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RESEARCH

CORRDINATION OF CARE FOR PREMATURE NEWBORNS: CHALLENGES FOR PRIMARY HEALTH CARE

COORDENAÇÃO DO CUIDADO AO RECÉM-NASCIDO PREMATURO: DESAFIOS PARA A ATENÇÃO PRIMÁRIA À SAÚDE

COORDINACIÓN DE CUIDADOS DEL RECIÉN NACIDO PREMATURO: RETOS PARA LA ATENCIÓN BÁSICA DE SALUD

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ABSTRACT

Objective: to analyze how the coordination of care for premature newborns in the second health region of the state of *Rio Grande do Norte* (RN) is understood. **Method:** the research had a qualitative approach was and was carried out with the primary health care managers of the municipalities that comprise the second health region of the state of *Rio Grande do Norte*. Data were collected from an event that occurred in the 2nd *Unidade Regional de Saúde Pública* in October 2016. The script was submitted to a pre-test for validation and the collection of data was made after the event. A convenience sample of seven participants from four municipalities of the health region participated in the study. The instrument used for data collection was an interview, and thematic content analysis was used as the analysis technique the. **Results:** the results showed three empirical categories, namely: return to the territory of the *Estratégia de Saúde da Família*; work process in the E*stratégia de Saúde da Família*; and municipal health management. **Discussion:** the first category addressed the situation of the team in the return of premature newborns to the territory based on the description of actions, the need for matrix support and fragility in articulation at different levels and places of service delivery; the second category describes the work process in the strategy of family health and newborn health before the difficulties in continued management, territorial invasion, referral culture, nurse-centered health responsibility, and the meanings of work for the population; and finally, the third category shows the implications for municipal health management.

Keywords: Primary Health Care; Health Services Accessibility; Infant, Premature; Public Health Nursing.

RESUMO

Objetivo: *analisar como é compreendida a coordenação do cuidado ao recém-nascido prematuro na segunda região de saúde do estado do Rio Grande do Norte (RN).* ***Método:*** *a abordagem da pesquisa é qualitativa e foi realizada com os coordenadores da atenção primária à saúde dos municípios que compreendem a segunda região do estado do RN. Os dados foram coletados a partir de um evento que ocorreu na 2ª Unidade Regional de Saúde Pública em outubro de 2016. O roteiro foi submetido a pré-teste para validá-lo e a coleta de dados realizada posteriormente ao evento. A amostragem por conveniência obteve sete partícipes, oriundos de quatro municípios da região. O instrumento de pesquisa utilizado para a coleta de dados foi a entrevista, e para a técnica de análise de dados a análise temática de conteúdo.* ***Resultados:*** *evidenciaram três categorias empíricas, quais sejam: o retorno ao território da Estratégia de Saúde da Família; o processo de trabalho na Estratégia de Saúde da Família; e a gestão municipal de saúde.* ***Discussão:*** *a primeira categoria expressa a condição da equipe frente ao retorno do recém-nascido prematuro ao território a partir da descrição de ações, da necessidade de apoio matricial e da fragilidade na articulação nos diferentes níveis e locais de prestação de serviços; a segunda categoria descreve o processo de trabalho na estratégia de saúde da família e o recém-nascido com as dificuldades no manejo*

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continuado, a invasão dos territórios, a cultura do encaminhamento, a responsabilidade sanitária centrada no enfermeiro e os significados do trabalho para a população; e, finalmente, a terceira categoria demonstra as implicações para a gestão municipal de saúde.

Palavras-chave: *Atenção Primária à Saúde; Acesso aos Serviços de Saúde; Recém-Nascido Prematuro; Enfermagem em Saúde Pública.*

RESUMEN

Objetivo: *analizar la coordinación de los cuidados del recién nacido prematuro en la segunda región de salud del estado de Rio Grande do Norte (RN).* ***Método:*** *Investigación cualitativa realizada con los coordinadores de atención primaria de salud de los municipios de la segunda región del estado de RN. La recogida de datos se llevó a cabo a partir de un evento en la 2ª Unidad Regional de Salud Pública en octubre de 2016 y después de validar el cuestionario con una prueba preliminar. El muestreo por conveniencia consistió en 7 participantes de cuatro municipios de la región. El instrumento de investigación utilizado para la recogida de datos fue la entrevista; los datos se analizaron según la técnica de análisis temático de contenido.* ***Resultados:*** *se destacan tres categorías empíricas: el regreso al espacio de la Estrategia de Salud de la Familia; el proceso de trabajo en la Estrategia de Salud de la Familia; y la gestión municipal de salud.* ***Discusión:*** *la primera categoría se refiere a la condición del equipo ante el regreso del recién nacido prematuro al dicho lugar con la descripción de acciones, de la necesidad de apoyo matricial y de la fragilidad en la articulación en los distintos niveles y lugares de la prestación de servicios; la segunda categoría describe el proceso de trabajo en la estrategia de sald de la familia y el recién nacido con las dificultades en el manejo continuado, la invasión de los espacios, la cultura de derivación del paciente y la responsabilidad sanitaria centrada en el enfermero y los significados del trabajo para la población; la tercera categoría señala las implicaciones para la gestión municipal.*

Palabras clave: *Atención Primaria de Salud; Accesibilidad a los Servicios de Salud; Recien Nacido Prematuro; Enfermería en Salud Pública.*

INTRODUCTION

The involvement of the *Estratégia da Saúde da Família* (ESF) team in primary health care (PHC) has been increasingly essential in the follow-up of premature newborns, in order to guarantee comprehensive care after hospital discharge.

Preterm newborns (PTNB) are those born with less than 37 weeks of gestation and low birth weight. Their characteristics are a greater risk of impaired development, requiring a differentiated attention both on the part of caregivers (parents) and the PHC health team.[1,2]

The survival rate of PTNB has called attention in meticulous studies conducted in developed and developing countries, demonstrating the vulnerability of such newborns (NB). The risk of death and sequelae may be due to the birth conditions, such as gastroesophageal reflux, visual and auditory deficits, delays in neuropsychomotor development and cerebral palsy, as well as retinopathy and preventable child blindness, thus creating a need for evaluation of a more accurate prognosis and follow-up in the long term.[2,3]

In this description, we highlight, on the one hand, indicators of mortality and hospital admissions per ambulatory care sensitive conditions (ACSC) in under-five children, a priority group for health programs of the SUS[4]. On the other hand, the *Política Nacional de Atenção Básica* is responsible for some functions to contribute to the functioning of health care networks.

The present study seeks to analyze the coordination of care and organization of networks based on the responsibility of professionals and their relationship of care with users in a continuous, comprehensive, resolutive, and equitable manner.[5] This coordination has as essence the task of making information on previous problems and services available, with due recognition of news related to the needs for the present consultation. The action comprises one of four essential attributes of PHC. If there is no longitudinality, it loses its potential, and comprehensiveness would be hampered and the role of the first contact would become merely administrative.[6]

Families that have to deal with prematurity in the coordination of care and in networks need support from the ESF teams to resolve doubts, facilitate the adaptation post-hospital discharge , and continue the therapies that rely on permanent assessments of the demands of both the NB and the family, according to the needs of the NB and parental skills.[7]

In this sense, the question investigated is: how does the coordination of care to the PTNB in the ESF in the second health region of the state of *Rio Grande do Norte* take place? Based on this problem, the objective of the study was to analyze how the coordination of care in the second health region of the state of *Rio Grande do Norte* is understood.

METHOD

The study had a qualitative approach and was carried out with the PHC managers of the municipalities that comprise the second health region of the state of Rio Grande do Norte in October 2016. The region is composed of 14 municipalities, with an estimated population of 448,939 inhabitants, covering the municipalities of Mossoró, Upanema, Grossos, Tibau, Serra do Mel, Baraúna, Campo Grande, Janduís, Messias Targino, Felipe Guerra, Apodi, Governador Dix-Sept Rosado, Caraúbas and Areia Branca.[8]

Data collection took place at an event held in the 2nd *Unidade Regional de Saúde Pública* in October 2016 with the purpose of making a conceptual offer about the coordination of care related to PTNB in the health region. One representative of each municipal secretariat was invited, according to the following eligibility criteria for data collection: a) work in the municipality of origin; b) time of coordination of at least six months; c) period considered opportune to contact the care network of the region.

The script was submitted to pre-test to be validated. Data collection occurred after the event and after approval by the *Comitê de Ética das Faculdades de Enfermagem e Medicina Nova Esperança*, protocol CEP: 101/2016 and CAAE: 58741516.4.0000.5179.

The convenience sample of the study consisted of seven participants from four municipalities (*Mossoró, Felipe Guerra, Messias Targino*, and *Governador Dix-Sept Rosado*), with a population estimated at 315,642 inhabitants. The research instrument used was an interview. It is noteworthy that the recruitment period, that is, the invitation to the event, was considered to be inadequate, to the detriment of the coordinators of the PHC, a fact resulting from failures in municipal elections, directly affecting the communication with the participants because the contract of the coordinators with municipal management has a commissioned natured. In order to keep the names of the interviewees confidential, they were identified through numbers.

Thematic content analysis was used as data analysis technique, respecting its methodological steps: pre-analysis, with the organization of data; reading and choice of documents; exploitation of the chosen material; clipping, enumeration and classification; and finally, data processing, that is, translation and interpretation to validate the data.[9]

RESULTS

Of the seven participants, 70% were women, aged between 26 and 75 years, with predominance of the age group between 20 and 31 years. The participants had graduated between the year 1966 and 2013; 80% did not have five years of professional performance after graduation; and 80% had taken postgraduate courses but only one of the participants had post-graduation in the area of family health.

The results revealed that 80% of the professionals had worked in PHC for less than four years, all had a direct management contract, and only one (15%) had statutory contract. In this respect, the fragility of labor ties is evident, because the others contracts have a temporary or a commissioned nature. Therefore, it is inferred that there is a career plan. Regarding remuneration, this occurs through performance, in which 60% of the individuals said they were paid according criteria related to the certification of the *Programa de Melhoria do Acesso e da Qualidade da Atenção Básica* (PMAQ), formalized by law or decree.[10] Table 1 presents the categories and their subcategories.

Table 1 - Empirical categories and subcategories of the comprehension analysis on the coordination of care to premature newborns in the second health region of *Rio Grande do Norte. Mossoró*-RN, 2016

Empirical category 1	Return to the territory of the ESF	
Empirical subcategory	Nuclei of meaning	Unit of record
ESF team on the return of premature newborns to the territory	Description of actions of the team in the return of the premature newborns P1; P2	I would make a visit with the ESF team and I would follow up with C and D (P2).
	Need for matrixing support P1; P4; P5	[...] it would not be a single action of therapeutic support, but rather a matrixing support taking the ESFN (P5).
	Fragility in articulation at different levels and places of care provision P1; P3; P4; P5	[...] there is no such articulation, seeing what the problems are, what has been diagnosed, what should be done (P1).
Empirical category 2	Work process in the ESF	
Empirical subcategory	Nuclei of meaning	Unit of record
Describing the work process in the ESF	Difficulties of the ESF in continuous management P1; P2; P3; P5; P6	[...] there is a patient who, for example, comes here for a private appointment, comes and goes back to the municipality, the doctor requested something, we start to lose control, because they do not go through primary care (P6).
	Invasion of the ESF territories P1; P3; P4; P5	[...] in my area there is a person who almost gave me nothing, just the name of the mother and the child and then I went to try to locate this child; it was from another city (P3).
	Referral culture P2; P5; P6	[...] if there is need, it is not because the patient arrives and thinks he has a headache for two or three days, the doctor has to evaluate to see if he is going to do a tomography (P6).
	Health responsibility centered on nurses P5; P6	[...] I remember that the training opportunities in microcephaly, in the regions, the municipalities, there were moments with the nurses, much more often with the nurses, throwing the sanitary responsibility on those professionals, and that makes things difficult for the nurses (P5).

Continue...

... continued

Table 1 - Empirical categories and subcategories of the comprehension analysis on the coordination of care to premature newborns in the second health region of *Rio Grande do Norte. Mossoró*-RN, 2016

Empirical category 2	Work process in the ESF	
Empirical subcategory	Nuclei of meaning	Unit of record
Describing the work process in the ESF	Meanings of the ESF work P1; P3	In Mossoró, people already come directly to the ECUs (Emergency Care Units), maternity hospitals and hospitals, and that's the end of the strategy (P1).
Empirical category 3	**Municipal Health Management**	
Empirical subcategory	**Nuclei of meaning**	**Unit of record**
Implications for the municipal health management	The issue of health judicialization P1; P6	[...] the prosecutor often has no knowledge that it is the duty of the state and not of the municipality. Then the prosecutor forces the municipality to buy it. The municipality buys but also enters into legal proceedings to overthrow the decision of the prosecutor, so that it becomes clear that it is the duty of the state. But after all that process the municipality spends a lot of money (P6).
	Agreements in the second health region P1; P3; P4; P5; P6	[...] I went to a meeting in Natal, the most beautiful thing, I arrived, look people, it is very easy, we will do so and so, we accepted everything at once. And after that? There is no vacancy. To summarize: the child is being followed-up in Fortaleza, Ceará (P6).
	Need to implement the Stork Network P1; P6	[...] I think that to have these consultations, to have this referral, to know where this NB is in the network, we have to build, first, the Stork Network (P1).
	The creation of flows in the network P1; P4	I think that in this logic of seeing how we are, where to start, I think we have to review some things, try to align others to direct this care to the premature newborn (P4);
	Need for continuing education in the health area P1; P3; P6	Because if there is no education in the health area for these professionals, continuity will never happen (P1);
	Need for evaluation of the Administrative Unit of the Region P1; P3; P4	[...] the general coordination was going to check how each municipality was doing, what it was doing, which it was not doing, [...] lately, I think this is happening very rarely (P3);
	Financial transfers between municipal, state and federal spheres P1; P3; P6	[...] the municipality has to pay everything, from where will it be taken? From primary care? Then the money that was already little will be even less (P1). [...] the federal government creates the programs, by the way the family health program, but the money that the government transfers to the municipalities is so little that the municipalities are already full and are unable to do it, because the amount of money sent to the health teams does not even pay the doctors (P3).
	Criticisms of the inaccessible action of the municipal health management P1; P5	[...] so, it is interesting that we are in the same building, but because there is a difficulty in the aspect of intersectoriality, it is inside the secretariat, imagine if we start to think of the outside? (P5);
	Aspects of health regulation P3; P5; P6	Only then, when you think about the agreement, this issue of regulation that includes the exams, high complexity and everything, I also think, how is this diagnosis, how is it there in primary care? (P5).

DISCUSSION

Return to the territory of the ESF

The results described in the present study about the conceptual offer on the coordination of the care for PTNB in the second health region revealed three categories: return to the territory of the ESF, work process in the ESF and municipal health management.

The first empirical category, which involves the return of PTNB to the territory of the ESF, highlighted: the description of the team's actions in the return of PN, the need for matrixing support, and the fragility in articulation between the different levels and places of care provision. All participants mentioned how the return to the domicile takes place.

Child care is limited to: health promotion, prevention, early diagnosis and follow-up of growth and development with the aim of guiding accident prevention, neuropsychomotor development assessment, clarifying doubts of the family, immunization, and encouragement of breastfeeding and follow-up in the first year of life.

The actions of the ESF team need to be organized to control the prevalent diseases in childhood, collaborating to

promote the quality of life and commitment of the family and the team.[11]

The participants of the study expressed a limitation in the management of PTNB by identifying fragmented and isolated approaches of professionals, such as home visits without evaluation of family risk and consultation C and D without relating it to the vulnerability risk inherent to the unique condition of the newborns. In this sense, the need for theoretical and conceptual deepening about the production of care in PHC is evident.

The nucleus of meaning "need for matrixing support" explained that specific support for some of the demands of PTNB is necessary on the part of the Family Health Support Nucleus (ESFN), understood as the main strategy of action of the team in the coordination of care. The ESFN, as matrixing support, allows the sharing of multidisciplinary care, increasing the capacity of resolution and sharing of practices and knowledge in the area as a way of thinking and interacting, and assisting in the search for continued care.[12,13]

In this context, there is a lack of knowledge about the real role of the ESFN, restricting the actions to outpatient care and pedagogical support in the work process and seeking to qualify comprehensive child care and possible referrals to the health care network.

The last nucleus of meaning treats the fragility in the articulation between the different levels and places of care provision, directly impacting the return of the children to the territory and the quality of the assistance that will be provided to them and to their families, as well as the referral and counter-referral in the various levels of complexity. This does not occur with articulation in the services, and it is sometimes ineffective and little used. In this sense, there is a rupture in the care that is responsible for the follow-up, aimed at guaranteeing other levels of care.[14]

The interviewees stated that there is no communication between PHC and the other points of the network that served the children. The results presented in the study indicated that the experiences of users in the use of PHC services are irregular, they are unaware of the central role of health promotion, prevention and maintenance, leading to little search for services and devaluation by users and of network services.[15]

The impact of this return to the territory, in the perspective of the participants, exposes a PHC with a slow and fragmented production, focused on the diseases and with little space for the production of bond and coordination of care, affecting the capacity of resolution of the services.

Work process in the ESF

The second category discussed the work process of the ESF team. As nuclei of meaning, the difficulties of the ESF with continuous management, the invasion of the territories of the ESF, the persistent referral culture, and the health responsibility centered on nurses were highlighted, and are indicated as difficulties of the ESF to carry out continued management.

PHC cannot play its role as organizer of care without a sound regional arrangement and virtuous articulation between the three federated entities (municipal, state, and federal). Coordination of fragile care is a major obstacle to ensure comprehensiveness, access and provision of quality health services[15]. Creation of new ways of conducting the care process, aligned with the attribute of coordination of care is necessary, as the professionals participating in the study reinforced that the care is still ambulatory.

Reports of experiences about strengthening PHC supported by the expansion and consolidation of the ESF contributed to the reduction of hospitalizations and mortality of under-five children, demonstrating that the department has not only the guarantee of the right to health, but also the ability to unburden the hospital services.[4]

Another obstacle in the work process is the reality of the invasion of the ESF territories. The subjects interviewed stated that it is common for the local health network to be invaded by other municipalities, including other states, such as *Ceará* (CE) and *Paraíba* (PB). It is observed that the territorial assignment of users to the ESF team is an administrative rule that induces or facilitates access to PHC, externalizes the weaknesses of the coordination of care in local health networks and the pilgrimage of users in the search for consultations and/or exams[16], especially when there is no 100% coverage in most of the municipalities in the region that comprises the study, and generates difficulties to access care. Thus, it is necessary to broaden the debate to create mechanisms that guarantee the access of PTNB to care in so as to resolve these aspects.

The referral culture still prevails in the ESF work process. In the view of the participants, this can be understood as discharges without due clinical criteria of referral for the most varied specialties and examinations/procedures, generating the pilgrimage of users in the network and the undue allocation of financial resources. Referrals are instruments of management and care. Thus, in order for the user to be referred to specialized care, dialogue with the teams of the different points of care is important, to include the potential for resolution and competence to coordinate care.[17]

The centering of health responsibility on nurses is also a nucleus of meaning that emerges from the ESF work process. This has already been identified in other studies emphasizing the centrality of educational actions, health promotion, and planning of individual and collective actions of the team on the work of nurses, converging to an exhaustive workload.[18] These responsibilities must be shared among the team, by add-

ing knowledge in the way of achieving the care directed to users, families and communities of the PHC/ESF territories.

The power to produce care centered on children, families and communities requires interprofessional action of the team, generating links, stimulating the autonomy and protagonism of the subjects involved in the work process, and overcoming the obstacles that exist in the collaborative and collective daily life.[14]

The "Meanings of the ESF work" completes the framework of the category Work process in the ESF. The results of a survey demonstrated that PHC service or PHC professionals do not coordinate care, with highlights for community health agents' visits as something bureaucratic. Furthermore, the BHU did not represent a regular point of care, but rather a place for getting more medical prescriptions and collecting medicines. A flow of care from PHC was not identified, which leads to the use of several gates of entry in specialized care.[15]

In the participants' speeches, the practical limitations of the current repertoire of PHC teams regarding the organization of the work process and the connections with the network were expressive. Composing other sets of works of the team requires valuing the successful experiences of the region that may have been neglected by the subjects with the predominance of negative discourses that involve some problems such as the case of PTNB. It is, therefore, necessary to look for other empirical, theoretical and conceptual references that strengthen PHC in regions similar to the researched scenario.

Municipal health management

The third and final empirical category, municipal health management, addressed implications based on the condition of PTNB in the network, with emphasis on judicialization of health, agreements in the second health region, construction of the *Rede Cegonha*, creation of flows in the network, the need for continuing education in the health area, inadequate performance of the administrative unit of the region, financial transfers between the municipal, state and federal spheres, and criticism about the inaccessible actions of the municipal health management and aspects of health regulation.

Judicialization has just started in the health systems of universal coverage, particularly in the studied region. In Brazil, there is a guarantee of health in the public and private spheres as a right of everyone and the duty of the State, the respect for the precepts of *Sistema Único de Saúde* (SUS) expressed in the "thematic category" analysis which reveals issues of equity, comprehensiveness, and universality. This theoretical-conceptual arrangement refers to the search for effective embracement of health needs through judicial decisions to guarantee the acquired right to access to treatments, surgeries and even medicines, when denied to the users in health units.[19]

The agreements in the second health region are fragmented and isolated and have no global vision. This reflects the lack of regional planning, with prioritizing of the administrative-bureaucratic and normative character from a sanitary perspective. This articulation weakens the organization of the care network and flows, with immediate unfolding in the access to the services, with the predominance of organizational arrangements for access the public health care network or, in most cases, the private network.

It is reinforced that health agreements involve the consolidation of goals agreed by the municipality in the activities carried out in the daily work, not always making sense for the local reality of health care. This commitment depends on the articulation of the social interpreters and on the various ways of seeing the habitual and perceived problems.[20]

The participants said that the construction of the *Rede Cegonha* is left in the theory. It is necessary to increase the access and improve the quality of prenatal care and overcome the flaws in the hospital care units. As a national policy of comprehensive health care, the Stork network advocates the complete protection of the gestation process (childbirth, birth, puerperium, and first years of life) in terms of care and system management, organizing health services and teams so as to respect reproductive rights in the possibility of improving health care for women and children.[21]

The creation of flows and itineraries in the network is urgent because of the difficult dialogue between the different points of care units and the lack of communication. The interaction between professionals limits the attention to users, hampering the intersectoral actions in the territory and, consequently, the care offered to PTNB.

On the one hand, PHC is fundamental to the health system and to the structuring of networks, being responsible for the interaction between the different levels of care, organizing and coordinating the care flows. The place of PHC provides a link between users and other points of attention, guaranteeing comprehensiveness and continuity of health care for users.[22] On the other hand, there is still a vertical relationship between health professionals and users, with the shortage of listening, instructions about access flow and construction of embracing spaces.

The continuing education in health (CEH) is a structuring core of a comprehensive health care network that reinforces the challenges faced by the health region. There is consensus that CEH should be the main management strategy to change the current care model, as it activates the process of transformation of knowledge and actions. However, disregarded from its original conception, it is seen as a partisan and not as a public health policy, with successive changes of management, punctual and discontinuous educational actions, and professionals and managers with dif-

ferent ideas about CEH whose prevailing actions consist in training and technical updates.[23]

The argument that the budget does not allow full implementation of the policy is not real because there is a significant number of opportunities for training in the region. The key would be to refine the idea of CE for workers and, especially, for health managers, redirecting municipal health planning to the full implementation of the policy and guaranteeing quality access to SUS.[23]

A study with managers discussed the topic of coordination of care and showed that the absence of formal mechanisms that allow the integration of team-services, the lack of organization of the flows with complete absence of monitoring and evaluation of queues, and the inexistence of mechanisms of continuity of information affect the ability to coordinate care in the health care network.[15]

Financial transfers between the municipal, state and federal spheres are a critical setback. The municipalities experience a scarcity of financial resources and transfers in a timely manner in face of the great demands in the health services. The values transferred by the *Ministério da Saúde* (BR) to the ESF do not cover the costs of services, inducing municipalities to finance federal policies with their own resources, even when these are not part of their priorities, and compromising actions geared to the needs of their populations, perceptible at this time of clear dismantling of public health policies.[24]

Regarding the criticisms about the performance of the municipal health management, the participants revealed the inertia of some managers in times of lack of financial resources, especially in the current political and economic scenario that Brazil is experiencing. There is a lack of essential materials and inputs in the PHC that discourages professionals and leaves the population abandoned, not to mention a lack of organized construction of access to care, necessitating a permanent schedule in the local health agenda and in municipal health plans.[16]

As the last category of the nuclei of meaning showed, health care regulation has the function of coordinating actions in health services such as consultations of health professionals, diagnostic and therapeutic procedures for patients with high risk, and accuracy and clinical indication in adequate time, selecting only procedures and consultations with clinical indication to be performed, and avoiding unnecessary consultations and/or procedures.[17] In this sense, difficulties in guaranteeing care to PTNB, either consultations, surgeries or procedures, were evident, with negative impacts for the children.

Equal access refers is liked to health regulation. It involves adapting the supply to the demand based on clinical evaluation and prioritizing cases that have the PHC as responsible for organizing the access of users to other levels of health care whose workers make use of the tools offered by the management to guide the itinerary in the network.[25]

FINAL CONSIDERATIONS

The data presented in this study reveal the lack of knowledge of the coordination of care attribute as essential in the process of production of care in the PHC. The coordinators who participated in the research expressed a limited repertoire in the production of networked services, seeing PHC not as an organizer of care, but as a reactive, ambulatory, fragmented point of care, centered on the diseases of children and with fragile support from the state and federal spheres in the administrative support of the health region.

Emphasis was given to the pilgrimage of PTNB in the network and the lack of sanitary responsibility of the ESF/PHC in the monitoring of the therapeutic itineraries of the children and the families, posing a distance from the best practice of PHC. It is therefore necessary to transpose the model of a programmatic PHC into an accessible, comprehensive and strengthened version.

The results of this research may be triggers for the organization of an action plan aimed at strengthening PHC and the health care network, impacting on mortality and hospitalizations rates due to PHC-sensitive conditions, in order to inaugurate another dialogical process between the components of the network in the region.

An opportune time should be selected to approach the coordinators of the network, for the participation was considered limited by the team of researchers because the data collection took place after the result of the municipal elections. Another important factor was the restricted approach to the problems regarding the care of PTNB in the region, when the local powers that could be shared with the region could also be addressed to generate another scenario in the follow-up of children.

In this sense, further studies that overcome the limitations of this study are necessary, in order to listen to PHC users and workers with the intention of qualifying the work process of the municipalities that compose the health region.

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