

The social interaction of puerperal women towards invasive childbirth procedures

Interação social de puérperas com procedimentos invasivos no parto

La interacción social de puérperas hacia los procedimientos invasivos en el parto

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ABSTRACT

Objective: to present a representative model of puerperal women's social interaction with invasive childbirth procedures, based on the meanings they attribute to them. **Method:** this interpretative, qualitative study was conducted at a public maternity hospital in Rio de Janeiro by interview of 12 puerperal women in three sample groups. Data were analyzed in accordance with Symbolic interactionism and Grounded Theory. **Results:** an invasive procedure is anything that lies outside or violates the natural course of childbirth. Women in labor feel uncomfortable with the physiological situations of childbirth. Trusting in the care professional, they submit to procedures that they consider necessary to their baby's birth. **Conclusion:** the representative model shows that women submit to invasive procedures, not considering them invasive. Strategies must be developed to permit women to understand and decide on their own bodies, and to encourage obstetric nurses to provide women's care based on non-invasive procedures.

Descriptors: Medicalization; Labor, Obstetric; Obstetric Nursing; Symbolic Interactionism.

RESUMO

Objetivo: apresentar modelo representativo da interação social de puérperas com procedimentos invasivos durante o trabalho de parto, a partir dos significados por elas atribuídos. **Método:** estudo interpretativo, qualitativo, realizada em maternidade pública do Rio de Janeiro. Foram entrevistadas 12 puérperas, de 18 a 45 anos, divididas em 3 grupos amostrais. Dados analisados segundo o interacionismo Simbólico e a *Grounded Theory*. **Resultados:** procedimentos invasivos significam tudo que foge ao curso natural do parto ou viole. Entrando na situação, as mulheres sentem-se desconfortáveis com situações fisiológicas do parto. Confiando no profissional, submetem-se a procedimentos considerando-os necessários ao nascimento do bebê. **Conclusão:** o modelo representativo aponta que as mulheres se submetem a procedimentos invasivos sem considerá-los invasivos. É necessário criar estratégias que permitam à mulher compreender e tomar decisões sobre seu próprio corpo, bem como estimular a atuação de enfermeiras obstétricas para o cuidado à mulher com base na não invasão.

Descritores: Medicalização; Trabalho de Parto; Enfermagem Obstétrica; Interacionismo Simbólico.

RESUMEN

Objetivo: presentar un modelo representativo de la interacción social de las puérperas con los procedimientos invasivos de parto, a partir de los significados que les atribuyen. **Método:** este estudio interpretativo, cualitativo, se realizó en una maternidad pública de Río de Janeiro mediante entrevista a 12 puérperas en tres grupos de muestra. Los datos se analizaron de acuerdo con el interaccionismo simbólico y la teoría fundamentada. **Resultados:** un procedimiento invasivo es todo aquello que se encuentra fuera o viola el curso natural del parto. Las mujeres en trabajo de parto se sienten incómodas con las situaciones fisiológicas del parto. Confiando en el profesional asistencial, se someten a los procedimientos que consideran necesarios para el nacimiento de su bebé. **Conclusión:** el modelo representativo muestra que las mujeres se someten a procedimientos invasivos, no considerándolos invasivos. Se deben desarrollar estrategias para permitir que las mujeres comprendan y decidan sobre su propio cuerpo, y para alentar a las enfermeras obstétricas a brindar atención a las mujeres con base en procedimientos no invasivos.

Descriptores: Medicalización; Trabajo de Parto; Enfermería Obstétrica; Interaccionismo Simbólico.

INTRODUCTION

Labor and delivery represent a multifaceted and complex relationship between mother and baby, resulting from emotional and physiological events, which result in the birth of a new life and/or family¹.

Historically, deliveries took place mostly at home, accompanied by midwives, with practical knowledge about birth². With the evolution of society, the male figure appears on the scene along with medical science and encouragement for interventions. This process culminated in the institutionalization of delivery, placing the woman in the situation of a patient, without autonomy, separating her from her family environment. Thus, childbirth started to be considered a pathological event, requiring interventions, reflecting a mechanistic and medicalized character³.

These professional practices disregard the preference and rights of women, characterized by forms of invasion of the body. Frequent vaginal touches are highlighted, as well as lack of autonomy in choosing the delivery position,

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deprivation of the presence of the companion and absence of listening⁴.

The medicalized model of assistance prevails in the Unified Health System, leading to the perception of delivery as a process that causes risks to the lives of women and children⁵. Most of these units do not offer assistance geared to the needs of women, in addition to imposing a way of dealing with the woman's body, depersonalizing it^{6,7}.

It is necessary to broaden the view on assistance to women in labor beyond biology, moving away from this context marked by invasive practices. It is urged for actions that stimulate the role of women, considering that care is not only invasive techniques⁸.

Considering that the meaning of invasive procedures during labor can be modified by women since based on their interaction with them and with their social group, allowing for the construction of new experiences and interpretations, the objective was to present the representative model of the social interaction of puerperal women with invasive procedures during labor, based on the meanings they attribute.

THEORETICAL FRAMEWORK

To understand the meanings of invasive procedures during labor attributed by puerperal women, symbolic interactionism was used. It is a theoretical perspective that works on the meaning of something in the conception of an individual as a result of their social interaction. It is indicated to analyze processes of social and behavioral interactions based on the interpretation of how the individuals act in relation to situations as they attribute meaning to them⁹.

Symbolic interactionism is based on three premises^{10,11}: people act according to the meaning that things have for them; these meanings arise from social interactions; when used in their interactions, such senses are manipulated and modified by the individuals themselves.

Charon¹² adopted a representative scheme of human action from an interactionist perspective. Thus, when defining the situation for themselves, people set goals, apply appropriate perspectives, take the role of others in the situation, punctuate and define objects in the situation for themselves, apply past experiences, consider the future, look at themselves in the situation and, from there, determine their line of action and act openly.

Then, after the individuals' actions, the others mean it according to their own interpretations, and they also act openly. The individuals then interpret the other's action and, in the light of the other's action, reinterpret their actions, review perspectives, redefine the situation and their line of action.

The guiding question of this manuscript is "How does the process of social interaction of puerperal women with invasive procedures during labor occur, based on the meanings attributed by them?"

When answering this question, it is believed to contribute in a qualified way of caring, meeting the expectations of women in this stage of life. This model favors the understanding of the process from the perspective of the other – taking the place of the other in the situation – in line with the interactionist perspective.

METHOD

A qualitative and interpretive research, with the theoretical and methodological support of the classic aspect of the *Grounded Theory*¹³. This is an analysis methodology originating in North American sociology, which seeks to understand social reality and socially constructed meanings. The result of this process is a theory that emerges from the analysis of qualitative data, through the comparison of incidents, revealing concepts. These are compared with more incidents to deepen on their theoretical properties and raise hypotheses. Finally, the comparison between concepts allows for the theory to emerge. This procedure is called constant comparative analysis¹³.

The study was held in Rooming-In area of a public maternity hospital in Rio de Janeiro, from March to July 2018. This is a place that has mothers who were assisted during the active phase of labor by both nurses and physicians. In addition, it allowed for the use of reserved areas to preserve privacy during the interview.

The inclusion criteria for the first sample group were the following: puerperal women, over 18 years old, who had vaginal delivery, and hospitalized in the rooming-in area. Women who had clinical or obstetric complications during delivery were excluded.

The social experience is interpreted by the process of comparative data analysis, which is simultaneously collected, coded, analyzed and compared. The comings and goings in the material are defined as circularity of data¹⁴, which directs the intentional procedure of theoretical sampling. Therefore, the relationship between concepts and assumptions identifies the need to collect new data and select new participants or contextual situations to fill gaps and confirm hypotheses emerging from the analysis. Diagrams and *memos* are tools for the researcher's theoretical sensitivity that

consists of creativity in this process of identifying and integrating concepts, underpinning the theory, without intervention in the data^{14,15}.

In this perspective, data from the first sample group showed that, because they suffered few invasive procedures, women meant it as something routine and necessary. Thus, the hypothesis arose that women who had some type of complication could have been subjected to more invasive procedures, to which they may attribute different meanings. Then, three puerperal women who met this criterion were included, making up the second sample group.

Continuing the analysis process, it was perceived that the women with or without complications subjected to the procedures presented a positive reaction, as it is a necessary routine and would have the *reward* of having their babies in their arms.

Thus, there was an awareness of the need for a third sample group, interviewing three more women who had natural stillbirths.

The data collection of each group was interrupted when it was verified that the data were being repeated, with no further relevance in the elaboration of the concepts. Finally, theoretical saturation occurred, that is, when theoretical sampling is satisfactory to support the construction of the representative model^{13,14}. Thus, a total of 12 women were interviewed, between 18 and 45 years old, in 3 sample groups.

For the interviews, a first face-to-face contact with the woman was made intentionally, with explanations about the research and its ethical aspects. The participants signed the Free and Informed Consent Form. The data collection instrument was a semi-structured script whose triggering question was the same for the three sample groups: Tell me about the care/procedures provided during your labor. Accompanied by topics that were introduced during the interviews, deepening on some points of validation of the statements in each sample group (Interventionist measures, Non-invasive care technologies, empowerment, privacy and autonomy). The interviews were recorded on a digital device in mp4 format and lasted a mean of 40 minutes.

The testimonies were transcribed for simultaneous comparative analysis of the data based on the assumptions of the *Grounded Theory*. This process followed the following steps of the classic aspect¹³, inductive, comparative and emerging analysis of the data. Simple tables were built for organizing and coding the data.

Substantive coding was processed by open and selective coding. In open coding, a free line-by-line analysis was performed and each incident was coded using verbs in the gerund. The codes were compared and grouped, by affinity, into categories. Subsequently, focusing on the phenomenon, we moved on to selective coding.

After this phase, theoretical coding was defined by the organization, densification and reduction of the provisional categories, aiming at the basic social process. The consolidation of this stage is the central category that represents the phenomenon of the study. During this process, diagrams were elaborated until an end version was defined. Finally, there was validation with presentation of the diagram to 3 participants.

The ethical procedures were respected, with approval by the Research Ethics Committee of the Fernandes Figueira Institute - Fiocruz, (opinion No. 2,508,292). Amendments were sent to insert new sample groups, in line with the methodology used (opinions No. 2,757,713 and No. 2,826,682). In order to preserve the participants' identification, the letter *G* was used followed by the number of the sample group, and the letter *E* followed by the number of the interview, such as G1E3.

RESULTS

The constant comparative analysis of the data allowed for the construction and integration of 3 categories: *Signifying the invasive procedure during delivery*, *Living a delivery with interventions* and *Considering the interventions as help or as necessary*. This integration and articulation resulted in the identification of the central category: *Being subjected to invasive procedures, without considering them invasive* and the consequent elaboration of the diagram representing the process of social interaction of puerperal women with invasive procedures during childbirth, that is, an explanatory model in the interactionist perspective. This model was based on the scheme proposed by Charon¹².

Signifying the invasive procedure during delivery

From experiences built in previous childbirths, in social life and through family ties, the interviewees report that invasive procedures mean everything that is out of the natural course of childbirth. The meanings of invasive procedures surround the premise of something that is not necessary, that could be avoided and that is extremely uncomfortable.

I think anything that runs away from the natural, if not extremely necessary (G3E11).

Something that is not necessary and that causes me discomfort, which could be avoided (G2E7).

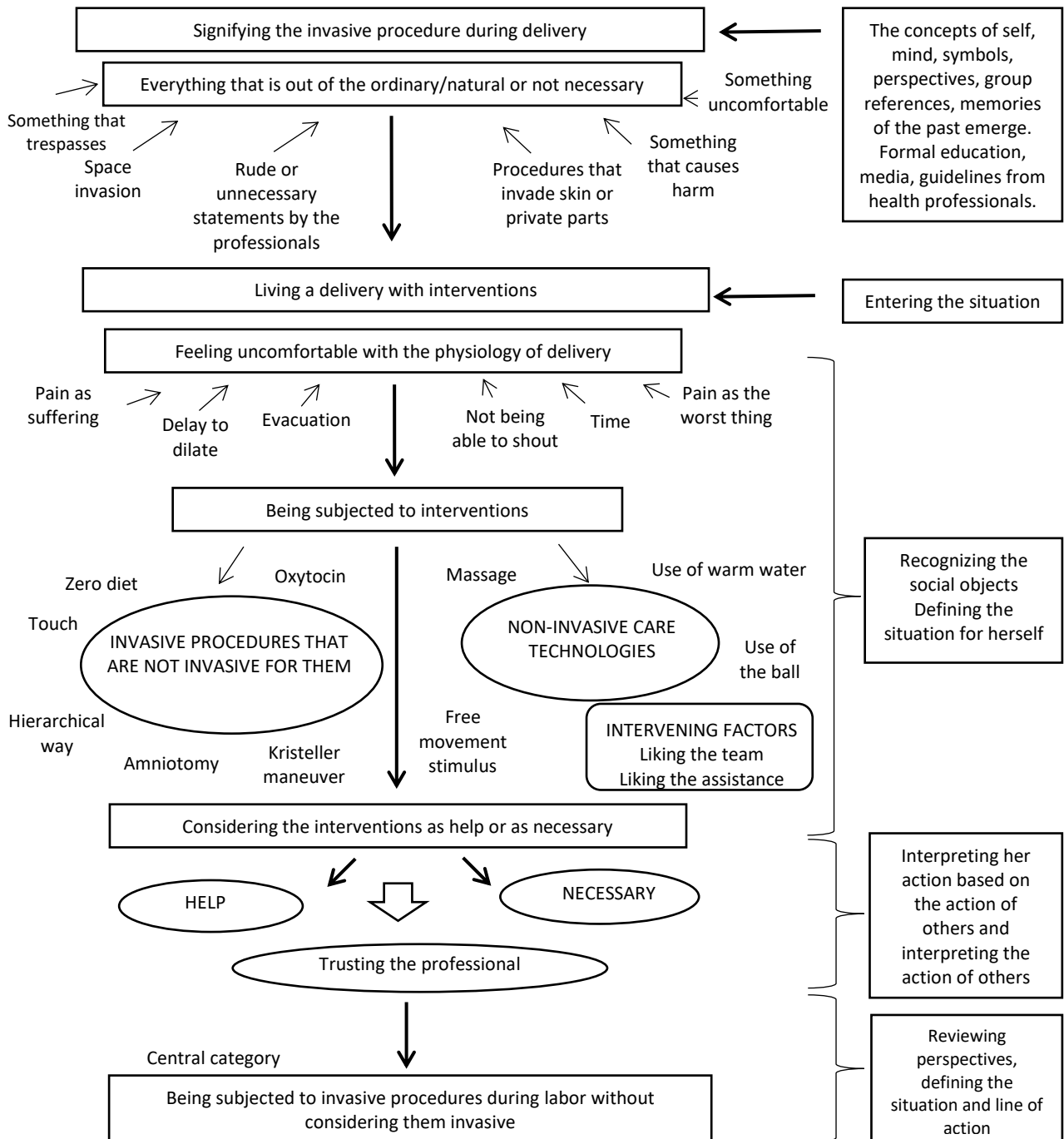


FIGURE 1: Diagram showing the representative model of the social interaction of puerperal women with invasive procedures during childbirth, according to the interactionist perspective. Rio de Janeiro, RJ, Brazil, 2018.

Women report that any conduct or position that unnecessarily trespasses, hurts or manipulates the body is considered an invasive procedure, as they understand the occasion of childbirth as a moment of total fragility for the woman.

I think it is something that violates me (G1E5).

Everything that has to do with manipulating the woman's body for me is invasion, that is not so necessary. In fact, childbirth is a moment of total fragility for us (G2E9).

That's when you take the other person's space, without asking them if you can. If you do not allow it, it is invasion (G3E12).

Based on this reality, the participants state that there must be respect on the part of the professionals during labor and that only procedures allowed by the woman should be performed.

Living a delivery with interventions

Entering the situation and defining it for herself, from the meanings attributed to invasive procedures, the woman constructs the meaning of discomfort in the face of physiological situations of labor. She considers that the physiological evolution of childbirth generates anxiety and distress. In addition, labor pain was considered as suffering. Thus, the longer the labor, the more the suffering.

It was the biggest suffering because it took me a long time to dilate. I entered the room it must have been midnight and fifty, she was born six and four, it was a long time of suffering, right? (G1E3)

It is a very strong pain, I was desperate, dying of pain... it is horrible (G1E4).

The participants consider that the procedures performed during labor are part of the routine. In their experiences they were imposingly subjected to procedures characteristic of both the technocratic and humanistic models.

They report discomfort and anxiety during procedures such as use of intravenous oxytocin, *Kristeller* maneuver, repetitive vaginal touch and drug delivery induction. They also report satisfaction and pain relief, citing some humanized interventions such as a warm sprinkling bath, massage, ambulation, and pelvic squat. But, for them they are routine conducts during labor, imposed by the professional.

And that (the finger) in there bothering you, then when she took it out, another doctor came to see the dilation, and you stay there, right? But, it is part because you have to see if the baby is there (G2E8).

The doctor explained that she was going to put a pill, that she was going to make me contract and go into labor. Sector routine, right? (G3E10)

When he put his elbow, the baby came out. His strength, along with mine, the child came out. (G1E5)

It relieves a lot when water runs down the back because I feel a lot of pain (G1E2).

It makes it easier, moving around makes it easier (G2E7).

At this moment, the woman recognizes the social objects involved and considers the assistance of the team to be good, respectful and careful, being configured as intervening factors in the process.

In normal childbirth, the pain is hopeless, we have to go through the pain, it's horrible, but I think that assistance helps, right? The way you are treated (G1E5).

They were very careful and with a lot of respect even to give touch... (G1E6)

Considering the interventions as help or as necessary

Interpreting their actions based on the actions of others and interpreting the actions of others, women do not consider the procedures they experienced during childbirth as invasive. For them, these procedures help or speed up the baby's birth and/or expulsion of the dead fetus. Therefore, even though they are uncomfortable, they consider it a necessary/essential routine to reduce the time of suffering caused by childbirth.

It bothers you, it's boring. Because he sticks his finger all time. [...]. I knew it was for the best, to see if my daughter was coming out or not, it was worth it (G1E2).

When I arrived at nine centimeters of dilation, they saw that I was no longer dilating at all, they induced [...]. They put me in the serum, right? [...]. Then, when they put serum, I said: "Now I'm sure it will be born" (G1E3).

It bothers, but it's part of it. Because you have to know about the baby, how it is [...]. So, if they don't touch you down there, how will they know? (G2E8)

When reviewing perspectives, defining the situation and the line of action, women reflect that they do not have enough capacity or knowledge to assess whether the professional's conduct is correct or not. They report that the professional is the most qualified to resolve childbirth issues and define the necessary conducts.

I didn't want to be hospitalized, but they did so. They, who have a diploma, right? They, who know, right? Then, it made me uncomfortable... I don't have the capacity to evaluate it (G1E5).

Because I wasn't going to make it. Then, they calmed me down and put me in a position that I was going to have him. (G1E4)

Five people came in and you believe that the five gave me a touch? You know how it is, right? We don't understand very well (G2E9).

DISCUSSION

Invasive means something related to the invasion or that harasses, with the word *aggressive*¹⁶ as a synonym. This definition is in agreement with the meanings attributed by the participants of this study. From the perspective of psychoanalysis, the body is subjected to regulatory and invasive medical interference, being treated as capable of withstanding any manipulation¹⁷.

In the context of women's health, the concept of invasive procedures has become a recurrent theme in the debates on assistance to parturient women, especially in the hospital environment, where attitudes that favor invasion of the female body prevail, with normative and hierarchical practices⁵. These attitudes, pointed out by women, show invasive procedures as something that trespasses and is out of the natural course of childbirth, strengthening the medicalization of the birth environment⁵.

The topic of medicalization is common in analyses in the field of health sociology. This term is used to describe biomedical interventions, with authoritarian social control over the body and behaviors, with predominance of medical knowledge over the individual¹⁸.

In obstetric care, some procedures started to be performed in a mechanized, segmented and dehumanized way, limiting female autonomy. Thus, they turn the birth scenario into an environment of violation of rights, manifested through verbal or psychological aggressions¹⁹. Medicalization is expressed by the high rates of cesarean sections and unnecessary interventions during delivery²⁰. In this study, the analysis showed a hierarchical imposition, even of supposedly non-invasive interventions, due to the absence of a shared decision.

Furthermore, normal delivery is often linked to the figure of pain and suffering to the detriment of its physiological character. The pain experienced by women in this period is a multi-factorial and individual sensation, which can be influenced by socio-cultural, economic, psychological, emotional and environmental factors²¹. In this sense, the woman must be welcomed and not underestimated, with training on the natural physiology of childbirth for safe and conscious choices^{21,22}. This suffering linked to physiological situations was also revealed in the analyzed data.

Therefore, an adequate environment provides women with a better ability to deal with the physiological events of childbirth, reducing the need for interventions and discomforts²³.

It is also essential to prepare them from the beginning of prenatal care, in order to enable positive experiences in childbirth. The protagonism in this process occurs through access to information, inclusion of companions, groups of pregnant women, considering the experiences and desires of women regarding normal delivery²⁴.

However, in Brazil, the technocratic model of obstetric care gained space and childbirth became a complex medical and hospital event²⁵. The current scenario of childbirth distances women from being the protagonist of their deliveries, subjecting them to the conduct and rules of the professionals even with discomfort and suffering²⁶. This study also points out that women undergo interventions without question because they understand them as part of the biomedical routine.

However, scientific evidence shows that certain procedures should not be used routinely in childbirth^{27,28}. However, there is a gap between recommendations and the current obstetric practice. The adoption of routine invasive obstetric procedures is consecrated in the training of professionals with a teaching standard based on the hospital-centered model, controlling the physiological process of childbirth and degrading the intrinsic potential of women to give birth^{3,25}.

In a counter-hegemonic way, strategies have been used to demedicalize obstetric care, based on non-invasive care technologies. Demedicalizing is understood as the act of presenting women with alternative care, in line with their autonomy and right to choose, disregarding medical reasoning as the only option, without, however, excluding professional or medical practices from care²⁹. These non-invasive technologies, used by nursing, minimize pain and provide comfort during labor, the result of a decision shared between professional and woman^{4,30,31}.

In this research, the use of non-invasive practices during labor was perceived by women as a positive experience. However, it is not configured as a non-invasive care technology due to the lack of shared decision and of a leading role of the woman.

The non-invasive care technologies are based on the following: the woman must be the focus of assistance, understanding the process beyond the biological aspect, contemplating experiences arising from emotional, social, cultural or mystical influences of the woman; the understanding that the process is one of care and not of control, defending respect for safety and privacy, procedures, either invasive or not, being performed only with the authorization of the woman²⁹.

This type of care is contrary to the established culture that makes women not believe in their ability to give birth, requiring professional and high-tech interventions for their deliveries^{32,33}. Thus, the woman assumes a passive posture in labor, without questioning the procedures used³, also evidenced by the interviewees, when women transfer the role to the professionals, electing them as the most qualified to decide on their deliveries.

At the same time, the professional does not recognize the woman as capable of taking responsibility for the care of her own health, and decides the best course of action. This asymmetric relationship between professional and parturient woman reinforces the medical model³².

Therefore, tools that contribute to the fight against unnecessary invasive procedures must still be provided in the early stages of pregnancy³². Women must have access to clear information on technologies and appropriate obstetric care for decision-making shared with the team, through qualified prenatal care, with educational activities in health that are free of prejudices^{21,22,24,28}.

To this end, the nurses working in primary health care and the family health strategy, at the gateway of care, must be sensitized and encouraged to include issues related to childbirth preparation from a humanized perspective in the care they provide³⁴.

In the scope of childbirth, the obstetric nurse has been a professional who shares and dialogs with the woman, establishing a relationship of partnership, respect and strengthening. This approach is fundamental for understanding the dimensions of the parturition process, including cultural and social aspects, so as to change the model³. The challenge is to find ways to break free from the technocratic model, marked by unnecessary invasive procedures and lack of autonomy³⁵.

Thus, it is important to reorganize the care system in order to unite the levels of care for women beyond the rigidity of the biomedical protocols.

CONCLUSION

In the interactionist perspective, and according to the model herein presented, the women understand that the interventions are necessary and beneficial routine conducts for the labor process. They undergo invasive procedures despite their discomfort.

Due to lack of knowledge or feeling of incapacity, they rely on professional decisions in relation to the procedures imposed on them, constituting hierarchical and normative assistance, where there is no shared decision regarding care. Thus, there is an invasion to the physiological event of childbirth as a consequence of the medicalization process, even in the use of humanized tools.

The importance of resignifying delivery and birth as a natural and physiological event is evidenced. For this, it is relevant to stimulate the performance of nurses at their levels of action, making use of the incorporation of non-invasive care technologies as a priority strategy of assistance to women, respecting their privacy and autonomy, placing them as the protagonists.

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