limitations, they tried to minimize the situation of Flora, in spite of the physical environment, once the treatment room was separated in half just by a panel wall that demarcated the doctor's and nurse's areas, which did not guarantee privacy to the user. Despite the persistence of precarious equipment and difficulty to have medical exams - which were carried out outside the basic unit and whose results were provided late - the emphasis was on Flora's care process.

At some moments, we could perceive the team's initiative to overcome institutional weaknesses by listening to the user, what would allow her to express her anguishes, such as the fact of having provoked abortion several times and the fear that her baby would suffer from malformation. In this case, as observed, in the family health team, intersubjectivity in the relationship between health professionals and the user works in such a way that affective movements take place with high emotional intensity, which provides opportunities for better care.

Through medical tests, the doctor noticed the presence of toxoplasmosis. This disease is caused either by eating undercooked meat that is contaminated with toxoplasmosis, or, in most cases, by the contact with animal urine and feces (Carellos, Andrade, Aguiar, 2008). As the infection was detected, Flora was sent to an infectologist.

For the nurse of the FHP team who participates in this study, toxoplasmosis is likely to cause many complications in pregnancy and may even cause malformation, premature birth and miscarriage. This fact was used to justify the restriction of Flora's prenatal care exclusively by the doctor. Consequently, doctor and nurse appointments were not alternated, and this disturbed Flora emotionally because she liked to share her experiences with the nurse of the family health team. Once again, as we can see - although the user could be attended by the PSF team - procedures continued to be bureaucratic as they prioritized the standard of conduct instead of the user's access to appointments with the nurse, as she wished.

Besides infection, the user suffered from hypertension, which was increased by the extra work required from Flora. Throughout her pregnancy, she worked as a maid, was responsible for cooking and cleaning the whole house where she worked, and had only one day a week off. With so many problems, swelling in her legs as well as other disorders increased. Then, the

unit team advised Flora either to stop working or to take a leave. However, due to the fact that she did not have a formal contract and needed her salary very much, once her husband was unemployed, this suggestion was not accepted.

At that moment, the team did not mention anything such as the fact that she should have her labor rights respected by the employer, although such information is essential in a model of health care that highlights the social aspect. Here we point out the need of the health team to be aware of services in order to provide appropriate orientation and actually implement a network of care that can encourage pregnant women's autonomy.

As it was also noticed, when she was taking care of Flora, the nurse of the FHP team gave her husband a bicycle, what enabled him to sell cleaning products and deliver them to the customers to help the family income. This initiative does not characterize attachment because this presupposes monitoring the therapeutic project using care techniques that encourage the users to take care of themselves. Obviously, there was a positive action of the professional to help the other to fulfill his need, but this does not demonstrate that attachment is a parameter in the organization of services. This fact appears as something isolated, although attachment is noticed in other care activities, which characterizes a search for alternatives to help the user in this process of care co-responsibility. This way, the lack of institutional tools that can handle the demands of the user is highlighted. Given this lack, professionals turn to their own values, judgments, and work resources, what personifies their actions since they are based on "assistencialist" models.

Nevertheless, in her interview, Flora repeatedly stressed the importance of her relationship with the unit's professionals. She said she was very grateful for their attention, advice and listening, as we can see below:

"If I hadn't had the possibility to tell everything I was going through I would have that stuck until I died. I couldn't say anything at home, I couldn't talk to the neighbors ... because they aren't worth a penny ... they gossip. I prefer to talk to my doctor, nurse ... they give me right advice "(Flora).

"My relationship with the doctor and the nurse was great, she monitored the baby and talked to me ..." (Flora).

According to Flora, the contact with the unit's health professionals was a way to make up for the rejection of her husband, who spent the seven months of pregnancy pressuring her to have an abortion or give the newly born for someone else to raise. The user also reported that, in other aspects, her gestation period was calm; there were not many physiological complications. As she highlighted, however, the greatest difficulty was

experienced in her "mind" because of her husband's rejection, as shown below:

"... My husband said he was disgusted with me, he wouldn't even look at me, I had no family, I just had contact with my mother recently ... I wasn't risen by her, so I had to put up with it all by myself ... I had nowhere to go ... "(Flora).

"I was so angry, God was very good for not having taken my son away... I spent the whole pregnancy crying ... I always cried because of my husband ... those were the worst months of my life. I was lucky to have the team in the clinic to count on... I was very lucky ... "(Flora).

"I had no complications ... just my husband, he was disgusted with me, I had no anemia, everything was normal ... the problem was at home and that affected my mind "(Flora).

Although we can see that there was an attempt of the family health team to consider subjectivity at some moments in order to redirect the therapeutic process towards an expanded health care, most of the user's experience in the BHU is resultant from failures in the public health system to provide minimum conditions for the care process to take place comprehensively. As noticed, provisions of comprehensive care are not established in health service but there are assistentialist practices, which are developed with basis on subjective criteria established by each professional. Perhaps the sequence of violated rights found in this case is resultant from a culture of resigned acceptance of disrespect shared by the health professionals. It is clear that the user was depressed and that the team either could not realize it or did not act to relieve her depressive status. That demonstrates how care process itself is still precarious in the FHP team, despite the dedication of some professionals.

Moment of completion of the therapeutic process: childbirth and puerperal period.

The completion of the therapeutic prenatal care concerns the act of sending the user to the maternity, professional monitoring at delivery time, required information received by the user to prepare for childbirth and home visits in the puerperal period.

Within this context, empirical data have converged to cause a critical knot in the preparation of Flora for childbirth by those professionals. We tried to know whether what would happen had been explained. According to her, she did not receive any explanation, and perhaps because it was not her first

pregnancy, professionals thought she wouldn't be in doubt. However, as stated in her report, she suffered a lot during pre-birth, thinking about the pain she would feel, as well as of her fantasy that the baby would suffer from malformation as a result of her attempts to abort. Thus, the lack of information stimulated the development of fears and fantasies about the unknown, as we can notice in the following talk:

"Before delivery time, I was afraid to be in pain again, but once I got there, the baby was born. I had had two babies, even so I was afraid of what could happen, I imagined he'd have some kind of malformation due to the drug to induce abortion I had taken..."(Flora).

We found another problem, which concerns the lack of professionals from the prenatal team at delivery time. In Flora's case, there was not even orientation to a specific maternity hospital. The patient herself, who had normal labor at the 36th week of pregnancy, looked for a hospital. As the user highlighted, she was unaware of the right to have a companion during delivery. Then, she was asked who she would have invited if she had known about that right. Flora promptly said the name of the doctor in the family health team, emphasizing that she would feel very safe if it had happened. This fact shows the connection established between the doctor and the user. However, it does not constitute the establishment of attachment, but it supplies the emotional needs of the user, who, even unattended in many aspects, still considers the health professional as a safe haven.

However, this action shows a moment of dis-responsibilization in the process of comprehensive care because neither did the team provide the necessary information nor the appropriate care during delivery time.

Still according to Flora, the team could go to her home to visit her during puerperal period. As at the time there were no visits, the user had to go to the unit to be attended. At this point, the doctor told her that the baby did not have any malformation or disease. According to the information provided by the coordinator of the health unit, during that period, the unit had no transportation to send the team to the families' houses.

According to the professionals, visits should occur by the seventh day after delivery; many times, however, they take place just 42 days later. Professionals justify the delay claiming that there is no transportation and that there is a large demand of users to be attended, which makes it impossible to leave the unit to go to the puerperal women's houses. It was evident that the users' demands require models of health care that are often not similar to the models used for care. Insufficient professional staff to cover all the demand, what consequently restricts the performance of some activities, such as puerperal visits, is highlighted.

According to what was revealed by the observations carried out in this study, the existing knots, besides referring to a macro-structural problem of public health, are also related to a problem in the microstructure of the work process within that basic health unit, such as a work plan that involves all

the workers in that service. These difficulties do take place and, consequently, result in directions from the coordination to the professionals without considering an attempt to co-administrate, since it is evident, in that unit, that the little availability of health workers to solve this problem still prevails.

As we can notice from the analysis carried out in this study, the family health team still does not provide comprehensive health care. There is a particular lack of important aspects to establish such care. According to Campos (2007), to achieve a shared practice of health work, it is imperative to expand the user's power in the services' routine. This can be done by valuing and/or giving the option of having a companion whenever possible; ensuring access to information, and considering the ability of self-care as an indicator of effectiveness of the provided care.

FINAL REMARKS

Based on the analysis carried out in this study, we can notice that the family health team has made efforts to develop actions in prenatal care to help the subject who needs them. Such actions, though, do not perform true comprehensive care.

As demonstrated, embracement and attachment, which are closely associated with this type of health care, were the most distant devices in the relationship between the professionals in the family health team and the user. However, at specific moments, certain actions favored the act of listening to the user, what points to the beginning of a process of embracement and attachment; though this process was not something institutionalized, but consisted of actions adopted according to personal values of each health professional.

Moreover, neither the comprehensive care that encourages sharing of neither psychosocial experiences nor co-responsibility for the therapeutic process were found in the actions of the members of team in the basic unit in focus. In addition, difficulties women face while trying to ensure their prenatal care are revealed in the analysis of the user's embracement by other health workers (first doctor who attended her and reception workers). Bureaucratized and tense relationships that show low responsabilization for the health of the other were observed.

The fact that there is a doctor who provides bureaucratic, non-embracement care and other professionals who produce a more open and receptive interpersonal relationship demonstrates that there is no uniformity in the way of providing care to pregnant women. This means that each professional conducts his/her work according to different models of care. This coexistence of different models leads, however, to tension and conflict with the proposal of providing users with comprehensive care. In this sense, the case described in this study shows several conflicts, working as an analyzer of the model of care production in the unit.

This study raises the possibility to rethink the care provided to women seeking for prenatal care from the moment they enter the basic health unit

until the moment of home visits in puerperal period, since this is a peculiar, very sensitive and delicate period in the life of each one of them.

COLLABORATORS

The authors worked together at all stages of production of the manuscript.

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ⁱ Translated by Maria Aparecida Gazotti Vallim.

Translation from **Interface - Comunicação, Saúde, Educação**, Botucatu, v.15, n. 38, p. 677 - 686, 2011.