Rede Cegonha network and the methodological challenges of implementing networks in the SUS

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Abstract *This paper addresses strategies employed in the implementation of the Rede Cegonha ("Stork Network") (RC), considering its contribution to change the delivery and birth care model in the Brazilian Unified Health System (SUS). It contextualizes RC as a project signed by SUS management interagency bodies and the importance of implementing the services' strategies. In this sense, it points out two essential axes supporting the RC, which are strategic to promote the intervention-analysis in obstetric-neonatal care, namely, institutional support (IS) and teamwork training. The IS enables the RC to become a collective construction assumed by teams in their action spaces and is pointed out as an innovative way of implementing health-related projects. The intervention-training methodology innovates training to intervene in work. These experiences are affirmed as potentiators of the RC in creating the conditions to change the technocratic rationale of management and care throughout labor and birth.*

Key words *Rede Cegonha network, Health systems, Professional training, Institutional support*

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The Rede Cegonha network as a care model changing device

The Rede Cegonha (RC) expanded the investments that the Ministry of Health (MoH) had been making in improving delivery and birth care. In 2011, one of the SUS thematic networks emerged to ensure humanized care in the prenatal, delivery, puerperium, childcare up to 24 months, and sexual, reproductive planning, and abortion care. Its set of resources aims to change the obstetric and neonatal care model, a challenge assumed by the MoH, joining voices alerting about the gaps in the hospital-centered and medical-centered predominant model, with invasive and non-humanized practices and high maternal and neonatal morbimortality rates[1,2].

In this paper, RC is addressed as a device, based on the references used in the National Policy for the Humanization of Care and Management in the SUS/PNH[3], in which the potential for intervention in the systems and processes established to generate institutional changes is recognized. This is how we understand the RC in light of our studies and support to health services. It started to operate in the context of SUS without being restricted to the typical instruments of project implementation through prescriptions and goals to be met. The RC also incorporated a methodology for addressing its object/services, seeking what PNH values as a *way of doing*, considering strategies for inter-federative integration and effective involvement of health teams in the shared responsibility with changes.

Its guidelines[2] bear the desired attributes of a new care model: pregnant women's territorial connection to network care, avoiding the pilgrimage of women and children; reception mechanisms, with risk and vulnerability classification; the right to a companion during hospitalization and procedures; adoption of a set of good practices based on scientific evidence; incorporation of obstetric nurses in usual-risk delivery care, promoting their role in the care and autonomy to act within the team; humanized care to situations of abortion and access to legal abortion; offering post-abortion reproductive planning actions; care for situations of sexual violence, ensuring all the criteria of privacy and reception; and adequacy of physical workspaces, creating favorable conditions for social and subjective care bonds. Other guidelines focus on the management, organization, and qualification of work processes, highlighting shared management as an incentive for the active participation of managers, workers, and users,

expanding levels of autonomy and shared responsibility; integrated work in a multidisciplinary team as a reference for care; social mobilization, turning to sexuality and reproduction; and the teaching-service integration, promoting the qualification of the network's work/teams. RC's instituting challenge can be seen with these horizons, challenging the conventional ways of operationalizing management, processes, and care practices. Hence, intervention device at work.

Evaluative studies of thematic networks in the SUS show the implementation directions and the limitations in their configurations and impacts[4]. These are essential contributions to advance the necessary adjustments to reach the population in their demands for comprehensiveness and networks' organization and functioning. These challenges are exponentially increasing in the current context of several structural changes in SUS, including resource constraints. Concerning the RC, the evaluations brought in this Supplement to Journal Ciência e Saúde Coletiva (C&SC) point to unquestionable impacts but also gaps yet to be overcome. Within these analytical perspectives, our RC approach focuses on two axes that evidence its implementation, demarcating our interest in specific *institutional learnings*, valuing potent paths in the *ways of doing* – axis of institutional support[5-7] and essential *strategies* to support the model transformation's goal – axis of teamwork[8] training.

Humanization as a method to implement the RC

RC incorporated the PNH as one of its structuring bases, adopting its theoretical-political framework in a systematic contribution of principles and operating ways. These referential approaches were demarcated in the Ministry of Health's institutional documents and a special notebook of the *HumanizaSUS* focusing on the humanization of delivery and birth[2]. In a recent publication[9], one of the critical stakeholders in articulating the PNH and RC in its structuring moments in the Ministry of Health, Pasche states that one of the most relevant investments of the PNH occurred in the RC. Pasche[9] mentions this approach between the RC and PNH, warning that the RC not only intended to organize seeking efficiency in care and management and change its course, and establish a way of doing politics and intervention in the field, taking the PNH as an ethical bastion and methodological benchmark for the change process that it sponsors. Such ref-

erential would have particular relevance in the RC due to its potential to analyze the complex setting of obstetric and neonatal care, extrapolating its technical scope and bringing to light its underlying ethical and political elements. Thus, humanization appears as a basis for analysis and intervention, a principle and method, whose central pillar is seeking the inclusion of different actors, respect, appreciation of the contradictory, and, as Pasche[9] emphasizes, operating with the generous confrontation between subjects and their differences for the leading and co-responsible reinvention of new things.

This is the scenario that we are interested in exploring in the RC, focusing on *work* in its conception of concrete *activity*[10], in other words, how groups articulate and reinvent themselves daily to ensure the *reality* of the institutions and their goals.

Traditional care, management, and training practices are in force in this concrete space of relationships. It is also where the (re)inventions of such practices operate, always in the instituted-instituting challenge that creates conditions for transformations. Also, using a precious PNH principle, we take RC as an emblematic case in which the premise that public policy is carried out in groups is shown[11], in other words, it is not facilitated by public machine-derived prescription, but operating with the movement of actors, disputing, and mixing their (different) interests and rearticulating them in the production of a common thing. That is how RC and its complex challenges associated with its action fronts and goals are launched.

Highlighting RC structuring axes

In this scenario - a challenge for new practices - we understand that two axes are essential to the RC. It is institutional support (IS), an essential implementing strategy, and teamwork training to sustain the desired changes. We emphasize the methodological prospects of institutional support[5,6] and training processes[8], in light of our experiences in such fields of knowledge and practices. As proposed by the PNH, the RC paves the way to affirm three inseparable work fields: care, management, and training. This principle guides the reorganization of services, indicating that delivery and birth care transformation requires a simultaneous change in the care, management, and training models in work. If this is a premise, we focus on IS as a way of subsidizing transformations in management modes in the SUS ser-

vices[12] and training-intervention[8,13] as a formative prospect leading work and its challenges to the core of educational processes to act as a team.

Institutional Support as innovation in the RC

Campos[12] proposes IS to pursue the creation of groupality, setting up organized group networks to produce health. The IS aims to reformulate the traditional way of managing, expanding the participation of managers, workers, and users in decision-making.

In the RC, support involves mediating the project agreed between managers, enabling it to become an object of the workers' agenda, effective as a group construction assumed by subjects who make the service work. In this direction, it transcends and exceeds the tradition of the MoH centered on the formulation of projects and the provision of resources to be carried out only by other bodies. Institutional support is essentially methodological support occupying the space between the ordinance signed between the management bodies (macro-sphere of management) and the services' action, helping to put the project into operation[6]. The IS primary purpose vector in the RC is creating conditions to help change the technocratic rationale of management and maternal and child health care.

Starting from the norms for its development[6], the MS commissioned evaluative research on IS in RC[7], which attested predominantly positive signs in the fields of supporters' interference: collaborative management, qualification of care and management, and in the articulation of planning, monitoring, and evaluation. The following stand out in these areas: strengthening inter-federative integration, RC design and articulation with other SUS networks, establishing shared management devices, alignments considering actors and their power relationships, offering technologies and methodologies for analyzing and reviewing the work processes, implementing good practices and protocols, training-intervention activities and team qualification, and expanding the institutional capacity for planning, monitoring, and evaluation.

Notwithstanding the power of IS and its recognition by those supported, it is a practice in permanent conflict amid the dispute for care models (between the established and what one wants to establish). In this sense, it must be valued as an innovation in implementing projects, mostly because it is in the intermediation of pub-

lic policy, in the challenge of making it effectively public because it is built on groups, as indicated by the PNH[11]. This gathers RC and IS objectives in the radical defense of a humanized delivery and birth care, exposing themselves to the disputes of interests that intersect at work. Amid disputes, support helps to overcome previously immutable situations, and it is a permanent challenge and instigating practice that indeed contributes to the results achieved with the RC.

Teamwork training and care model change

Professional training is one of RC's components and is understood as a strategic agenda for changing paradigms. In our experiences, we start from the premise of bringing work to the center of educational processes, and we take the work within the meaning of spaces where different subjects are in constant debate of norms, rules, moving between traditional practices and the challenge of their reinventions. This is the concept of work as an activity and as a meeting[10], which is materialized, especially in the connections or meetings between situations and production subjects within the SUS: workers, managers, and users. Following humanization as a policy[3,11], the proposed action is expanding interaction between such subjects from the concept of cross-sectionality[14], seeking greater openness in the communicational relationship between them. This conception brings about the need for the subjects' active and inventive participation, sharing, assuming co-responsibility, and building joint projects. The power of action of workers' groups increases[6,14] as the degree of cross-sectionality increases, challenging the boundaries of knowledge and attitudes.

By stirring reflection on obstetrics and neonatology work, we highlight the complex, broader field of delivery and birth care[8]. A field where multiple subjects of interest and multiple values traverse the scientific scope: it involves women, family, professional categories, services, social movements, gender, the church and its dogmas, the state and its principles, and others. On the other hand, as in the whole health sector, the obstetric and neonatal practice occurs amid escalating technologies, medicalization, and procedural standards, strengthening the care relationship, with loss of workers' autonomy and isolation in the task. This increasingly requires more significant group analytical and intervention capacity to share the responsibility in facing these trends.

Delivery care involves articulating different knowledge and stories, including women's own,

and the challenge of making it a meeting in the ethics of defending life and otherness. If the needs of health production subjects transcend the objective and techno-practical dimensions, this requires articulating knowledge not as a sum of professionals, but especially in the sense of an interlocution of disciplines to realize the complexity of care. In contrast, the exchange of knowledge and professionals is associated with the tradition of how relationships are established in health services, in the technical and social division of labor. This tradition harbors a marked asymmetry of powers between the different categories, between professionals and their managers, and between all these and users. Professional juxtaposition and qualification are insufficient to act individually to overcome them; it is necessary to balance individual and collective autonomies[15]. Thus contextualized, it is not through the field of care alone (sphere of technical skills and competencies) that services will be transformed. Management enables analyzing both the ways of caring and managing interrelating with those of training. This is an essential basis for teamwork, overcoming the vertical hierarchy of knowledge-power relationships and advancing towards a lateralized organization from the perspective of cross-sectionality.

The training-intervention concept increases the power to act at work. It values teamwork training by building joint projects that meet the interests of users, the (different) workers, and the institution. Training expands the qualification for analysis-intervention in the organization and management of work processes, a necessary condition to change the model. Our experiences in qualification projects in the neonatal obstetrics field[8] are guided by these principles, in line with the ethical-aesthetic-political horizons of humanization in light of cross-sectionality and interprofessional bridges. Such training to address SUS realities requires that the reality of work organization be taken as an agenda. However, in general, in the tradition of education, this is neglected or underestimated, focusing on restricted skills that only guarantee a specific qualification. The singular realities bring needs that would not be solved only with the prescriptions or antecedent norms for the work to be done. The principle of training as an intervention proposes interference at work, within and with it, articulating knowledge production, care and management practices, health, and subject production inseparably. The substantial work experience and its analysis point out the need for qualification, the recreation of practice and knowledge, enabling the applicabil-

ity of knowledge and technologies. This is done with the permanent (re)invention of norms and a collective debate of values towards joint action.

Conclusion

The RC underpins the Ministry of Health strategies, bringing the challenging mark of changing a model of practices, thereby reverberating in the SUS as a whole, especially in management[2]. In this context, the highlighted strategic, implementing axes bring the challenging mark of new ways of qualifying work in its organization and institutional and subjective relationships, along with the challenge of training to sustain changes. These challenges extend in the broader perspective of networks in the production of articulations in various spheres, traversing the resources and linkages that ensure comprehensiveness and break with traditional frontiers of knowledge and powers that hinder a joint, co-responsible act, a scope that we instigate be faced with the idea of cross-sectionality.

We argue that IS and training-intervention interpenetrate as structuring axes in the RC because they are channels for developing the Network, in the sense of collective action and on a path of permanent sharing among the actors involved, thus directing the training of professionals on new ethical and political bases for new ways of acting in health. They are structuring axes because they manage to update ways of discussing work (and work training) through their collective analysis, bringing out tradition and transformative potential. Thus, we believe that they contribute to the sustainability of practices that are changing or that the group production of autonomy contributes to the sustainability of RC as a public policy. For all these reasons, we affirm that the IS and the training for teamwork help produce the desired results in the RC, thus underscoring the importance of innovations in care and training networks.

Collaborations

SB Santos Filho and KV Souza participated in the conception, writing, and review of the content until the final version of the manuscript.

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