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REDE CEGONHA NA VISÃO DE PROFISSIONAIS DE SAÚDE: DESAFIOS E ESTRATÉGIAS DE SUPERAÇÃO
THE STORK NETWORK IN THE VIEW OF HEALTH PROFESSIONALS: CHALLENGES AND THEIR OVERCOMING STRATEGIES
LA RED CIGÜEÑA EN LA VISIÓN DE LOS PROFESIONALES SANITARIOS: RETOS Y ESTRATEGIAS DE SUPERACIÓN

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RESUMO

Introdução: A Rede Cegonha (RC) visa articular as ações materno-infantil, buscando um atendimento humanizado e integral. Porém, há desafios a serem compreendidos no processo de implementação dessa política púplica no Brasil.
Objetivo: Analisar a percepção dos profissionais da Atenção Primária à Saúde sobre os desafios e suas estratégias de superação na implementação do cuidado na Rede de Atenção à Saúde e na Rede Cegonha.
Métodos: Grupos focais com duas equipes Saúde da Família (eSF) e duas de Unidade Básica de Saúde (UBS) que acompanham as gestantes, totalizando 35 participantes. Realizada análise de conteúdo, modalidade temática com os dados coletados.
Resultados: Percebe-se que o trabalho em rede não tem funcionado no município, tendo deficiência com relação ao estabelecimento dos fluxos, com pouca capacidade de resolução das situações frente aos processos de comunicação formal. As propostas de superação dos desafios passam pela reconstrução dos fluxos, protocolos e comunicação entre os serviços, mas também num movimento de cogestão.
Conclusão: Outras investigações são necessárias frente às novas políticas públicas implementadas no Brasil, o que gera desafios frente à proposta de integralidade no cuidado em saúde.

Palavras-chave: política pública; serviços de saúde materno-infantil; integração de sistemas; saúde da mulher

ABSTRACT

Introduction: The Stork Network (RC) aims to articulate maternal and child actions, seeking a humanized and comprehensive care. However, there are challenges to be understood in the process of implementing this public policy in Brazil.
Objective: To analyze the perception of Primary Health Care professionals about the challenges and their overcoming strategies in the implementation of care in the Health Care Network (RAS) and in the Stork Network.
Methods: Focus groups were performed with two Family Health Teams (FHTs) and two Basic Health Units (BHUs) that follow pregnant women, totaling 35 participants. The content analysis of the collected data was performed, using the thematic modality.
Results: It was observed that networking has not shown a good performance in the municipality, showing a deficiency in relation to the establishment of flows, with little capacity to resolve situations in the face of formal communication processes. The proposals for overcoming the challenges go through the reconstruction of flows, protocols and communication between services, but also include a co-management movement.
Conclusion: Further studies are necessary considering the new public policies implemented in Brazil, which creates challenges in the face of the proposed integrality in health care.

Keywords: public policy; maternal and child health services; systems integration; women's health

RESUMEN

Introducción: La Red Cigüeña pretende articular las acciones materno-infantiles, buscando una atención humanizada e integral.
Objetivo: analizar la percepción de los profesionales de la Atención Primaria a la Salud sobre los retos, así como elaborar estrategias de superación para actuar en la Red Cigüeña.
Métodos: Grupos focales con 34 profesionales de las Estrategias de Salud de la Familia (ESF) y Unidades Básicas de Salud (UBS) que monitorizan a las embarazadas. El análisis realizado fue por medio del análisis de contenido, modalidad temática.
Resultados: Se han tratado dos temas en este artículo: Retos y propuestas para la actuación de los profesionales de la ESF en la Red de Atención a la Salud y la Red Cigüeña; y, Retos y propuestas para la actuación de los profesionales de las UBS en la Red de Atención a la Salud y la Red Cigüeña.
Conclusión: Se identificó la fragilidad en el trabajo en red, como el establecimiento de los flujos, la baja capacidad de resolución de las situaciones frente a los procesos de comunicación formal y la rotación de los profesionales de la salud. Las propuestas de superación de los retos pasan por la reconstrucción de los flujos entre los servicios y la implantación de la Red Cigüeña en el movimiento de cogestión.

Palabras Clave: políticas públicas; servicios de salud materno-infantil; integración de sistemas; salud de la mujer

INTRODUCTION

One of the great challenges related to women's and children's health care is to guarantee high-quality prenatal care. This goal is tangible when pregnant women exercise their rights through the existence of spaces aimed at the sharing of experiences and questions, preparing them for the moment of delivery (Brasil, 2007).

Comprehensive prenatal care ensures conditions for a healthy pregnancy and birth, considering biopsychosocial aspects, through health education and prevention activities. The comprehensiveness of prenatal actions and services must be articulated from a network perspective, consistent with the doctrinal principles of the Brazilian Unified Health System (SUS, *Sistema Único de Saúde*), at all levels of care (Costa et al., 2016).

Currently, a standardized work pattern still persists, which limits the work of the professionals, preventing more creative actions with closer relationships and with a greater degree of freedom. Hence, networking seeks to acknowledge the uniqueness of the individuals, allowing embracement, the building of bonds, accountability, as guidelines of the health model, in addition to providing multiple connections, favoring the effectiveness of care (Franco, 2013).

To overcome the challenges of disarticulation, the Ministry of Health (MH) proposes that services can be organized into care networks. The ordinance that established the guidelines for the organization of Health Care Networks (RAS, *Redes de Atenção à Saúde*) was published in 2010 (Brasil, 2010).

The production of care in networks directed by the RAS guidelines and built through horizontal relationships, considers Primary Health Care (PHC) as the organizer of the entire system, the link between the individual and the levels of technological complexity. PHC is the gateway to the system and must meet the health needs of the population in the territory under its responsibility. In this context, the professionals of the teams are responsible for the production of health care and for sharing the objectives and expected results (Cecílio et al. 2012; Santos, 2017).

Considering a scenario of fragmented and disarticulated care production between the health services for the mother-child binomial, the proposal to implement the Stork Network (RC, *Rede Cegonha*), created in 2011 by the Ministry of Health (MH) appeared, focused on the integrality of the care. The RC was structured into four components: prenatal care, childbirth and birth, puerperium and comprehensive care to children's health and a logistical system related to sanitary transportation and regulation (Brasil, 2011).

At the regional level, a document was prepared in 2012 proposing the implementation of the RC and the Action Plan contemplating the MH guidelines, with a new organizational model that would allow establishing coping strategies and implementations in the maternal-child area (Costa et al., 2016).

Therefore, the RC aims to articulate maternal-child actions, seeking humanized and comprehensive care, promoting the connection between the flows, the integration of health actions and services to enable an efficient and high-quality assistance at all points of care, focused on user satisfaction and the improvement of maternal and child morbidity and mortality indicators (Assis et al., 2019).

In this sense, the RC faces the challenge of establishing a change in the health care model and, particularly, in the field of management, requiring new forms of qualification and organization of work and the institutional and subjective relationships. Thus, it is possible to build a transformative potential for the sustainability of the RC practices as a public policy and the production of the collectives' autonomy in health, strengthening its results and the innovations in care networks (Santos & Ventura, 2021).

Therefore, it is necessary to explore how health teams are carrying out their practices in health services, considering that we live with the care models of the Family Health Strategy (FHS) and Basic Health Units (BHUs) in PHC, in Brazil.

Hence, in this context, the following question is asked: What is the PHC health teams' perception in relation to Health Care Network (RAS, *Rede de Atenção à Saúde*) and the RC, considering the gestational period? How do these teams operationalize the actions recommended by the networks?

The objective is, therefore, to analyze the perception of Primary Health Care professionals about the challenges and their overcoming strategies in the implementation of care in the Health Care Network and in the Stork Network.

1. METHODS

A qualitative, exploratory-descriptive study was carried out in the Health Units that comprise the PHC Network in a medium-sized municipality in the interior of the state of São Paulo, Brazil.

1.1 Sample and inclusion and exclusion criteria

In this context, 38 Family Health Teams (FHTs) and 12 Basic Health Units (BHUs) were organized.

To carry out the investigation, the inclusion criteria comprised a FHT and a BHU team, from the assessed municipality, with the highest number of registered pregnant women and the highest number of referrals to the high-complexity hospital and a FHT and a BHU team with lowest number of registered pregnant women and highest number of referrals to a high-complexity hospital.

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The sample was obtained by convenience, in which the BHU scenario included professionals who provided care to pregnant women and, for the FHT, the proportional representativeness of the professional categories that comprised the team was defined.
The focus groups were carried out in different places, with two teams at the BHU and two at the FHT. In the *Diamante* and *Safira* FHTs, the groups consisted of: three physical therapists, two physicians, two nurses, two nursing assistants, two oral health assistants, a writing assistant, five community health agents (CHAs), a nutritionist, two endemic disease control agents (ECAs), two cleaning assistants and an undergraduate sixth-year medical student from *Faculdade de Medicina de Marília* (FAMEMA).
In the *Esmeralda* and *Rubi* BHU teams, the groups consisted of: two nurses, two obstetricians, three nursing technicians, four community health agents and an endemic disease control agent.

1.2 Data collection instrument
Data collection was carried out from July to October 2019. The focus group (FG) technique was used, which aims at collecting data through the interaction between the participants to explore the guiding topics (Nyumba et al., 2018). A script was used that included guiding questions about the challenges and the overcoming strategies in the implementation of the RAS and RC in the PHC of the assessed municipality. A meeting was held for each group, with an average duration of 60 minutes. The group was led by the main researcher and was supported by two others who had experience on the topic and the collection method.

1.3 Data analysis
The content analysis technique was used to analyze the focus groups' data, using the thematic modality, where the central concept is the topic (Minayo, 2013). In the pre-analysis, the content of the focus groups was organized for a floating and exhaustive reading. During this process, the categories of analysis related to the challenges and overcoming strategies for the implementation of the RAS and RC were defined. The material from the FHT and the BHU was processed separately, with a separate Excel spreadsheet, so that the categories were explored considering the professionals' perception in each care model (FHT and BHU).
The second phase comprised the exploration of the collected material, selecting the speech fragments according to the established categories. Then, the synthesis of each category was carried out, which allowed identifying the core of meaning and group them into topics (Table 1). The coding of data was performed by a researcher and validated by two others with a PhD and experience in the analysis method.
The third phase consisted in the presentation, discussion and interpretation of the collected data. In this phase, the authors worked with the references of integrality in care and co-management in health.
Aiming to preserve anonymity, the Health Units were identified by aliases: FHT *Diamante*, FHT *Safira*, BHU *Rubi* and BHU *Esmeralda*.

Chart 1 – Presentation of the topics and cores of meaning of the interviews with the professionals from the FHTs and BHUs, Marília, São Paulo, Brazil, 2020.

Topics	Cores of meaning
Challenges and proposals for the performance of FHT professionals in the Health Care Network and Stork Network	- Difficulties in the transition from the biomedical model to the FHS; - Disarticulation between the different services of the Health Care Network and Stork Network; - Need to increase the number of professionals and acknowledgement of their work; - Need for clarity in the definition of roles and protocols; - Importance of health education actions;
Challenges and proposals for the performance of BHU professionals in the Health Care Network and Stork Network	- Organization of the work process makes it difficult to carry out health promotion and prevention actions; - Divergence of guidelines and flows among the professionals of the PC team; - Disarticulation between the different services of the Health Care Network and Stork Network; - Lack of knowledge about the public policies on the part of the professionals and pregnant women; - Insufficient structural and organizational resources; - Importance of health education actions and the reduced number of professionals; - Need to qualify professionals for humanized care; - Need to increase the number and variety of professionals; - Intensify preventive actions to impact on health indicators;

Source: Research data

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3. RESULTS
The topics and cores of meaning identified from the speeches of the FHTs and BHU professionals will be shown below.

3.1 Challenges and proposals for the performance of FHS professionals in the Health Care Network and the Stork Network (*Rede Cegonha*)

One of the challenges faced by the FHTs is the change from the curative model to that of disease prevention and health promotion, as service users demand urgent care and believe in the power of medication to solve their problems. The professionals report that this occurs due to people's difficulty in understanding. Moreover, the validity of the two Health Care models in the municipality also makes the implementation of the FHS difficult, weakening the CN and RC (Oliveira et.al., 2021)

> "*The people, they are very demanding [...] they are looking for a more curative model, they want medication and that is it [...]. It is the lack of understanding, it is the urgent care. And, as there are two models of assistance [in the municipality], the BHU is different from the Strategy. [...] it makes it a little difficult, due to the very comprehension".* (FHT, team *Diamante*).
>
> The respondents point out that the perspective is to develop a practice with quality, but this goal is not achieved due to lack of time caused by the high demand, as there has been an increase in SUS-dependent users. And, moreover, due to the insufficient number of health workers in the FHTs.
>
> *"[...] we end up not having enough time to work with the quality we wanted, because the demand is very high, the population is much more "SUS-dependent" [...], we currently do not have a sufficient number of professionals".* (FHT, Team *Diamante*)

The Family Health Support Center (NASF, *Núcleo de Apoio à Saúde da Família*) teams do not have an established frequency in the units, which makes them lose the characteristics of the FHS. Nevertheless, the Secondary Hospital contacts the PHC services in order to develop the RAS. In relation to the NASF, it created orientation and/or operational groups in partnership with different professionals from the FHTs, as this activity was considered essential to operationalize the principles of the FHS. However, this action is currently not considered essential.

> *"At NASF we do not have a frequency at the Units and the strategy is lost, a little bit of the characteristics of the Strategy [...] the Strategy is no longer able to play its role. The Secondary Hospital continues to work within a possible flow [...], when one talks about Strategy, one thinks [...] we talk about the group, it is no longer like that, it was not like that anymore, but it was a little more. Today the demand is greater and so is professional turnover*. (FHT, Team *Diamante*)

In this context, the FHT professionals indicate that they live with a model that is values the quantitative production of "procedures" and not the integral care of the pregnant woman, being influenced and determined by the reduced number of professionals in the team and in NASF, in addition to the turnover of these professionals, thus not allowing the possibility of creating a bond between professionals for the success of the teamwork, seeking the intention of reconstructing practices.

The professionals who comprise the FHTs recognize the importance of guidance and/or operative groups for pregnant women, despite the low adherence when they are carried out. In the set of statements, they state that it is necessary to use appeals or to have the participation of the physician to increase the number of pregnant women.

> "*The group is very important [...] it is the population that has a low adherence, there has to be something very appealing for them to attend the groups [...] the groups that are most frequently attended are the ones that we say the doctor will be present or when they will get something*". (FHT, Team *Diamante*)

Professionals report that with the implementation of the e-SUS (Electronic Health System), there was an improvement in user information, allowing access to service networks and records of the production of each PHC professional for some specialties. However, there is no established effective flow of referral and counter-referral and annotation in the pregnant woman's pregnancy card about the care provided. They understand that interdisciplinarity is important for the comprehensive care of pregnant women in all areas of Health Care. The exception is the secondary referral hospital, as mentioned above. They indicate the need to create an intermediate-risk outpatient clinic to overcome the difficulty of communicating with the high-risk one, as well as improve the operation of the latter.

> "*With the E-SUS, it has improved for some specialties, but it doesn't work in hospitals [...] the communication [...] on both sides. To facilitate this channel, because it is very difficult to integrate the network, mainly because the system is not the same, so there is no way to have other information, unless someone gives it to us. It is different in the hospital [...], I can see it because it is the same system. Communication is important."* (FHT, Team Safira)
>
> "*In all areas of care, I believe that interdisciplinarity at the time of evaluating and addressing the health needs will be important".* (FHT, Team *Safira*)
>
> "*There is no counter-referral. Everyone wants us to refer to them, the counter-referral to know what was done with the patient, never".* (FHT, Team *Diamante*)
>
> *"We lack a medium-risk and intermediate-risk outpatient clinic, and we lack a better high-risk outpatient clinic, because the high-risk outpatient clinic in Marília is very complicated [...] with the intermediate-risk outpatient*

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clinic, a good part of these difficulties that we have with the high-risk would be resolved". (FHT, Team *Safira*)

There were also weaknesses regarding the communication between the members of the FHT itself and between the FHT and the Municipal Health Secretariat (SMS, *Secretaria Municipal de Saúde*) to discuss cases, making it difficult to establish a bond. They point to the lack of implementation of protocols for the care of pregnant women in the municipality and the addition of new tests with the definition of parameters for referrals to different health services, aiming to facilitate the creation of effective flows in care promotion.

> "*They are very seriously overloaded there, because they (SMS) also have to attend to the entire municipality, and it is not just those things related to pregnant women, there are several other things [...] they (SMS) are also in meetings all the time, they are talking to someone, that bond is missing".* (FHT, Team *Safira*)

> *"This part of calling them and discussing (with the Technical Area of Women's Health in the SMS) is complicated [...], because when we have (doubts) we call, then there is no one there or, if there is someone, they are busy: could you call later? [...] it is very difficult for us, because as we don't know where to send this pregnant woman, because we don't have the level of complexity that she needs, we have to keep calling and discussing the case all the time".* (FHT, team *Safira*)

> *"There is no protocol in the municipality [...], protocol B is something that is already collected [...] here, in the municipality, there is no such thing [...] there are diabetics who become pregnant and pregnant women who become diabetics, and there is the risk level of this patient [...]. There is a patient who has an indication for insulin use and there is a patient who is diabetic, but it is not severe, where do we send her to?".* (FHT, Team Safira)

Moreover, they imply that humanized childbirth is not present, and it is necessary to train professionals to do so.

> "*I think there is a lack of preparation for the humanization of childbirth, we hear a lot about humanized childbirth [...] but there is no such thing".* (FHT, team *Safira*)

3.2 Challenges and proposals for the UBS professionals' performance in the Health Care Network and Stork Network

Health workers say that PHC has, among its attributions, prevention through groups, such as pregnant and postpartum women, but due to the "acute complaint" of the population, which demands rapid resolution, and the reduced number of professionals, their development is no longer a priority for the team.

> "*Primary Care predicts dealing a lot with prevention and we end up not having the resources to actually make prevention happen, through groups [...] here we have many pregnant women and this work could be done [...] but we lack professionals [...] we have a situation of acute complaints that needs quick resolution, the groups always end up being overlooked, information ends up being overlooked*". (BHU, team *Esmeralda*)

The professionals who comprise the UBS teams report that one of the challenges is communication and the flow of PHC with Secondary Care. They consider that if the user is referred from PHC to the hospital, they are forwarded to the PHC Emergency Room (ER). However, the secondary service has as its purpose the qualified hospital discharge, but they also have operationalization difficulties. Therefore, the PHC services hardly receive this counter-referral.

> "*I was taught that if I need to seek out the HM, which is the referral for pregnant women, that won't happen. Because the person goes there and they send her back to the ER. So, I think this is not well established, screened*." (BHU, Team *Rubi*)

> "*The Secondary Hospital works a lot with qualified hospital discharge, they try to work with this tool, but they don't have conditions to do that to all patients. So that happens very rarely."* (BHU, Team *Esmeralda*)

There is a lack of information on the part of professionals and pregnant women about public policies and there is no training for workers regarding this issue.

> "*The lack of information, both on the part of the population and the professionals, about the public policy, is not worked out, trained, I have never seen anyone train a team in public policies".* (BHU, Team *Esmeralda*)

They also indicate the lack of structural and organizational resources such as: offering exams, administrative incompetence and the lack of availability of managers to transform the current scenario.

> "*In the municipality [...] two thousand late ultrasounds, X-rays, surveys from all units [...] if there is an indication for resonance [...]".* (BHU, Team *Esmeralda*)

> "*The managers are incompetent [...] it is not the financial type, but there is administrative incompetence [...]. We are abandoned".* (BHU, Team *Esmeralda*)

In the set of statements, there is a suggestion to increase the number of professionals, in all categories.

> "*This is the suggestion: more physicians, more professionals, social workers, nutritionists, I think that would solve one of the problems, but we don't have enough professionals in the network*". (BHU, team *Rubi*)

The professionals point out that the health unit is not playing its role of promoting preventive actions, such as, for instance, they do not carry out home visits. Furthermore, they do not generate indicators that allow them to acquire knowledge on these people to develop these activities. They believe that these are PHC attributions and that they do not fulfill them due to lack of resources.

> "*The preventive exam would be more the responsibility of the Family Health Unit (FHU), the home visit that you have to do, where you have to go, get the vaccine, the preventive would be the responsibility of FHU [...] it is also stopped, it is not fulfilling its purpose. The only thing missing are the indicators, we cannot generate indicators due to this lack of resources [...] we need to generate indicators to recognize that population: I need to work on prevention, syphilis [...] with this lack of resources, we cannot really fulfill the role of Primary Care".* (BHU, Team *Esmeralda*)

4. DISCUSSION

One of the central challenges experienced by PHC teams are the changes in the health care model. We live with the biomedical model and the health surveillance model, producing different understandings about how to implement the actions proposed in the RC.

In the assessed municipality, it was observed that pregnant women have access to start their care both with the FHT and in the BHU. However, the provision of care still shows difficulties for its occurrence in a team, including the NASF, with one of the determinants being the reduced number of professionals to develop the proposed actions.

The challenge of building, together with the pregnant women, a practice focused on health promotion and disease prevention has also been perceived. This indicates that pregnant women require practices anchored in the biomedical model; however, this transition of the care model is a process that occurs between professionals, managers, as well as the pregnant women.

The pregnant women's conception of health care is based on the biomedical model, evidenced by the greater appreciation of medical consultations and the procedures of hard technology that are performed, centralizing their health production in the medical act and may disregard collective actions or those by other professionals in the construction of assistance in prenatal care. Fogaça et al. (2017) state that the pregnant women's attitude could be different if there was an understanding of their role as a co-participant in the production of their care during the creation of the care plan in prenatal consultations.

It is understood that the biomedical model was socio-culturally established with people over decades, and its deconstruction requires agreed actions between managers, professionals and the community, in addition to involving professional training, in a co-management movement. The focus lies on the analysis of the work as a concrete activity, understanding how collectives operate daily, what the teachings are between the segments, how they articulate and reinvent themselves (Santos & Ventura, 2021).

With the increase in the number of users who depend on access to the SUS, much more work is done regarding the number of scheduled appointments and the needs of pregnant women, adults, children, adolescents, hypertensive patients, diabetics, the elderly, unable to make home visits. In this context, the FHT professionals indicate that they live with a model that is valuing the quantitative production of "procedures" and not the integral care of pregnant women, being influenced and determined not only by the reduced number of professionals in the team and the Family Health Support Center (NASF) but also the turnover of these professionals, thus not allowing the possibility of building a bond between the professionals themselves for the effectiveness of teamwork, aiming at practice reconstruction.

The availability of a sufficient number of professionals humanizes and qualifies the provision of care. Qualified listening strengthens the bond with pregnant women assisted in prenatal care (Silva et al., 2018). That is, even if there is an effort on the part of the teams to make changes in the organization of care for pregnant women, there is a public policy proposition to structure practices aimed at a quantitative production to the detriment of the search for quality anchored in the integrality of care.

A regression of the FHS care model and the multidisciplinary teams in PHC policies can be observed, with the reduction in the number of professionals working in health units. New organizational models were allowed from the 2017 National Primary Care Program (PNAB, *Programa Nacional de Atenção Básica*) in Brazil, with the reduction and even the absence of the NASF and Community Health Agents (CHAs) in the teams and that influences the conception of the social determination of the health-disease process and the extended clinic. The physicians will be able to reduce their workload and their work tends to be focused on curative and individualized actions (Giovanella, Franco & Almeida, 2020).

The extinction of the accreditation and federal funding of NASF highlights another point of involution. The concept of multiprofessionality and interdisciplinarity tend to disappear, as the priority will be individual care and the meeting of spontaneous demand. According to Giovanella et al. (2020), there is a tendency for the FHS to be mischaracterized in its work process, from the capillarity of the teams in the communities and the organization of actions. It may compromise the

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longitudinality and coordination of care, disarticulated from the emergency networks and directed at acute demands and disease management, with the monitoring of severe cases awaiting transfer. To considering only the registered population, in practice, means breaking up with the universality and equity of the SUS.

The professionals who constitute the PHC teams report that another challenge is network care, based on integrality as a guiding principle, that is, the communication of the PHC with Secondary Care and Hospital Care, between the members of the FHT itself and between the latter and the SMS to discuss cases, in addition to the difficulties regarding counter-referral by hospital care.

These teams, which are responsible for the production of care, point out the lack of implementation of protocols for pregnant women in the municipality and the addition of new tests with the definition of parameters for referrals and places for delivery, and identification of effective flows of care in the municipality.

The professionals understand that interdisciplinarity is important for the comprehensive care of pregnant women and in all areas of Health Care. They state that the secondary referral hospital works within a possible flow with the discussion of some cases creating networks within the PHC health units.

With the implementation of the electronic system for recording data in the SUS (e-SUS), there has been an improvement regarding user information, allowing access to service networks and records of the production of each PHC professional for some specialties. However, as there is no established effective flow of referral and counter-referral and annotation in the pregnant woman's card about the care provided, the networking remains compromised. For that purpose, it is suggested that professionals be trained on the public policies of the RAS and RC, so that they, together with the managers, can establish the reorganization of care.

The organization of RAS and RC is essential for humanized care, being focused on comprehensive care, ensuring access, embracement and effectiveness (Silva et al., 2018). Pregnant women being monitored in health units experience different scenarios, which require different perspectives.

The professionals list as proposals to overcome the challenges the need to improve the definition of roles and protocols of health services, aiming at integration of care and creating the intermediate risk or medium complexity outpatient clinic to discuss cases that generate doubts for professionals.

One proposal would be to redesign the Health Regions, defining them as responsible for the management of medium and high-complexity cases and of Health Surveillance, including Hospital Care that has been operationalized, disconnected from PHC and operating with efficiency and effectiveness problems.

Aiming to contemplate the presented proposals and SUS sustainability, it is necessary to train professionals and multiprofessional teams, which will address the health needs of the territories and their contexts, with the management focused on this context. Interdisciplinary practice should be encouraged, as well as the sharing of responsibilities and tasks. Campos (2018) highlights that the fragmented care process between services, and the movement of users as sliding pieces, has inhuman, ineffective and inefficient results. It is essential that there be an improvement in communication and integration of services for the democratization and sustainability of SUS, and the FHS expansion is a strategy to be considered.

CONCLUSION

It is observed that networking has not been effective in the municipality, showing deficiencies in relation to the establishment of flows, with little capacity to resolve situations in the face of formal communication processes, either through a referral and counter-referral system, or even between the team professionals, whose number have been reduced and also considering professional turnover both in the referral team and in the NASF.

The proposals for overcoming the challenges go through the reconstruction of flows, protocols and communication between services, but also with the municipal management of women's health area, aiming to provide the collective construction of the implementation of the RC in a co-management movement.

A new look at the dynamics of centralization and decentralization of actions established on National Health Policies, built and approved by the SUS co-management bodies: Conferences, Councils and Tripartite Commissions is essential. There is a recent tendency to dismantle these policies, further fragmenting SUS and exposing state and municipal administrations to the pressure from external groups' interests to take advantage of SUS.

The study limitation related to the portraying of Networking in a single municipality is recognized; therefore, further investigations are necessary considering the new public policies implemented in Brazil, which creates challenges in the face of the proposal of integrality in health care.

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