REME • Rev Min Enferm. 2019;23:e-1237
DOI: 10.5935/1415-2762.20190085

RESEARCH

EVERYDAY SCENES OF CARE: THE STORK NETWORK UNDER CONSTRUCTION

CENAS COTIDIANAS DO CUIDADO: A REDE CEGONHA EM CONSTRUÇÃO

ESCENAS COTIDIANAS DE CUIDADOS: LA RED CEGONHA EN CONSTRUCCIÓN

Roberta Lima Gonçalves [1]
Cláudia Maria de Mattos Penna [2]

[1] Universidade Federal de Campina Grande – UFCG, Unidade Acadêmica de Enfermagem. Campina Grande, PB – Brazil.
[2] Universidade Federal de Minas Gerais – UFMG, Escola de Enfermagem. Belo Horizonte, MG – Brazil.

Corresponding author: Roberta Lima Gonçalves
E-mail: berttalima@gmail.com

Author´s Contribuitions:
Conceptualization: Roberta L. Gonçalves; ***Data Collection:*** Roberta L. Gonçalves; ***Investigation:*** Roberta L. Gonçalves; ***Methodology:*** Roberta L. Gonçalves, Cláudia M. M. Penna; ***Project Management:*** Cláudia M. M. Penna; ***Supervision:*** Roberta L. Gonçalves, Cláudia M. M. Penna; ***Validation:*** Roberta L. Gonçalves; ***Visualization:*** Roberta L. Gonçalves; ***Writing - Original Draft Preparation:*** Roberta L. Gonçalves; ***Writing - Review and Editing:*** Roberta L. Gonçalves, Cláudia M. M. Penna.

Funding: No funding.

Submitted on: 2018/09/18
Approved on: 2019/02/13

ABSTRACT

Objective: to unveil the daily scenes experienced in the health services that make up the Stork Network. **Method:** case study of qualitative approach, based on Comprehensive Sociology of Everyday Life. Data collection occurred between July and September 2017, through documentary analysis and semi-structured interviews and non-participant observation with social actors involved in the Stork Network of a municipality in the state of *Paraíba*. We performed data triangulation and thematic content analysis. **Results:** two categories were identified: who enters the Stork Network? Everyday scenes: (un)care in evidence. It was demonstrated the creative and dynamic production of the Stork Network by social actors, which build the paths to be covered in the search for care, and identified the gaps in the diagnostic and therapeutic support system that can hamper care. **Conclusion:** the Stork Network is reconstructed daily by the sociality present among the social actors of health services that offer maternal and child care.

Keywords: Public Health Policy; Unified Health System; Comprehensive Health Care; Maternal and Child Health; Maternal-Child Health Services; Women's Health.

RESUMO

Objetivo: *desvelar as cenas cotidianas vivenciadas nos serviços de saúde que compõem a Rede Cegonha.* ***Método:*** *estudo de caso de abordagem qualitativa, fundamentado na Sociologia Compreensiva do Cotidiano. A coleta de dados ocorreu entre julho e setembro de 2017, por meio de análise documental e entrevistas semiestruturadas e observação não participante com os atores sociais envolvidos na Rede Cegonha de um município paraibano. Foram realizadas a triangulação dos dados e a análise de conteúdo temática.* ***Resultados:*** *identificaram-se duas categorias: quem entra na Rede Cegonha? Cenas cotidianas: o (des)cuidado em evidência. Comprovou-se a produção criativa e dinâmica da Rede Cegonha pelos atores sociais, que constroem os caminhos a serem trilhados na busca do cuidado, bem como identificaram-se as lacunas no sistema de apoio diagnóstico e terapêutico que podem comprometer o cuidado.* ***Conclusão:*** *a Rede Cegonha é reconstruída cotidianamente pela socialidade presente entre os atores sociais dos serviços de saúde que ofertam cuidados materno e infantil.*

Palavras-chave: *Políticas Públicas de Saúde; Sistema Único de Saúde; Assistência Integral à Saúde; Saúde Materno-Infantil; Serviços de Saúde Materno-Infantil; Saúde da Mulher.*

RESUMEN

Objetivo: *desvelar las escenas cotidianas de los servicios de salud que conforman la Red Cegonha.* ***Método:*** *estudio de caso de enfoque cualitativo, basado en la sociología comprensiva de la vida cotidiana. La recogida de datos tuvo lugar entre julio y septiembre de 2017, a través del análisis de documentos y entrevistas semiestructuradas y observación no participante con los actores sociales involucrados en la Red Cegonha de un municipio de Paraiba. Se realizó la triangulación de datos y el análisis de contenido temático.* ***Resultados****: se identificaron dos categorías: Quién ingresa a la Red Cegonha? Escenas diarias: el (des) cuidado en evidencia. Se confirmó la producción creativa y dinámica de la Red Cegonha por parte de los actores sociales, que construyen los caminos a seguir*

How to cite this article:
Gonçalves RL, Penna CMM. Everyday scenes of care: the Stork Network under construction. REME – Rev Min Enferm. 2019[cited _____ ___ ___];23:e-1237. Available from: _____ DOI: 10.5935/1415-2762.20190085

en la búsqueda de atención, así como las brechas en el sistema de apoyo diagnóstico y terapéutico que pueden comprometer la atención. ***Conclusión:*** *la sociabilidad entre los actores de los servicios de salud que ofrecen atención materna e infantil reconstruyen diariamente la Red Cegonha.*

Palabras clave: *Políticas Públicas de Salud; Sistema Único de Salud; Atención Integral de Salud; Salud Materno-Infantil; Servicios de Salud Materno-Infantil; Salud de la Mujer.*

INTRODUCTION

Brazilian Federal Constitution institutionally contemplated integrating network services, determining that the actions and services of the Unified Health System (UHS) (*Sistema Ùnico de Saúde*-SUS) should integrate a regionalized and hierarchical network. However, for more than two decades, UHS remained characteristically fragmented and without giving satisfactory answers to the epidemiological changes that occurred in the Brazilian population health.

In this sense, in 2010 the Ministry of Health (*Ministério da Saúde*-BR)proposed an organizational design for UHS called the *Rede de Atenção à Saúde* (RAS), which aims at integrality and to overcome the fragmentation of the system, promoting regional interactions that ensure the offer of actions and services to users under their responsability.[1] For this, network connection points need to be articulated for continuous, orderly and coordinated care by primary health care (PHC).[2]

Some areas were considered priorities due to epidemiological criteria, such as the Stork Network (*Rede Cegonha*), which aims, among its objectives, to increase access and improve the quality of obstetric care to reduce maternal mortality and with emphasis on the neonatal component. This includes actions in prenatal care, childbirth, puerperium, reproductive planning and monitoring growth and development of children from zero to 24 months old. In addition, the Stork Network has principles and guidelines that guide women's care that put in the agenda the gender approach, equity promotion, respect for human rights, cultural, ethnic and racial diversity and guarantees sexual and reproductive rights both for women and men.[3]

However, the complex normative structure that guided the Stork Network should not be observed only in the macro political context, because it does not contemplate the diversity present in the micro political dimension of everyday experiences.[4] Moreover, all RAS, in their composition and execution, aim at integrality. Therefore, they need to be seen as living networks in motion and with creative powers, because, within their interior, they have networks of existential territories, with relationships that are produced in act, in their social actors' way, when they seek and/or promote care.[5]

Yet, there are still few studies involving this thematic network to better understand the daily nuances of maternal and child care. In this perspective, this study aims to unveil the daily scenes experienced in the health services that make up the Stork Network of *Campina Grande* (PB).

METHODS

The study has a qualitative approach, outlined by the research strategy case study based on Comprehensive Sociology of Everyday Life, originated from a doctoral thesis. The qualitative approach allows capturing, through the views and perspectives of the participants, the meanings they give to facts in which everyday life of the Stork Network is inserted.[6] We chose to look through Comprehensive Sociology of The Everyday Life based in Michel Maffesoli, because it captures the details of everyday life and allows to describe the experience in its essence, thus discerning the plural visions of the different actors involved.[7]

We opted for the methodological strategy of single-case study, because it is adequate to study contemporary social phenomenon inserted in its real-life context and because it has the potential to unite different methods of data collection that, associated, allow further apprehension of the attitudes and actions that build and strengthen the Stork Network.[8]

The study was developed in *Campina Grande* (PB), in the services that regionally integrate the Stork Network in the three levels of care that comprise the basic health units (BHU) of the Family Health Strategy (FHS) (*Estratégia Saúde da Família*-ESF) and the three maternity hospitals. To choose the BHU, we carried out draws that defined the sequence of realization. In relation to maternity hospitals, all were included.

The sample consisted of social actors who experience daily life in the Stork Network: users, health professionals and managers. As inclusion criteria of the users, we considered the following: those who were followed-up at some stage of the puerperal pregnancy cycle, with at least four prenatal consultations, which represents the minimum necessary for quality care;[9] users who have given birth to at least one child since 2012 (which was the year of the Stork Network implementation in *Campina Grande*); users of reproductive planning for at least six months in the BHU or the reference service of the municipality.

The health professionals included were those active and with a time of practice of at least one year performing activities in the Stork Network, because it was considered enough time of experience in this network everyday life. Regarding managers, since they are key informants, all of them were invited. In this perspective, the saturation criterion[10] was used only to outline the sample referring to the segments of health professionals and users.

Thus, the total sample was 58 participants, of which 15 were users, 31 health professionals and 12 managers, identified, in respect of anonymity, by a code according to the segment to which they belong, followed by a sequential number according to the time of the interview. That is, US for user, HP for health professionals and M for managers.

Data collection was performed with authorization of the participating subjects. We performed documentary analysis, observation (Observation notes – ON) and guided interviews with a semi-structured script specific to each group, and the last two techniques occurred simultaneously. In this perspective, all empirical data were triangulated, allowing the researcher to develop convergent lines of research, producing greater depth of the analysis.[8] In possession of the material, thematic content analysis was performed according to Bardin.[11]

The research followed Resolution Nº 466/2012 and was approved by the Research Ethics Committee of the *Universidade Federal de Minas Gerais* under Opinion 2,054,087. The participants signed the Free and Informed Consent Form, expressing interest in participating in the study, shortly after informing and clarifying doubts about it.

RESULTS

The daily scenes of the Stork Network allow us to understand health services as a sociality locus, characterized by pluralities of affections, feelings, exchanges, bonds and expressions. Thus, in addition to the narrow morals of "must be", the data unveil the dynamicity of social actors, weaving this thematic network, where they are presented by two categories of analysis, namely: who weaves in the Stork Network?; and everyday scenes: (un)care in evidence.

Who weaves in the Stork Network?

The findings indicate that, in daily life of maternal and users often choose the gateway to access health services and obtain care childcare.

> *I had a sore throat and I brought her [the daughter] to this doctor [from HBU], but she answered me didn't give much attention, just looked like that, looked over it, said she [the daughter] didn't have her throat sored and told me to give her dipyrone. The bacteria settled in the throat and it grew, turned into a lump. Then I went to the hospital [pediatric urgency], she [the daughter] stayed there for a week, hospitalized. She was discharged, [...] she [the hospital doctor] passed [the antibiotic] so I could give her at home another week. But the lamp didn't get smaller. I was terrified! I went back there on my own, the doctor looked at me and said, "Continue with the antibiotic five more days" - and told me to go to UH [University Hospital] for a specialist appointment. But I was desperate! Then I remembered a pediatrician that was very good, she was very good and dedicated in the week she was admitted, and I searched her on my own, I went up to the hospital [of pediatric urgency] without anyone seeing me and went there and I found this pediatrician and talked to her : Doctor, for God's sake, help me! She referred me to a friend [doctor] of hers, phoned to the UH [University Hospital] and got an appointment [...]. He took the lump out, did the biopsy, it was nothing. Then I went back there, showed the doctor [of pediatric urgency], on my own too, because I couldn't!* (US 11).

The data describe the path traveled in search of care. At the beginning of her daughter's health problem, she sought PHC, however, the doctor "looked over it", not giving proper attention. In addition, she said at the end of the interview, things are very difficult, so with the evolution of the "lump" in the daughter throat, she did not return to the physician of the HBU. To be treated at HBU, appointments have to be scheduled or the child has to present fever, and this would require more time, since she understood that their demand was not within HBU requirements.

Thus, the absence of resolution in PHC and the need for health perceived by the user in relation to her daughter encouraged her to assume the leading role and management for care in search of access and consumption of health services. In this course, the affective relationships established between the user and the physician of the pediatric emergency hospital were also relevant for the positive outcome, because she was a reference regarding good care during the first hospitalization and sympathized with the request for help, operationalizing the continuity of the child's care with the specialist.

Other findings demonstrate the choices of users in relation to the place of delivery. In the municipality there is a map that links pregnant women to maternity hospitals, so that every sanitary district of Campina Grande (PB) has the maternity reference for parturient. In practice, however, users reported how they made their choices:

> *I'm going to [M2] anyway. [...] It is because the people here [of the community] speak very well* (US 3).

> *I want to go to M1, because my other two were born there and I liked it* (US 15).

The determination of the Municipal Health Department to refer pregnant women to maternity hospitals has not

been successful. The personal choices and opinion of other members of their community are the factors that guide the paths in search of care for delivery and birth.

Similarly, women also choose services for prenatal care. Health professionals and managers reported other situations performed by users, in which this occurs.

> *We have a lot of pregnant women who come like this, to join the family. She lives somewhere else and comes into the house [...] of someone in the family. She gives their address and registers for prenatal care* (HP 18).

> *It's funny [laughs], they lie [...]. I discovered Wednesday a woman from [neighboring town], but gave the address of the sister-in-law, close to the unit, just to stay in the unit, [...] she talks, it seems that she lives in the area, she even gives details of the place!* (M 6).

Women use creativity to ensure care at PHC in *Campina Grande* (PB). They create a "mask of cunning" and "double game", simulating they live in places of health teams coverage or even moving to live in their family members homes who live in these places.

In the findings, it is possible to capture the territorial movements that women perform in search of prenatal care, both in the city focused on this study and in surrounding cities. Some reasons for this to occur can be highlighted:

> *Those who live in one of these houses, where it was invasion land, is kind of without a reference unit. [...] so they self-reference here [...]. Other pregnant women too, who came to do prenatal care with us because, as they know that the team is, it is always the same team, right, we already have [...] a bond with the community that believes in our work* (HP 18).

> *[...] Some [pregnant women] left here [from the neighborhood] and did not adapt with another team* (HP 14).

In the reports it is possible to capture that the affective relationships, bond and trust existing in daily life were determinant to choose the place and health professionals to perform prenatal care. Besides, other users, due to the feeling of belonging to the community and the family health team, returned to the places where they had already lived to ensure care.

It is noteworthy that the municipality of *Campina Grande* (PB) has more than 90% coverage by the Family Health Strategy, and even in the places that are not covered, there is a reference health center to serve users and their children. However, during the interview, HP18 stated that pregnant women preferred to try to insert themselves into a service that was closer, which was not always the health center, as was the case of pregnant women living in the invasion site near their HBU.

The statements describe the attitude of health professionals towards women's actions to obtain care:

> *[...] until the city does a remapping, register [...] more teams, [...] we cannot leave these people without care, we do not have the courage to say no* (PS 18).

> *I have one that I did her daughter-in-law prenatal, [...] and now the mother-in-law [...] lives on the other side and has already asked me [...]. So, so I can't say no [laughs]. [...]. So, there is a bond, we're a reference. [...]. So we manage and welcome them [...]* (PS 14).

The results show that, regardless of the users' reasons to seek out health professionals, they also have bonds and were not limited to the territorialisation drawings, which in these cases could be excluding. Thus, it is evident that professionals assumed an ethical, welcoming and responsible posture for care.

Sociality built on a daily basis in the territory makes it more flexible and show that, in addition to the geographical issue that guides RAS and PHC, territorial delimitation did not limit the professionals' practices. Even inserted in UHS services and, therefore, with standards to be met, they are, in a way, autonomous and manage care they must provide.

Everyday scenes: (un)care in evidence

In this research, we perceived that access for women and their children was facilitated in PHC. In all the HBU visited, there were specific shifts to attend the public, but they are flexible for spontaneous search. However, they gave more attention to women in the gestational period and children up to 12 months old, being shy and/or nonexistent the actions in other phases of the woman and child's lives.

In the field of health in Brazil, the Stork Network was initially implemented in municipalities that had high indicators of maternal and infant mortality, as is the case of *Campina Grande* (PB). Since then, there have been undeniable advances that can be observed in the maternal and child area and are important for all cities that depend on obstetric care in this municipality. There was the reactivation of the Maternal and Infant Mortality Research Committee, an improvement in the ambience of maternity hospitals, the implementation of obstetric screening with risk classification and advancement in the technological apparatus with the inauguration of the Intensive Care Unit (maternal ICU) and an increase of neonatal ICU beds.

On the other hand, outside the scenarios in which childbirth occurs, these changes had little echo. When asked about the assistance provided and/or received in the Stork Network, social actors' positions are different. The excerpts describe some obstacles to care.

> *They took our sonnar today, [...] we were three teams. A [team] moved this week, so it took the sonnar we had. And then the nurse went there to pick it up today [...]. And then she's taken it. It's complicated [laughs]! I'm not buying a sonnar to work!* (HP 15).

> *Gosh, gosh! That's where my problem is! To have an idea, I only got one sonnar [...] so, so I'm going to give it a unit that's very precarious [located in the rural area], which has been without a sonnar for over four months, it's no joke! [...] they [health professionals] demand and they are!* (M 6).

> *In the high-risk prenatal outpatient clinic, which receives women from all over the state of Paraíba, it was possible to observe the logistics of sharing this equipment. The medical consultations took place simultaneously in some offices and the sonnar was transported by the reception staff or by trainee medical students who were under obstetricians' supervision. We observed that this delayed care, generating more time for pregnant women while waiting for consultation, as well as pregnant women referred by PHC in Campina Grande and other municipalities in the interior of the state, who often waited more than a month to get the first consultation with the obstetrician* (ON 1).

One of the health district managers talked about the lack of this input and acknowledged that it was a gap in the care of pregnant women in their HBU when he said: "Gosh! That's where my problem is!" and "they demand and they are right!" That way, since they have only one sonnar, the manager prioritized a HBU from a more distant community with lower socioeconomic status.

The results revealed how the daily offer of other items that are also part of care during prenatal care occurred.

> *We have problem with medicines, often we run out of them [...] some buy, others report during the consultation that they have no conditions to buy* (HP 3).

> *We have difficulty scheduling more specific tests, such as serology, [...] and it also takes a long time to schdule obstetric ultrasound scanning* (HP 4).

> *It's been a year our lab is closed. Then that's a lot... It's frustrating for us, you know? [...] they perform [in Campina Grande] at least one, but you know there are three. But they try* (HP 17).

> *I had a lot of toothache, I suffered a lot during all the pregnancy [...] there I came and could not do anything, they said that there was no anesthesia for the tooth, then I, said: do want to know something, I won't any longer! Then I never came back [for prenatal care]* (US 7).

The Stork Network scenario highlights the weaknesses of the support system (diagnosis and therapeutic), since inputs, medicines and tests are not offered in due course and according to women's needs. Most of them do not have financial conditions to buy medicines and/or perform exams and procedures outside the public health system, which may even discourage women from doing prenatal care. In the rural area, the situation of financial shortage of users is even greater and besides this difficulty, users have to pay the commute to the city to carry out the exams.

> *Municipal managers talked about the offer of the same items, but exposed a view contrary to that of health professionals. With short and objective answers, we noticed that, at those moments, the interviewees took their eyes of the researcher, looking to the sides and down* (ON 2).

> *In relation to inputs we do not have problem, right, we guarantee this issue, right, of the inputs and medicines that are important* (M 10).

> *All tests that are necessary for the pregnant woman will be performed* (G 12).

It was possible to learn that managers omitted information regarding gaps in the support system. In addition, the professionals stated that municipal management was aware of these weaknesses. The omission of managers may be related to the commissioned positions they held and for fear of exposing themselves to the municipal health administration, highlighting the gaps.

Health professionals, perceived the management passivity in the face of the problem, which permeated by noises the theme "support system", but daily they created strategies to deal with the gaps.

> *Our doctor receives a lot of free sample, she has a very organized little store, then suddenly, when she takes one of these who cannot at all, she gives to someone. If I'm the*

> *one who's going to prescribe and there's no medicine here, we're going in there and, like, manage to do something, you know? [laughs]* (HP 10).

> *When we see that it is the financial issue [the difficulty in taking the exam], then we go there, here: look, we got this for you* (PS 9).

The data reveal that, despite the daily difficulties with lack of basic resources to provide care during prenatal care, health professionals were sympathetic with the most needy users and tried, within the possibilities, to minimize the gaps, even if provisionally. This professional posture can contribute to the absence of users' reports about the items of the support system mentioned above.

DISCUSSION

The results of this study indicate that the Stork Network is "woven" daily in meetings and actions between social actors, demonstrating the creative potential that each of these has, when it enables care, even in the face of adversity.

The users were producers of the Stork Network and protagonists of the their care and their children's when making their choices in relation to services and health professionals. Thus, the established logic of network organization, with care ordering and coordination conducted by PHC[2], was not effective because it did not allow care continuity.

In this context, when involving into the network of medium and high complexity services that that take care of the municipality children, US 11 began to build the care map of her own network. That is, under the logic of her daughter's health needs and within the limits and possibilities of health professionals' services and activities, the user created all the paths and connections necessary to have a solution.[12]

This trajectory was possible because there is the daily empirical knowledge of each person and the community that cannot be ignored, because it is what determines the "know-to-live", "know-to- say" and "know-how" of the of services and professionals choice in search for care. Moreover, the attitudes show that, in the "lived space"[7] in the pediatric emergency service, integrality materialized in the care provided, in which care was coordinated to flow in a systemic way.[13] This reinforces the understanding that, from the perspective of RAS, all services are important in care coordination.[14]

It was also important the fact that, to shorten the time of case resolution, the pediatric emergency service professional did not allow the user and her daughter to once again begin the pilgrimage in the service network. By establishing contact with a specialist friend, the attitude of the professional became a powerful network producer, for providing flows and connections between services, workers and the user.[15]

Other findings also indicate the unpredictability of the paths to be followed by women when seeking care. Regarding childbirth, users were motivated to choose maternity through personal criteria and, mainly, by the opinion of the community in which they lived. With regard to prenatal care, women wore "social masks"[16] to ensure care when they did not belong to the geographic territory of health professionals in which they wanted care.

Maffesoli[16:122] argues that "masks" and "double play" teach that the show is an integral part of social life, it is not organized according to others, but depending on the actor themselves". Nevertheless, they cannot be understood as falsehood, but as a possibility of health protection.[17]

The masks assumed in everyday relationships are necessary in everyday life, in which what prevails is the "ethics of the instant, here and now".[7:231] Therefore, the desire and need perceived in the user to start prenatal care is what determines the way of acting to achieve care, and this "theatricality is what constitutes the very plot of everyday life".[7:187]

The users trusted and felt linked to health professionals and these aspects are constructed in the spaces of "being-together" in daily life, which is permeated by affections, feelings and that serve as "social cement" in the sociality present in the services of health.[18]

In this perspective, this relational process that contributes to the bond occurs in a multifactorial way, passing, among others, through social and subjective aspects.[19] The nature of the established relationship dictates the type of bond constituted and its potential for development of health actions.[15]

Other data show that health professionals also had bonds with the users, even belonging to another geographic territory. Thus, when health professionals took responsibility of taking care of women from other areas, they recognized the existential territories that move each of them longer distances, through their choices and ways of producing their life. Thus, it is understood that care network that emerges is alive and powerful, since connections of territories are established and allow users have possibilities of care.[20] It is important, therefore, that the health professional place the centrality of care practices in people's demands and needs and give new meaning, from there, to the standards established.[21]

In health services everyday life there are "feelings, affections and conversations that gradually constitute the social plot ".[16:61] They may not be visible to the policymakers of public health policies,[15] because, to see them and understand their importance, they have to be aware of simple and small things. There are "multiple interactions, absolutely subtle, that do not allow to be reduced, *stricto sensu*, and it is vain the attempt to deny them".[16:21]

The Stork Network is no longer given as a structure to be filled in a protocol way, because it has, within it, several micro networks that are being woven, through different events by social actors,[4] understood, in this study, as the producers of the network. However, for women and their children care is efficient, some components of the support system need to be present.

In this study, we evidenced weaknesses in the supply of essential items for women care during pregnancy. It is noteworthy that the findings are contradictory with what the *Ministério da Saúde*-BR recommends, which suggests that women start prenatal care early, in order to ensure the provision of basic procedures, which include dental consultations, clinical-obstetric and laboratory examinations patients need, both for good follow-up and also to intervene if clinical changes that require other practices arise.[9]

In relation to this contradiction, we perceived that there is a "conflicting harmony" in the speech of managers and health professionals about the support system. According to Maffesoli[16], conflicts are present in the interactions between individuals and are founded on alterity, so that all sociality is conflictive and, therefore, the most important is not to solve them, but mainly to look for harmony points.

The context of insufficiency of the support system is characterized by a health system that remains fragmented, inaccessible, inefficient and which has implications for the quality of care.[14] Despite this, the data reveal that, even with these difficulties, health professionals were solidified by the most needy users and tried, within the possibilities, to minimize gaps, even provisionally, because in everyday life the ethics of the moment prevails.[7]

The implications of these professional attitudes, however, are not enough to guarantee all users the minimum of items necessary for quality monitoring. Thus, more proactive attitudes are needed on the part of municipal and regional management in order to contribute to build and strengthen the Stork Network.

FINAL CONSIDERATIONS

The results of this study based on Comprehensive Sociology suggest that the Stork Network is reconstructed, daily, by the sociality present among social actors who use health services that offer maternal and child care.

The normative framework established by the Stork Network can trigger some protocol actions that dictate the "must do", " must be", "must say", but it is the plurality of various natures crosses that are present in sociality and the desire to "be together" that define the actions, choices and behaviors of social actors.

From this perspective, managers, health professionals and users are potential producers of the Stork Network, both because they act and enable the paths of care, the choice of services and health professionals, and also because they allow the sociality developed by affections makes the territory more permeable for the entrances and exits of users into the network.

Regarding the weaknesses of the Stork Network, we highlight the fragmentation of care and the support system, which are issues that cause impact on the quality of care and reduce the adherence of pregnant women. In addition, we can infer the invisibility of these gaps for municipal management.

We repeat the limit of this single-case study, which aimed to focus and deepen a specific reality, and may not allow generalizations in other scenarios. However, because it was unprecedented to look at Comprehensive Sociology on everyday life of the Stork Network, the results found can provide subsidies for social actors to reflect on the main obstacles and potentialities of a living network in order to better understand the dynamism of everyday life and make the Stork Network more powerful.

We suggest to conduct further studies in other municipalities to deepen the issues presented and analyzed, since the Stork Network is a recent strategy of the UHS in women and their children care, thus needing to expand the discussions about the social phenomena that occur in everyday life.

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