Cogitare Enfermagem

ORIGINAL ARTICLE

AVOIDANCE OF INFANT AND FETAL DEATH: INTERLOCUTION BETWEEN THE COMMITTEE AND PRIMARY HEALTH CARE

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ABSTRACT

Objective: to investigate how the interlocution between the Committee for the Prevention of Maternal, Infant and Fetal Death and Primary Health Care takes place in the municipality of Florianópolis, Santa Catarina.

Method: a single case study, with a qualitative approach, which had the Committee mentioned as the context, justified by the decisive case of the Northern Health District. ,Four sources of evidence were used in the data collection and the explanatory construction technique in the analysis,.

Results: the implantation and organization of the Mother and Infant Mortality Study Technical Group was highlighted, this being the interlocutor agent between the Committee and primary care, which reviews behaviors and work processes and proposes improvements in prenatal care.

Conclusion: the management strategies implemented by the Northern District can be taken as an example for other scenarios, especially for the promotion of an effective interlocution with primary care.

DESCRIPTORS: Health management; Public health surveillance; Child mortality; Fetal mortality; Committee of professionals.

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EVITABILIDADE DO ÓBITO INFANTIL E FETAL: INTERLOCUÇÃO ENTRE COMITÊ E ATENÇÃO PRIMÁRIA À SAÚDE

RESUMO

Objetivo: evidenciar como ocorre a interlocução entre o Comitê de Prevenção do Óbito Materno, Infantil e Fetal e a Atenção Primária à Saúde no município de Florianópolis, Santa Catarina.

Método: estudo de caso único, com abordagem qualitativa, que teve como contexto o referido Comitê, justificado pelo caso decisivo, o Distrito Sanitário Norte. Na coleta de dados foram utilizadas quatro fontes de evidência e, na análise, a técnica de construção da explanação.

Resultados: evidenciou-se a implantação e organização do Grupo Técnico de Estudos sobre Mortalidade Materno-Infantil, como o agente interlocutor entre o Comitê e a atenção primária, que revisa condutas e processos de trabalho e propõe melhorias na assistência durante o pré-natal.

Conclusão: as estratégias de gestão implementadas pelo Distrito Norte podem ser tomadas como exemplo para outros cenários, sobretudo para a promoção de uma interlocução efetiva com a atenção primária.

DESCRITORES: Gestão em saúde; Vigilância em saúde pública; Mortalidade infantil; Mortalidade fetal; Comitê de profissionais.

EVITABILIDAD DEL ÓBITO INFANTIL Y FETAL: DIÁLOGO ENTRE COMITÉ Y ATENCIÓN BÁSICA A LA SALUD

RESUMEN:

Objetivo: evidenciar cómo ocurre el diálogo entre el Comité de Prevención del Óbito Materno, Infantil y Fetal y la Atención Básica a la Salud en el municipio de Florianópolis, Santa Catarina.

Método: estudio de caso único, con abordaje cualitativo, que tuvo como contexto el antedicho Comité, justificado por el caso decisivo, el Distrito Sanitario Norte. En la obtención de datos se utilizaron cuatro fuentes de evidencia y, en el análisis, la técnica de construcción de la explanación.

Resultados: se evidenciaron la implantación y la organización del Grupo Técnico de Estudios sobre Mortalidad Materno Infantil, como el agente de diálogo entre el Comité y la atención básica, que revisa conductas y procesos de trabajo y propone mejorías en la asistencia durante el prenatal.

Conclusión: las estrategias de gestión implementadas por el Distrito Norte pueden ser ejemplo para otros escenarios, sobre todo para la promoción de una interlocución efectiva con la atención básica.

DESCRIPTORES: Gestión en salud; Vigilancia en salud pública; Mortalidad infantil; Mortalidad fetal; Comité de profesionales.

INTRODUCTION

Used worldwide as a sensitive indicator of the quality of life of the population, the infant mortality rate reflects the living conditions of the society, since it encompasses several social determinants of the health-disease process, including biological, environmental, social and economic factors. It is composed by the number of deaths of children under one year of age per thousand live births, in the population living in a given geographical area, in the year considered[1].

Reducing the infant mortality rate is one of the persistent challenges for health services, with an emphasis on the United Nations Sustainable Development Goals. A component of Goal 3 is to ensure a healthy life and promote well-being for all at all ages, to eliminate preventable deaths of newborns and children under 5 by 2030 and to reduce neonatal mortality to below 12 per 1,000 live births and the mortality of children under 5 years of age to below 25 per 1,000 live births[2].

In 2016, 67.3% (n=24,423) of infant and fetal deaths in Brazil were considered preventable, that is, these deaths would not have occurred if timely access to qualified and resolutive care had been guaranteed. Potentially preventable deaths are sentinel events, that is, their occurrence begins an investigation to understand the factors that led to the outcome, since the occurrence possibly reflects failures in the healthcare and indicates the need for improvements in the sectors involved in the care of this population group[3].

Regarding classifications of avoidability, the component with the highest index in the national scenario was the classification "reducible through adequate care during pregnancy"[4-6]. This data reveals the existence of weaknesses in prenatal care, indicating the need for management strategies to reduce preventable deaths in Primary Health Care (PHC)[7].

One of the strategies for reducing infant mortality is the establishment of a Committee for the Prevention of Infant and Fetal Mortality (CPIFM). Each CPIFM is composed of a multiprofessional team, with representatives from several institutions related to the health of the child, from hospital care to primary care. Its goals are to provide visibility, monitor and follow-up on infant and fetal deaths, defining strategies and intervention measures together with the services[8].

With this, the practice of the CPIFM has a significant role in the detailed analysis of infant and fetal mortality, exposing the situations that require intervention. It is their responsibility to analyze and discuss the deaths with the professionals involved in all levels of care to the mother-infant binomial, as well as to propose recommendations so that similar cases do not happen again. These recommendations should be sent to the managers of health institutions as part of the work of mortality surveillance and reorganization of the services, to discuss the circumstances associated with the deaths and qualify the care[9].

The transmission of the recommendations to the health institutions requires mechanisms of interlocution between local managers to carry out this action. In Florianópolis-SC, the CPIFM has a maternal component, being established as the Committee for the Prevention of Maternal, Infant and Fetal Mortality (CPMIFM). A mechanism for interlocution between the CPMIFM and PHC was introduced in Florianópolis with the creation of a Technical Group, in a Health District, as a feasible way to make recommendations to health units that serve the defined area.

Based on the above, this study adopted the following theoretical propositions: (1) the majority of the deaths classified as preventable are related to prenatal care, in which the predominant context is related to PHC; and (2) the CPMIFM is responsible for promoting the interlocution with PHC in order to reduce the number of preventable fetal and infant deaths. These propositions support the aim of investigating how the interlocution between the CPMIFM and PHC occurs in a Health District of Florianópolis.

METHOD

This decisive type, single case study used a qualitative, explanatory and descriptive approach. This type of study is recommended when, in the selection of the case there is a clear set of circumstances that can be related to the theoretical propositions of interest[10]. In this study, in the context of the CPMIFM, the case was the Northern Health District (NHD), selected for being the only one in the city to have implemented a Technical Study Group on Maternal and Infant Mortality (TSGM), which effectively conveyed the CPMIFM recommendations to PHC. It is important to clarify that in the CPMIFM, the professionals representing the five Health Districts (Central, Continental, Northern, Eastern and Southern) carry out the surveillance of infant deaths, investigating these when they occur in hospital, outpatient and home contexts. However, only the Northern District created a structure to work with PHC, becoming decisive for making the interlocution effective.

Data were collected through four sources of evidence: documentary research, direct participant observation, direct non-participant observation, and a focused interview with a key informant. The documents used in the documentary research were the minutes of the ordinary and extraordinary meetings of the CPMIFM of the last three years (2014 to 2016), totaling 36 records. The direct participant observation took place in the years 2015 and 2016, through a university extension project carried out by one of the authors with the Child Health Coordination of the Municipal Health Department, registered in monthly folders of the activities and in four follow-up reports of the actions carried out.

The non-participant observation occurred in two CPMIFM meetings in September and December 2016. This stage had a structured script to guide the observation according to the aim of the study. The focused interview with the key informant followed a previously prepared script, with open questions, being recorded and later transcribed. The key informant of this study was chosen due to acting concurrently in the CPMIFM, NHD and the TSGM, aiming to share and seek to comprehend the work process that makes the health district distinct and unique.

The strategies used for analyzing the data were guided by theoretical propositions and the development of the case description. With them, the explanatory construction technique was applied, formulating an explanation for the case. The organization and systematization of the data for the analysis were performed using the MaxQDA®plus program.

The study followed Resolution 466/2012 of the National Health Council and was approved by the Ethics Committee for Research with Human Subjects of the Federal University of Santa Catarina (CEP/UFSC), with authorization No. 1.556.889.

RESULTS

The results were organized into two topics. Initially, the process and work dynamics of the NHD for infant mortality surveillance in that area are described. Next, the mechanism of interlocution that the NHD promotes between the CPMIFM and the PHC through the TSGM is explained.

The Decisive Case: Northern Health District, Florianópolis

The NHD consists of 11 Health Centers, one polyclinic and one Emergency Care Unit, with its administrative headquarters attached to the ECU.

In relation to infant mortality, Epidemiological Surveillance professionals of the Health Districts are included in the CPMIFM. The cases are divided according to the area, with the Epidemiological Surveillance of each district being responsible for carrying out the

investigation of maternal, infant or fetal death.

The surveillance process begins with the Declaration of Death (DD), followed by the outpatient investigation through the electronic medical records of the woman, analyzing all the care during the pregnancy period.

If the death of a child occurs, additional data are collected from the child's medical records. Surveillance professionals perform the home interview, reconstructing with the family the facts that led to the death and recording the perception of the family members regarding the outcome.

They also perform the hospital investigation in the maternity ward where the birth took place and in the institution that attended the child until the death. The investigation process ends with a summary of the reconstruction of the history, highlighting the most important points of the case.

After completing the summary, the deaths are discussed with the CPMIFM multidisciplinary team, where they are analyzed, making observations and recommendations at all levels of the care to avoid similar cases.

The NHD implemented the TSGM, with the aim of producing systematized work that facilitates the interlocution with PHC. The need for the formation of this TSGM came from the perception of the limitation of the CPMIFM regarding changes in the work processes, and from the desire to reduce the infant mortality rate in the NHD, through working closer with the health units in the area.

The difference between the Committee and the TSGM is the change in the work process. The Committee does not work to change processes, it only recommends changes. In turn, the TSGM, by including the District manager in its composition, is able to change the work processes in an urgent and resolutive manner. Therefore, the TSGM of the NHD has an interventional and resolutive nature, acting in its area of performance, recommending and acting only for the institutions that comprise its formative framework.

We wanted a way to act [...], I have to change this work process now, I cannot just make recommendations "you should ...", no, you have to change today, you have to intervene in the work process itself. [...] So we decided to assemble this group of people in order to intervene. (Key informant)

The dynamics of the TSGM meetings are similar to those of the CPMIFM. It is a multidisciplinary group, with monthly meetings, being composed of the primary care supporters, the NHD manager, the nurses responsible for mortality surveillance, the family doctor, pediatrician and obstetrician gynecologist. The summary of the case, weaknesses and potentialities are presented, highlighting the situations raised, proposing the appropriate recommendations and evaluating the death, defining it as avoidable, inevitable or inconclusive. With the accomplishment of this work by the TSGM, the case is potentially more mature and detailed when it goes to the Committee, having already been discussed and evaluated, with the situations already highlighted and recommendations indicated.

The seminar of the NHD takes place annually, in which the results of the indicators agreed by the managers are presented. In this seminar, the child mortality data is presented, so that all the professionals of the district can see the reality of the NHD, even those of the Health Centers that do not have deaths.

In relation to the difficulties encountered, the lack of professionals and the fact that, due to being a professional of the network, the care professional leaves during the period of the meeting. In addition, the TSGM is constituted by few professionals and when they are on vacation or sick leave there is a significant decrease in the evaluation of deaths, with them not being easily substitutable due to their comprehension of the process. The result of these situations is the accumulation of cases, with difficulty achieving the target date of

120 days for the TSGM to finalize the investigation and evaluation.

For the TSGM to function better, some changes are projected, such as the institution of a 60-day limit to perform the whole process of investigation, evaluation and interlocution with the units, as well as the incorporation of a member of the Health Surveillance Department, targeting interventions in situations that are responsibility of this specialty.

In summary, the aim of the creation of the TSGM within the NHD was to carry out the interlocution with the units of the district, aiming to reduce the rate of infant mortality, with a focus on the deaths considered avoidable. This interlocution is the realization of a conversation, presenting the situations raised and recommendations proposed, with the actors involved in the care for the woman and the infant. Figure 1 represents the interlocution between the CPMIFM and the PHC, through the TSGM of the NHD.

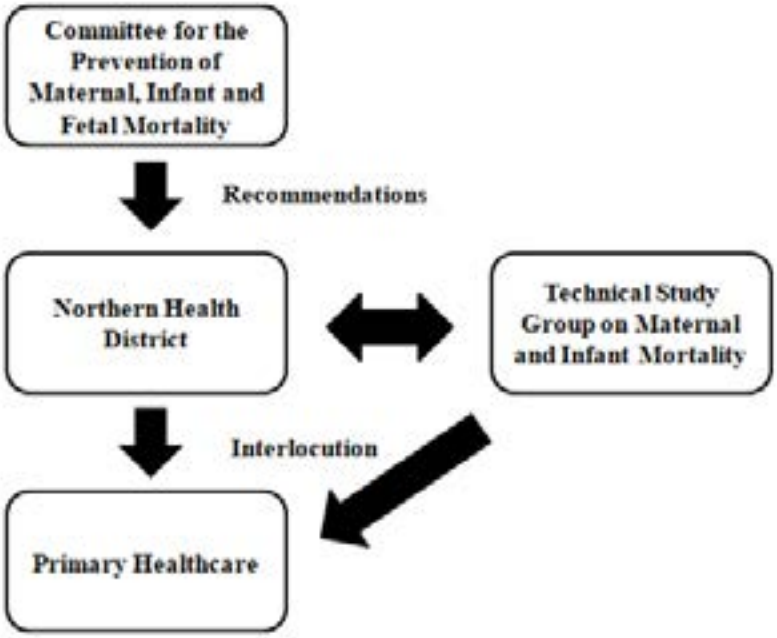

Figure 1 - Interlocution between the CPMIFM and PHC. Florianópolis, Santa Catarina, Brazil, 2017

Interlocution with Primary Health Care

After the analysis of the death by the TSGM, the interlocution with the PHC is carried out, more specifically, with the referral Health Center for the area in which the mother lives. This conversation is carried out by the primary care providers, who are professionals that provide technical support to the health centers or, in more serious cases, by the Epidemiological Surveillance professionals of the NHD.

The general meeting of the Health Center is the moment chosen for the interlocution, seeking the involvement and reflection of all the professionals, those who attended the woman and the child, and the other teams, so that it is possible to have joint growth.

We do it [the interlocution] at the general team meeting, because we think this involvement helps in something that the team did not do, but it's not free to do. (Key informant)

The supporters present the summary of the case, together with the situations raised, the recommendations and the avoidability assessment proposed by the TSGM. After the

presentation of the case, the team discusses whether it agrees with the points raised, giving suggestions and adding further points. This moment of interlocution is also used to resolve doubts regarding the mother and infant health care.

An evaluation by the professionals regarding the process of interlocution presented a favorable result. The teams respond positively to the interlocution, considering the discussion of the case to be important and understanding that it is a way to review attitudes, dynamics and work processes that can be improved, being highlighted as a moment of continuous education.

The teams are prepared to receive the feedback, in a special and permanent way, this being the real objective of carrying out this interlocution, with emphasis on the change of conduct and the minimization of weaknesses and errors. The aim is to focus on the reduction of infant and fetal mortality, and not the culpability of the actors involved in the death. When a subject is more delicate, the professional is individually called upon to talk about the behaviors taken.

It was something that we worked hard on, not to apportion blame, to make sure that the work processes occur, with our technique based on that, because we do not have time [...] but that we always have to review our processes and discuss this at meetings to avoid or minimize these weaknesses, these errors, these things that can compromise the care. (Key informant)

Time is an important issue, and the interlocution is carried out as rapidly as possible, so that the case is still fresh in the memory of those involved and more details can be considered. When recommendations refer to hospital care or private practices, the CPMIFM is responsible for the interlocution.

As the CPMIFM is not able to conduct the evaluations in real time, the NHD has opted not to wait for the evaluation of the Committee to carry out the interlocution with PHC. Thus, when the CPMIFM evaluation occurs and there are divergences from the recommendations made by the TSGM, the district surveillance contacts the coordinator of the Health Center to review the new guidelines or correct some previously recommended conduct.

The interlocution is performed with the summary of the case, the situations raised, the recommendations and the evaluation of the case. The main situations raised for the NHD, from 2014 to 2016, were related to: unplanned pregnancy; ease of access to prenatal care; lack of data in private prenatal care; maternal Urinary Tract Infection; obesity; smoking mother; rupture of membranes; preterm labor; pregnancy-specific hypertensive disease; untreated vaginosis; chorioamnionitis; multiparity; lack of bond with unit; untreated maternal syphilis; lack of adherence to prenatal care; serious social case; HIV positivity; and lack of registration in prenatal care.

Also, the main recommendations related to the PHC of the DSH in the previous three years were: review planning of sexual and reproductive life; review Urinary Tract Infection screening; referral for genetic counseling; review guidelines issued by the Family Health Strategy; perform active search; attention to the fundal height curve; teach the correct position for the baby to sleep in and provide instructions and material for bronchoaspiration; sensitization for the treatment of smoking; involve the street clinic staff; record actions in the medical records; treat partner with syphilis; involve the Expanded Family Health Center; guidance on fetal movement and alarm signs and review referral for high-risk prenatal care.

Of the 48 cases of the NHD evaluated by the CPMIFM between 2014 and 2016, 26 were considered avoidable, 20 of which were considered events avoidable through adequate care for women during pregnancy - prenatal care. A total of 16 cases were considered unavoidable and 6 inconclusive.

DISCUSSION

Regarding the infant mortality rate, studies have highlighted the reduction of rates in certain Brazilian cities in recent years, such as in the Federal District, Fortaleza and Recife[4-5,11]. Based on these data, Florianópolis presented a significant reduction, falling from 9.15 in 2012 to 5.29 deaths per thousand live births in 2016, in line with the national scenario[12].

The CPMIFM performs the analysis of maternal, infant and fetal mortality in Florianópolis when performing mortality surveillance. The role played by the committees was considered relevant to the decline in infant mortality. The committees were appointed as a space of continuous education, where the discussion with the local health teams regarding the process that resulted in the death was carried out[13].

A study carried out in Recife showed several similarities in the structure and organization of the committee in relation to the TSGM. Like Florianópolis, the administrative division of Recife is in Health Districts, with the managers and professionals of care and surveillance forming the mortality surveillance group, similar to the reality of the NHD. Furthermore, the process of implementing mortality surveillance is equivalent to the result of this study, dividing it into the confirmation and identification of the deaths, from the DD, epidemiological, domiciliary outpatient and hospital investigations, discussion of deaths with the professionals in charge and referral of the proposals to the institutions involved[14].

The idea of creating the TSGM of the NHD was derived from the data of the district related to mortality. As presented in the results of this study, in Florianópolis, approximately 54.1% (n = 26) of NHD deaths were considered avoidable through adequate care to women during the pregnancy, reflecting a potential for reduction associated with improving the prenatal care performed in the district. Due to these data, local managers proposed the creation of the TSGM in order to carry out interlocution with PHC and change the reality of the NHD in relation to mortality.

Regarding avoidability, studies show a similar picture to that of Florianópolis, where the results show that the large majority of deaths in Montes Claros and the Federal District, considered avoidable, most frequently presented the component "reduced by adequate attention during pregnancy"[4-5].

The committees have an educational and formative character, seeking to prevent deaths by means of training and sensitization of the professionals and institutions. They suggest measures of prevention and intervention to the institutions, with a view to correcting possible distortions and reducing infant mortality[8].

The health services have an essential role in preventing avoidable deaths, such as the surveillance of infant deaths, since the analysis of these deaths makes it possible to assess the quality of care, identifying the needs for intervention, change and organization of the process, seeking to improve care[15].

By performing the interlocution with PHC, the NHD creates a means of communication and review of conduct to improve the mother and infant health care provided. One study emphasized the performance of interlocution with the health teams of Recife, showing that the discussion of deaths with those involved in the care of women and infants is carried out in the Health District or in the hospitals where the deaths took place. This interlocution has educational, reflexive and propositional goals, which are not coercive or punitive, and focuses on the search for determinants and avoidability factors, to evaluate the healthcare and to propose intervention measures[14].

A study carried out in Londrina, Paraná, showed that one of the main challenges to reduce infant mortality is related to the qualification of prenatal care, care that is in great demand and is provided by PHC. The absence of adequate registration in the medical records and problems in the communication between professional and pregnant women

were also mentioned as contributing to a lack of quality. These challenges show that, despite the good coverage of prenatal care, it is necessary to invest in improving its quality. Therefore, the importance can be seen of investments to improve the quality of the care, to motivate and train healthcare providers for adequate adherence to existing protocols, and to promote the articulation of primary care and childbirth care[13].

Regarding the prenatal care, another study showed that, despite the increase in the number of prenatal visits and coverage, the care provided is unsatisfactory, which compromises the prevention, diagnosis and treatment of mothers and infants[16].

These results reflect that, even with the increase in coverage of the Family Health Strategy and the reduction in the infant mortality rate in the national context, the indices are still very high and incompatible with a good quality of life.

FINAL CONSIDERATIONS

This case study evidenced the organizational strategy of the NHD when creating the TSGM to carry out the interlocution of the recommendations with the health services. This was a unique initiative in the municipality, serving as an example to the other districts, to ensure that the Committee is empowered to provide feedback to the health institutions involved in the case of death.

The construction of the explanation was in line with the initial propositions of this study, revealing that the process of interlocution with PHC occurs monthly in the team meetings of the health center, through the presentation of the case and dialogue with the team. Furthermore, the study extends the propositions by revealing the forms of interlocution, through meetings, documents and dialogue with the professionals involved. The technical group, when carrying out the data presentation at the annual seminar held in the NHD, promotes an indirect interlocution with the other teams that do not have any deaths, this being a form of continuous education.

The interaction between the Committee and the TSGM favors the efficacy of the work carried out, reflecting in the quality of the care provided and, consequently, the review and reduction of harm, decreasing preventable infant mortality. In this way, this study contributed to demonstrate a positive example of local management, serving as a model for the other districts of the municipality and for the health system as a whole.

Although this study is limited to a single context and case, it can be interpreted as exemplary, due to the efficacy of the interlocution between the central and local levels through a structured organ. Studies with this theme could be developed in other contexts and with other cases, seeking to comprehend the different ways of working, combining and sharing experiences, with a view to improving mother and infant health care and management.

REFERENCES

1. Gaiva MAM, Fujimori E, Sato APS. Maternal and child risk factors associated with neonatal mortality. Texto contexto- enferm [Internet]. 2016 [access on 21 abr 2017]; 25(4). Available at: http://dx.doi.org/10.1590/0104-07072016002290015.

2. United Nations (UN). Sustainable development knowledge platform. [Internet]. 2015 [access on 25 abr 2016]. Available at: https://sustainabledevelopment.un.org/.

3. Silva VLS, Santos IS, Medronha NS, Matijasevich A. Mortalidade infantil na cidade de Pelotas, estado do Rio Grande do Sul, Brasil, no período 2005-2008: uso da investigação de óbitos na análise das causas evitáveis. Epidemiol. Serv. Saúde [Internet]. 2012 [access on 24 mar 2017]; 21(2). Available at: http://

dx.doi.org/10.5123/S1679-49742012000200009.

4. Oliveira E, Souto MB, Santos RO, Fonseca RL, Matos FV, Caldeira AP. Mortalidade infantil evitável em Montes Claros, Minas Gerais, Brasil, 1999-2011. Rev. baiana saúde pública [Internet]. 2015 [access on 25 jun 2017]; 39(2):397-407. Available at: http://rbsp.sesab.ba.gov.br/index.php/rbsp/article/view/1688/1245.

5. Canabrava PBE, Rocha JLFN, Costa AM, Elias KJ, Lima RV. Mortalidade infantil por causas evitáveis no Distrito Federal no período de 2003 a 2012. Rev Med Saúde Brasília [Internet]. 2016 [access on 21 mar 2017]; 5(2). Disponível: https://portalrevistas.ucb.br/index.php/rmsbr/article/download/7000/4564.

6. Oliveira CM, Bonfim CV, Guimarães MJB, Frias PG, Medeiros ZM. Infant mortality: temporal trend and contribution of death surveillance. Acta Paul. Enferm. [Internet]. 2016 [access on 23 mar 2017]; 29(3). Available at: http://dx.doi.org/10.1590/1982-0194201600040.

7. Figueiredo PP, Lunardi Filho WD, Lunardi VL, Pimpão FD. Mortalidade infantil e pré-natal: contribuições da clínica à luz de Canguilhem e Foucault. Rev. Latino-Am. Enfermagem [Internet]. 2012 [access on 28 nov 2017]; 20(1). Available at: http://dx.doi.org/10.1590/S0104-11692012000100026.

8. Ruoff AB, Andrade SR, Schmitt MD. Atividades desenvolvidas pelos comitês de prevenção do óbito infantil e fetal: revisão integrativa. Rev. Gaúcha Enferm. [Internet]. 2017 [access on 01 out 2017]; 38(1). Available at: http://dx.doi.org/10.1590/1983-1447.2017.01.67342.

9. Ministério da Saúde (BR). Secretaria de Vigilância em Saúde, Secretaria de Atenção à Saúde. Manual de vigilância do óbito infantil e fetal e do comitê de prevenção do óbito infantil e fetal. 2. ed. Brasília: Ministério da Saúde; 2009. 96 p.

10. Yin RK. Estudo de caso: planejamento e métodos. 4.ed. Porto Alegre: Bookman; 2010.

11. Sanders LSC, Pinto FJM, Medeiros CRB, Sampaio RMM, Viana RAV, Lima KJ. Mortalidade infantil: análise de fatores associados em uma capital do Nordeste brasileiro. Cad. saúde colet. [Internet]. 2017 [access on 17 abr 2017]; 25(1). Available at: http://dx.doi.org/10.1590/1414-462x201700010284.

12. Ministério da Saúde (BR). Departamento de Informática do SUS (DATASUS), Sistema de Informações sobre Mortalidade - Dezembro de 2016. Painel de Monitoramento da Mortalidade Infantil e Fetal. Brasília: Ministério da Saúde; 2016.

13. Pizzo LGP, Andrade SM, Silva AMR, Melchior R, González AD. Mortalidade infantil na percepção de gestores e profissionais de saúde: determinantes do seu declínio e desafios atuais em município do sul do Brasil. Saúde Soc. [Internet]. 2014 [access on 26 mar 2017]; 23(3):908-918. Available at: http://www.scielo.br/pdf/sausoc/v23n3/0104-1290-sausoc-23-3-0908.pdf.

14. Oliveira CM, Bonfim CV, Guimarães MJB, Frias PG, Antonino VCS, Medeiros ZM. Infant mortality surveillance in Recife, Pernambuco, Brazil: operationalization, strengths and limitations. Epidemiol. serv. saúde. [Internet]. 2017 [access on 15 maio 2017]; 26(2). Available at: http://dx.doi.org/10.5123/s1679-49742017000200019.

15. Santana M, Aquino R, Medina MG. Efeito da Estratégia Saúde da Família na vigilância de óbitos infantis. Rev. Saúde Públ. [Internet]. 2012 [access on 17 maio 2017]; 46(1). Available at: http://dx.doi.org/10.1590/S0034-89102011005000081.

16. Silva ALA, Mendes ACG, Miranda GMD, Santos Neto PM. Assistência ao parto no Brasil: uma situação crítica ainda não superada. Rev. Bras. Saúde Matern. Infant. [Internet]. 2016 [access on 25 abr 2017]; 16(2). Available at: http://dx.doi.org/10.1590/1806-93042016000200004.

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