


CHAPTER 39

The importance of institutional support in the implementation of protocols and care flows in primary health care in municipalities in the state of amapa: experience report

 [10.56238/pacfdnsv1-39](https://doi.org/10.56238/pacfdnsv1-39)

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ABSTRACT

The Assistance Protocols and Flows in the work routine are important to face problems in assistance and in the management of services. These instruments are guided by clinical and organizational guidelines and are based and validated by studies and scientific evidence, in addition to incorporating new technologies into services. In this aspect, aiming at the organization of the Health Care Networks in the State of Amapá, specifically at this moment the Maternal and Child Care Network, the Care Network for People with Chronic Non-Communicable Diseases and the Urgency and Emergency Network, it was observed during the accomplishment of a Situational Diagnosis the need to implement Protocols and Assistance Flows, as well as the accomplishment of in-service training for the health professionals of the cities of Laranjal do Jari, Vitória do Jari, Oiapoque, Cutias do Araguari and Amapá, thus aiming qualification in the assistance provided to users of the Unified Health System and the strengthening of the referred networks in the State. The research is descriptive with a qualitative approach of the Experience Report type. The period of carrying out the activities in the municipalities took place during the year 2021, from March to December and the beginning of the year 2022 from March to April. It is important to highlight that the state institutional support process was established with the development of actions and activities through the use of active methodologies, delivery of guiding documents, presentation of proposals for Assistance Flows and Protocols and realistic in-service training, aiming at optimizing and qualification in clinical and care management, in addition to improving health indicators and strengthening Health Care Networks.

Keywords: Institutional support, protocols, flows, Trainings, Health Care Networks.

1 INTRODUCTION

According to Andrade et al. (2014) Institutional Support (AI) proposes, from a new perspective, changes that seek the effectiveness of health practices and the production of groups and health teams in a more solidary way and with co-responsibilities. In this way, it is configured as a way to encourage

participatory management, which is an important instrument for promoting changes in health management and practices, which results in effective and motivating care for work teams. It is important to highlight that the institution and supporters monitor the process of change in organizations, articulating technologies and proposing strategies and searching for ways to operate for the management team.

The Ministry of Health (2010 a) defines as institutional support functions: 1) to encourage the creation of collective spaces, through arrangements or devices that facilitate interaction between subjects; 2) recognize the relations of power, affection and the circulation of knowledge, enabling the viability of projects agreed upon by institutional and social actors; 3) to mediate together with the group the construction of common objectives and the agreement of commitments and contracts; 4) bring to the work of coordination, planning and supervision the qualification processes of institutional actions; 5) to allow groups to exercise criticism and for health professionals to be able to act based on new references, contributing to improve the quality of management in the SUS. Thus, institutional support is configured as a device that expands the capacity for reflection, understanding and analysis of groups, which could thus qualify their own intervention, their ability to produce more and better health with others.

With regard to Health Care Networks (RAS), Mendes (2009) and UFMA (2016) emphasize that they are organized by health care points, which are places where health services are offered and must be strategically distributed. in the territories. In the RAS, the priority door for health care is the Primary Health Care (PHC), which must be able to resolve most of the population's problems, being, therefore, the organizer of care.

of the RAS operational structure are : communication center (Primary Health Care); attention points (secondary and tertiary); support systems (diagnostic and therapeutic, pharmaceutical assistance, telecare and health information); logistical systems (electronic health records, clinical records, systems of regulated access to care and health transport systems); and governance system (of the health care network) (MENDES, 2009; UFMA, 2016).

It is worth mentioning that the guidelines for the organization of Health Care Networks within the scope of the Unified Health System (SUS) were established by the Ministry of Health through Ordinance No. 4,279/10. The networks established in the Ordinance are divided into: Rede Cegonha, established through Ordinance No. 1,459/11 and currently called Maternal and Child Care Network (RAMI) established by Ordinance GM/MS No. 715/2022; Urgency and Emergency Network (RUE), established by Ordinance GM/MS No. 1,600/2011; Psychosocial Care Network (RAPS), established by Ordinance GM/MS No. 3088/2011, for people with suffering or mental disorder and with needs arising from the use of crack, alcohol and other drugs; Care Network for People with Disabilities (Living Without Limits), established by Ordinance GM/MS nº 793/2012; and Health Care Network for People with Chronic Diseases , by Ordinance GM/MS No. 483/2014 (BRASIL, 2010b; BRASIL, 2011a; BRASIL, 2022; BRASIL 2011b; BRASIL, 2011c; BRASIL, 2012a; BRASIL, 2014a) .

Regarding the use of Assistance Protocols and Flows in the work routine, Werneck, Faria and Campos (2009) mention that these instruments are important to face problems in care and service management. They emphasize that these instruments are guided by guidelines of a clinical and organizational nature and are based and validated by studies and scientific evidence, in addition to incorporating new technologies in the services.

In this regard, aiming at the organization of RAS in the State of Amapá, specifically at this moment the Maternal and Child Care Network (RAMI), the Care Network for People with Chronic Non-Communicable Diseases (RDCNT) and the Urgency and Emergency Network (RUE) , it was observed during the accomplishment of a Situational Diagnosis the need to implement Protocols and Assistance Flows, as well as to carry out in-service training for health professionals in the municipalities of Laranjal do Jari, Vitória do Jari, Oiapoque, Cutias do Araguari and Amapá, thus aiming at qualification in the assistance provided to SUS users and the strengthening of the referred Networks in the State.

2 GENERAL OBJECTIVE

Implement Protocols and Assistance Flows of the Networks of Attention to Maternal and Child Health, Non-Communicable Chronic Diseases and Urgency and Emergency in the municipalities of Laranjal do Jari, Vitória do Jari, Oiapoque, Cutias do Araguari and Amapá.

3 METHODOLOGY

The research is descriptive with a qualitative approach of the Experience Report type, which according to Córdula and Nascimento (2018) is considered as a written expression of experiences, capable of contributing to the production of knowledge on the most varied themes.

First, the technical team of the State Department of Health – SESA, through the articulators of the Health Care Networks (RAS) and the management of Primary Health Care, carried out the Planning of the activities to be carried out in the municipalities of the State of Amapá. Subsequently, the team displacement processes and travel and activities schedule were set up.

A situational diagnosis of the RAS was carried out in the municipalities, which identified the main weaknesses and priority problems, which enabled strategic planning with actions directed towards service needs (PANTOJA; CARMO, 2021).

The logistics were organized by SESA and the Municipal Health Departments of the municipalities articulated the space and the convening of primary care professionals for the presentation of proposals and training. It is noteworthy that the displacement of the technical team took place by land and river as necessary to the municipalities.

The period of carrying out the activities in the municipalities took place during the year 2021, from March to December and the beginning of the year 2022 from March to April.

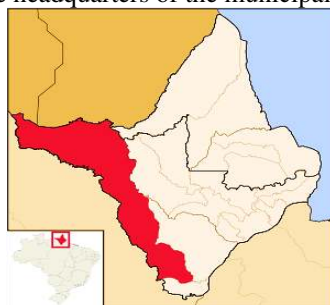
It is important to highlight that the process of state institutional support was established with the development of actions and activities through the use of active methodologies, delivery of guiding documents, presentation of proposals for Assistance Flows and Protocols and realistic in-service training, aiming at optimizing and qualification in clinical and care management, in addition to improving health indicators and strengthening RAS.

4 CHARACTERIZATION AND DEFINITION OF PRIORITIES OF THE MUNICIPALITIES OF LARANJAL DO JARI, VITÓRIA DO JARI, OIAPOQUE, AUTIAS DO ARAGUARI AND AMAPÁ

The municipality of **Laranjal do Jari** is the third most populous in the state of Amapá and has an estimated population of 52,302 inhabitants in 2021 (IBGE, 2021). The IDHM is 0.665, GDP per capita is 18,252.70 BRL. The infant mortality rate in 2019 was 23.2 deaths per thousand live births. The climate is tropical with an average temperature of 27.2 °C. There is significant rainfall in most months of the year. The annual average rainfall is 2244 mm.

The headquarters of Laranjal do Jari is made up of the following neighborhoods: Agreste, Mirilândia , Nova Esperança, São Pedro, Santarém, Sarney, Malvinas, Cajari , Centro, Samaúma , Castanheira, Nazaré Mineiro, Buritizal, Prosperidade, Sagrado Coração de Jesus.

Figure 1 – Map of the headquarters of the municipality of Laranjal do Jari.



Source: Pantoja and Carmo (2021)/ SESA - AP.

The Health Establishments of Laranjal do Jari that are included in the National Registry of Health Establishments (CNES) add up to a total of 26, with emphasis on those belonging to the public administration: 01 Hospital, 01 Emergency Care Unit Size I, 03 Health Posts , 10 UBSs, 01 SAMU Base (inoperative), 01 CAPS I (Hug me), 01 Specialized Center for Municipal Rehabilitation, 01 Clinical Analysis Laboratory, 01 Municipal Cold Network Center and 01 Municipal Imaging Center Maria Alice.

The municipality has 659 health professionals registered in the CNES. It has 20 Family Health Strategy Teams (FHSs) that work in Basic Health Units and territories covered, with 18 FHSs working in the urban area of the city and 02 teams working in the rural zone. In general, the ESFs have a total of 107 Community Health Agents (ACS), in addition to 14 Oral Health teams.

In this regard, it has 100% ESF coverage and 100% Primary Care coverage (e-GESTOR, 2021).

Vitória do Jari , in turn, is a municipality in the extreme south of the state of Amapá. 180 km away from the capital Macapá. It has an area of 2,508,979 km². Access is by land and river. It has an estimated population in 2021 of 16,572 inhabitants. The IDHM is 0.619, GDP per capita is 12,137.17 BRL. The infant mortality rate in 2019 was 10.27 deaths per thousand live births. The climate is rainy tropical. The maximum temperature is 34° and the minimum is around 20° centigrade. The municipality comprises the Vitória do Jari headquarters, the districts of Jarilândia , São João do Cajari and Marajó.

Figure 2 – Map of Vitória do Jari Municipality Headquarters.



Source: Pantoja and Carmo (2021)/ SESA - AP.

The Health Establishments of Vitória do Jari that are included in the National Register of Health Establishments (CNES) add up to a total of 12, with emphasis on those belonging to the public administration: 01 Mixed Unit (State Management), 02 Health Posts, 06 UBSs, 01 Psychosocial Care Center (CAPS I). There is no reference Hospital, Emergency Care Unit, Clinical Analysis Laboratory, Health Academy and Specialized Rehabilitation Center in the municipality.

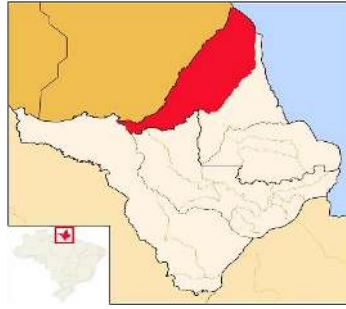
The municipality has 205 health professionals registered in the CNES. It presents as organizational health arrangements: 07 Family Health Strategy Teams that work in Basic Health Units and territories covered. In general, the ESFs have a total of 43 Community Health Agents (ACS), in addition to 06 oral health teams. It is worth emphasizing that the municipality also has 02 Riverside Teams registered, 01 team linked to UBS Aterro do Muriacá and 01 team linked to UBS de Jarilândia .

In this aspect, it has 100% ESF coverage and 100% Primary Care coverage (E-GESTOR, 2021).

The municipality of **Oiapoque** is the only city in Amapá that has an international border – it borders French Guiana, the French Overseas Department in South America. It has an estimated population in 2021 of 28,534 inhabitants. The IDHM is 0.658, GDP per capita is 16,003.40 BRL. The infant mortality rate in 2019 was 6.71 deaths per thousand live births.

The headquarters of Oiapoque is made up of the following neighborhoods: Beira Rua, Centro, Fazendinha, Infraero, Nova Esperança, Nova União, Oiapoquinho , Paraíso, Planalto, Russo, Teles, FM, SESC, Universidade, Vila Vitória, Vitória do Oiapoque. As districts: Clevelândia do Norte recognized area of military detachment of the army and Vila Velha. The following communities are still part of its territory: Ponte do Caciporé , Rio Cassiporé , Vila Brasil, Taperebá and other smaller (indigenous) villages such as: Aldeia do Manga, Santa Isabel, Espírito Santo, Açaizal, Urucaura , Incruzo , Flexa , Kumenê , Kumarumã

Figure 3 – Map of the Municipality of Oiapoque.



Source: Pantoja and Carmo (2021)/ SESA - AP.

The Health Establishments of Oiapoque that are listed in the National Registry of Health Establishments (CNES) add up to a total of 33, with emphasis on those belonging to the public administration: 01 Hospital, 05 Health Posts, 05 UBSs, 01 SAMU Base (inoperative), 01 CAPS I (Espaço Caridar), 01 Frontier Laboratory of Oiapoque (LAFRON) maintained by LACEN, 12 Indigenous Health Centers, 01 Home Health Unit for the Indian (Casai Oiapoque) and 01 Dental Care .

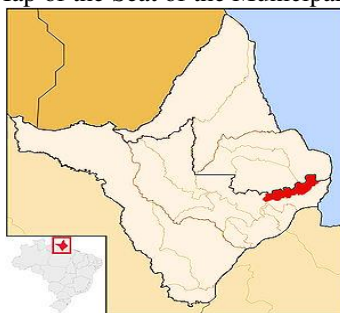
The municipality has 351 health professionals registered in the CNES. It has 06 Family Health Strategy Teams that work in the Basic Health Units and territories covered. In general, the ESFs have a total of 35 Community Health Agents (ACS), in addition to 05 oral health teams.

In this aspect, it has coverage by the ESF of 75.91% and coverage by Primary Care of 88.67% (e-GESTOR, 2021).

With regard to the municipality of **Cutias do Araguari** , it has an area of 2,179,114 km² with a distance of 163 km from the capital Macapá. It has an estimated population of 6,217 inhabitants in 2021 (IBGE, 2021). The IDHM is 0.628, GDP per capita is 12,993.99 BRL. The infant mortality rate in 2019 was 33.33 deaths per thousand live births. The predominant climate is tropical rain, with a short dry period and an average annual temperature never lower than 18 degrees Celsius. The rainfall reaches 2,800 mm of annual rainfall and the relative humidity is around 80%.

The municipality has 19 locations: Cutias (headquarters), Alegria do Araguari, Alta Floresta, Bom Amigo, Bom Destino, Bom Jesus do Araguari, I believe in God of Araguari, Deus Por Nós, Guanabara do Araguari, Gurupora , Jacitara, Liberdade do Araguari , Livramento, Marachimbé , Natal do Araguari, Nova Esperança, Pracuúba do Araguari, Sacred Heart of Jesus, Sacred Heart of Mary, Samaúma , São Paulo do Araguari, São Raimundo and São Sebastião do Pacuí .

Figure 4 – Map of the Seat of the Municipality of Cutias.



Source: Pantoja and Carmo (2021)/ SESA - AP.

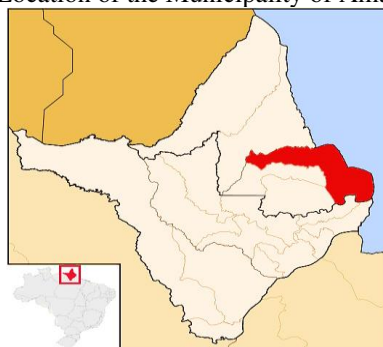
The Health Establishments of Agoutis that are included in the National Registry of Health Establishments (CNES) add up to a total of 10, with emphasis on those belonging to the public administration: 0 Mixed Health Unit, 04 Health Posts, 03 UBSs 01 Health Academy . There is no reference Hospital, Emergency Care Unit, clinical analysis laboratory, CAPS and CER in the city.

The municipality has 127 health professionals registered in the CNES. It presents as organizational health arrangements: 02 Family Health Strategy Teams that work in Basic Health Units and territories covered. In general, the ESFs have a total of 18 Community Health Agents (ACS), in addition to 02 oral health teams.

In this aspect, it has 100% ESF coverage and 100% Primary Care coverage (E-GESTOR, 2021).

Finally, the municipality of **Amapá** is located in the north of the state, 312 kilometers away from the capital. Access is by land, through the BR-156, as well as by sea and air. It has an area of 9,203.50 km². It borders the municipalities of Calçoene (north and west), Pracuúba (south) and Atlantic Ocean (east). It has an estimated population in 2021 of 9,265 inhabitants. The IDHM is 0.642, GDP per capita is 15,202.70 R\$. The infant mortality rate in 2019 was 11.83 deaths per thousand live births. The predominant climate is hot and humid. The maximum temperature is 34 °C and the minimum is 20 °C.

Figure 5 – Location of the Municipality of Amapá.



Source: Pantoja and Carmo (2021)/ SESA - AP.

The municipality of Amapá has the following communities: Amapá (headquarters), Santo Antônio, Vista Alegre, Raimundo, Volcão do Norte, Amapá Grande, Calafate, Piquiá , Cruzeiro, Cachoeira Grande, Sucuriju , Celso, Ilha Grande, Air Base, Paratu and Araguaiçaua .

The Health Establishments of Amapá included in the National Registry of Health Establishments (CNES) add up to a total of 15, with emphasis on those belonging to the public administration: 01 Mixed Unit (State Management), 01 Polyclinic, 06 Health Posts, 02 UBSs, 01 Health Academy Pole and 01 Diagnostic and Therapy Support Service Unit. There is no reference Hospital, Emergency Care Unit, CAPS and CER in the municipality.

There are 234 health professionals registered in the CNES. It presents as organizational health arrangements: 03 Family Health Strategy Teams that work in Basic Health Units and territories covered, with 02 ESF' developing their activities in the urban area of the city (Headquarters) and 01 ESF working in the rural area. In general, the ESF's have a total of 22 Community Health Agents (ACS) and 03 oral health teams.

In this aspect, it has coverage by the ESF of 37.87% and coverage by Primary Care of 37.87% (E-GESTOR, 2021).

Regarding the priorities observed in these 05 (five) municipalities, through meetings with Primary Care professionals, it was found that service needs and priority demands were: reorganization of services and work processes, definition of flows and counter-flows , connectivity of UBS's , modernization of assistance with the implementation of electronic medical records, construction of assistance protocols, training regarding the care of users with chronic non-communicable diseases, pregnant women, children and in urgency and emergency situations.

5 PROPOSALS FOR IMPLEMENTING TECHNICAL INSTRUMENTS IN THE CARE ROUTINE

According to the survey of priorities in the five municipalities, critical nodes and common demands related to the work process of PHC professionals were found, as well as the need to review these processes through new techno-assistance settings in health . In this sense, the RAS team and PHC Management selected Protocols and Care Flows that addressed these demands.

It is important to point out that the instruments presented as proposals are validated by the Ministry of Health and entities such as the Pan American Health Organization, the Brazilian Society of Cardiology, the Brazilian Society of Diabetes, the *American Diabetes Association*, the World Health Organization and States and Municipalities with experiences and successful programs, so adaptations were suggested according to the local reality.

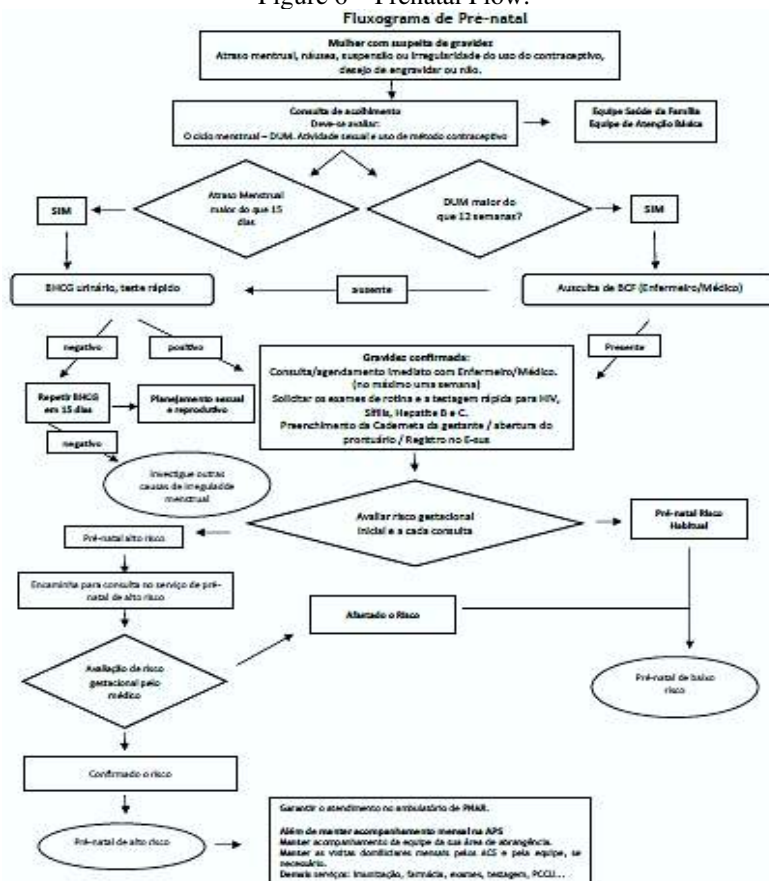
For training, health professionals and the management team of the municipalities received the printed and media instruments for implementation in the care routine. In addition, the SESA team used audio, video and computer equipment as extra resources for content fixation and the use of active methodologies such as gamification (use of the Kahoot[®] Q&A platform), problem tree and concept map .

The professionals who participated in the meetings are part of the PHC multiprofessional team, thus including doctors, nurses, nursing technicians, community health agents, physiotherapists, psychologists,

nutritionists, dentists, directors of Basic Health Units , Program Coordinators and health surveillance agents.

Thus, the Mother and Child Care Network presented the following proposals: the Prenatal Flow (BRASIL, 2012); Child Care Flow (BRASIL, 2009; BRASIL, 2014b; BRASIL, 2015); Primary Care Gestational Risk Classification Form (PIAUI, 2019); Protocols aimed at the Health of Children (Nursing Consultation for Childcare (COLOMBO, 2012) and Consultation Calendar (BRASIL, 2014b)).

Figure 6 – Prenatal Flow.



Source: Adapted from Brazil (2012).

Figure 7 – Gestational Risk Classification Sheet.

CLASSIFICAÇÃO DE RISCO DA GESTANTE NA ATENÇÃO BÁSICA

I - ORIGEM DA PACIENTE:
 UNIDADE DE SAÚDE: _____
 MUNICÍPIO: _____
 DATA DO ATENDIMENTO: ____/____/____

II - IDENTIFICAÇÃO:
 NOME: _____
 CARTÃO DO SUS: _____ Nº DA ESF: _____
 COR: BRANCA () PRETA () PARDA () AMARELA () INDÍGENA ()
 ESTADO CIVIL: CASADA () UNIÃO ESTÁVEL () SOLTEIRA () DIVORCIADA () OUTRO ()
 ENDEREÇO: _____ DATA DE NASCIMENTO: ____/____/____ IDADE: _____

III - ASSINALE COM CÍRCULO O NÚMERO CORRESPONDENTE A RESPOSTA:

1. IDADE:	PONTUAÇÃO	8. ANTECEDENTES OBSTÉTRICOS	PONTUAÇÃO
< 15 anos	2	Abortos espontâneos < 3	5
de 15 a 19 anos	1	Abortos espontâneos 3 ou mais	10
de 20 a 34 anos	0	1. Natimorto/prematuro/ôbito perinatal	5
> 35 anos	1	Mãe de 1 filho prematuro / natimorto	10
		Cesária 3 ou mais	5
		Pré-eclâmpsia leve	5
		Pré-eclâmpsia grave	10
		Eclâmpsia	10
		Placenta prévia	5
		Descolamento Prematuro da Placenta	5
		Incompetência Íntima Cervical	10
		Restrição de Crescimento Intrauterino	5
		Malformação fetal	5
		Último parto < 12 meses	2
		Intervalo Interparto < 5 anos	5
		Trombose Venosa Profunda/Embolia	10
		Estérilidade/Infertilidade	5

2. RENDA FAMILIAR per capita:	PONTUAÇÃO	9. PATOLOGIAS NA GESTAÇÃO ATUAL	PONTUAÇÃO
Até 1/3 salário	1	1. OBSTÉTRICAS e GINECOLÓGICAS	
2/3 salário	0	Doença Hipertensiva da Gestação	10
		Diabetes Gestacional	10
		Câncer Maligno	10
		Citologia Cervical Anormal (NIC II-III)	10
		Nódulos à palpação mamária	10
		Placenta prévia	10
		Ischemização	10
		Malformações Fetais/ Arritmia fetal	10
		Restrição de Crescimento Intrauterino	10
		Poliâmnio/Oligotamnio	10
		Gêmeos múltiplos	10
		Incompetência Íntima Cervical	10
		Ameaça de Aborto	5
		Anomalia do trato Geniturinário	5

3. Avaliação da GRAVIDEZ	PONTUAÇÃO	2. OBSTÉTRICAS e GINECOLÓGICAS	PONTUAÇÃO
Alta	0	Doença Hipertensiva da Gestação	10
Não Alta	1	Diabetes Gestacional	10

4. ESCOLARIDADE - alfabetizada	PONTUAÇÃO	3. OBSTÉTRICAS e GINECOLÓGICAS	PONTUAÇÃO
Sim	0	Câncer Maligno	10
Não	1	Citologia Cervical Anormal (NIC II-III)	10

5. HÁBITOS	PONTUAÇÃO	4. OBSTÉTRICAS e GINECOLÓGICAS	PONTUAÇÃO
Tabagista	2	Nódulos à palpação mamária	10
Etílico	5	Placenta prévia	10
Drogas (cocaína, crack, outras)	10	Ischemização	10

6. FATOR RH	PONTUAÇÃO	5. OBSTÉTRICAS e GINECOLÓGICAS	PONTUAÇÃO
Negativo	4	Malformações Fetais/ Arritmia fetal	10
Positivo	0	Restrição de Crescimento Intrauterino	10

7. AVALIAÇÃO NUTRICIONAL	PONTUAÇÃO	6. OBSTÉTRICAS e GINECOLÓGICAS	PONTUAÇÃO
Baixo peso (IMC < 18,5 kg/m ²) e/ou ganho de peso inadequado e/ou anemia	2	Poliâmnio/Oligotamnio	10
Peso adequado (IMC 18,5 – 24,9 kg/m ²)	0	Gêmeos múltiplos	10
Sobrepeso (IMC 25 – 29,9 kg/m ²)	2	Incompetência Íntima Cervical	10
Obesidade (IMC > 30 kg/m ²)	5	Ameaça de Aborto	5
		Anomalia do trato Geniturinário	5

II. MÉDICAS E CIRÚRGICAS

MÉDICAS E CIRÚRGICAS	PONTUAÇÃO
Hipertensão Arterial Crônica	10
Diabetes Mellitus/Endocrinopatias	10
Cardiopatias	10
Pneumonia Grave	10
Doenças Autoimunes (Colúdenose, lúpus)	10
Doença Renal Grave	10
Epilepsia/Doença Neurológica	10
Doenças Hematológicas	10
Infecção Urinária de Repetição	10
Infecções Graves	10
AIDS/HIV	10
Hepatite B	10
Tuberculose/Hanseníase	10
Toxoplasmose	10
Alterações Genéticas Maternas	10
Doenças Psiquiátricas	5

CLASSIFICAÇÃO DE RISCO

CLASSIFICAÇÃO DE RISCO	TOTAL DE PONTOS
Vermelho Alto Risco	≥ 10
Amarelo Médio Risco	De 5 a 9
Verde Baixo Risco	≤ 4
TOTAL	

IMPORTANTE
 Fatores socioeconômicos não são critérios isoladamente para encaminhamento ao PNAR¹. Mas, garantem o atendimento diferenciado na Atenção Básica.

ALTO RISCO: somatório de 10 ou mais pontos, encaminhar ao PNAR.
MÉDIO RISCO: somatório de 5 a 9 pontos, atendimento com calendário de consulta diferenciado no PNRH.
BAIXO RISCO: somatório de até 4 pontos, atendimento com calendário de consulta preconizado no PNRH.

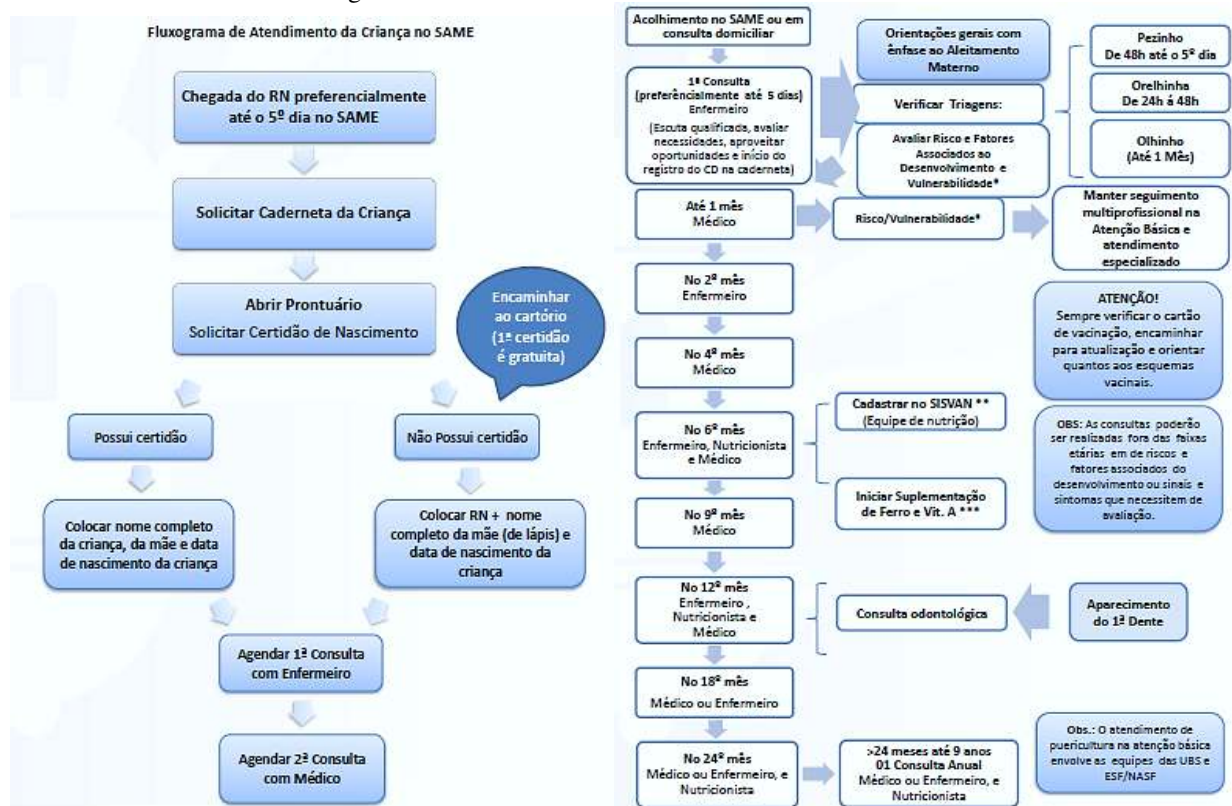
O atendimento no PNRH deve intercalar consultas médicas e de enfermagem.

1. PNAR - Pré-natal de Alto Risco; 2. PNRH - Pré-natal de Risco Habitual

Profissional Responsável
 (Assinatura e Carimbo)

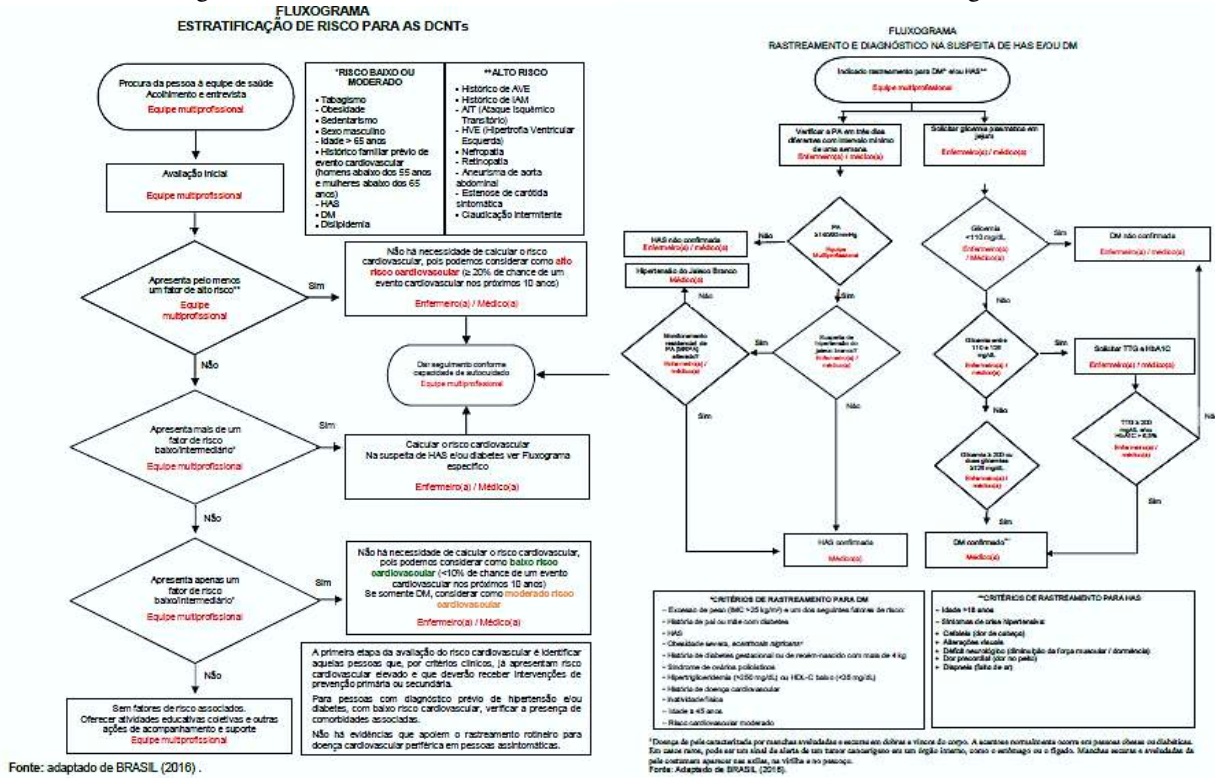
Source: Adapted from Piauí (2019).

Figure 8 – Child Care Flow and Consultation Schedule.



Source: Adapted from Brazil (2009), Brazil (2014b) and Brazil (2015).

Figure 10 – Risk Stratification Flow for CNCD and HAS and DM Tracking Flow.



Source: Adapted from Brazil (2016).

Figure 11 – Assessment Instrument for Diabetic Feet and Applications for Cardiovascular Risk.

Como avaliar os pés dos pacientes diabéticos?
 Teste do toque nos dedos dos pés, ou Ipswich Touch Test



Aplicativos da SBC
 para plataformas Apple e Android

CardioRisco Framingham 2020
 Calculadora ER 2020

Se o paciente sentir cinco ou seis dos seis toques realizados, sua sensibilidade é normal e não há risco aumentado para problemas nos pés causados por alterações da sensibilidade. Reavaliações anuais devem ser programadas para todos os portadores de diabetes com sensibilidade normal nos pés.
 Se o paciente não sentir dois ou mais dos seis toques é muito provável que sua sensibilidade esteja reduzida, o que pode significar risco aumentado para ulcerações.

Source: Adapted from ADA (2015) and SBC (2020).

Figure 13 – Materials and equipment used in urgency and emergency training.



Source: RAS/SESA-AP logbook (2021).

The proposals for protocols and flows presented to the PHC in Laranjal do Jari, Vitória do Jari, Oiapoque, Cutias do Araguari and Amapá provided support both for service managers as a guideline for the implementation of public health policies and for health professionals so that develop the work with more autonomy and resolution in the different ministerial programs and life cycles.

In this aspect, the moments of permanent education planned and conducted by the state RAS according to the weaknesses provided by the Situational Diagnosis, promoted dialogue between professionals and their respective management teams, seeking to build strategies and use innovative practices in care to the user.

Proof of this is the inclusion of applications via ' *smartphone* ' in consultations for the evaluation and monitoring of chronically ill patients, which optimizes the time of care and guides professional conduct based on scientific evidence. The *CardioRisco Framingham 2020 application* [®] and *Calculator ER 2020* [®] , for example, in addition to allowing the calculation of cardiovascular risk, provide information on the platform regarding physical activity, medication and return time for a new evaluation.

The results of the work developed can still reflect positively on the improvement of health indicators, on the degree of user satisfaction, on the quality of care, on the quality of reception and risk classification, on the reduction of waiting time during consultations, on the reduction of referrals to referral services unnecessarily, in reducing the worsening of the conditions, in the reduction of mortality rates and sequelae, in the organization and strengthening of the RAS, in the greater adherence, retention and connection of the user to the services, in the degree of commitment of professionals, in stimulating the

discussions of cases considered complex in the territory through the use of the Singular Therapeutic Project, among others.

The use of care flows as graphic tools of the work process, such as those presented by RAMI and RDCNT, demonstrate the steps to be followed by the professional and user, that is, the sequence and interaction of activities, in addition to creating standard norms for the execution of the processes. It is noteworthy that, when they are implemented, the flows allow professionals to also identify the flaws and weaknesses in the process, seeking to resolve them.

The training by RUE sought to fill possible deficiencies and gaps in the training of professionals on the subject. During the survey of problems in the municipalities, the need for qualification and training for care in urgent and emergency situations was unanimous. Health professionals, even working in PHC, must be prepared to recognize the signs of severity and physiological instability of the patient, aiming at the stability and early intervention of the condition. Due to the geographical distance of some municipalities to the capital Macapá, which concentrates the most complex services, professionals must understand aspects of prevention of risk factors and situations in communities and, if necessary, proceed with the safe transport of the patient. In addition, the professional must know how to use equipment that assists in ventilatory management, monitoring and defibrillation when necessary, preventing the worsening of the condition and death.

6 FINAL CONSIDERATIONS

One of the main actions developed and perhaps the most significant of Institutional Support was to make PHC and its actors see themselves as coordinators and organizers of the Health Care and Care Networks, since all the wear and tear in relation to the various work fronts and the various problems of the territory often lead actors to “put out fire”, restricting the moments of planning, evaluation and monitoring of actions.

Following this assumption, the process of state institutional support was established with the development of actions and activities through the use of active methodologies, health applications used by smartphones, delivery of guiding documents, presentation of Proposals for Flows and Assistance Protocols and training realistic in service, aiming at the optimization and qualification in the management of the clinic and care, in addition to the improvement of health indicators and strengthening of Health Care Networks in Amapá.

In this context, it was possible to promote the reorganization of work processes and establish discussion and connection between the professionals of the multidisciplinary team and the management team, resulting in improvements in communication and more lightness in actions, which began to be shared as an actor understood that their doing is linked to the doing of the other, finding similarities and empathy, and with that the user is once again the main target of actions and care.

It is imperative to highlight the local difficulties with a view to a territory full of peculiarities as they are Amazonian municipalities, one of them borders a European territory, which is the case of Oiapoque, and another with the State of Pará, which is the case of Laranjal do Jari. In view of this, it was of fundamental importance to carry out the Situational Diagnosis of the five municipalities, which made it possible to highlight the main weaknesses faced and on top of that interventions were drawn up with a focus on improving these weaknesses.

Finally, it is timely and opportune to report this successful experience as a moment of sharing ideals and strategies based on scientific evidence, directing services and actions in a “surgical” way due to the urgency required at the moment. In addition to promoting transversality between the actors involved.

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