HEARING HEALTH NETWORK CHARACTERISATION IN A SPECIFIC REGION OF SANTA CATARINA STATE

Caracterização da rede da saúde auditiva de uma regional de saúde de Santa Catarina

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ABSTRACT

Purpose: professionals and services characterize who compose the municipal and regional network for hearing health levels related to the Basic and Specialized Attention. **Methods:** qualitative research, which has used the universe related to hearing health people involvement. Questionnaires were applied to managers and speech therapists; identify the subjects focus and actions developed with the indicated cities hearing impaired. The inclusion criteria were: act in the Health System, accept the research participation, have at least three months of experience with attendance, plus users Hearing Health Service guiding. Later, they had been invited, to participate in a workshop for returnable data`s questionnaires feedback and quarrels. The used method treatment data came from the workshop`s quarrels and the speech analysis content, identifying from the following categories: The cities structure for the Hearing Health Attention; the professional performance front for Hearing Health Attention; and networking organization. **Results:** it was identified that 45% managers have less than a year in the field, 82% patients in the basic attention were identified not having receive any accompaniment and 81.9% speech therapists are centered in the specialized care. **Conclusion:** most of the speech therapist and otolaryngologists doctors are centered in the specialized care. The majority of cities don't have actions directed to the hearing deficient accompaniment which that means; it doesn't have an articulated support to supply the users for a basic care accompaniment. There is a rigid and vertical flow. The patient with hearing complaints is led to the service reference.

KEYWORDS: Management in Health; Primary Health Attention, Hearing

INTRODUCTION

Through The Hearing Health National Politics – An Ordinance **nº 2,073 of 28/09/2004** was published for implementation direction lines – The Hearing Health Attention Services was created, in order to regulate the hearing deficiency people attendance. The hearing health politics appeared because, the high cost procedures for the hearing recovery, execute the process necessity for the hearing[1] deficiency citizens regulation, evaluation, attention and control of these population access and condition.

The attendance must be interdisciplinary and compatible with the individual necessities and collective with the hearing deficiency, promotion, prevention and rehabilitation attending actions. The hearing health promotion strategy for the Health System Department (SUS) was the Hearing Health Attention State Networking creation. These composed networks for Hearing Health actions for Basic Attention, is for Median and High Complexity. The Ministry of The Health Department, by the Ordinance 793, April, 2012 form instituted the deficiency citizen's network cares in the SUS ambit which foresees the rehabilitation care network centers – CER. This Ordinance revoked the Ordinance 2017/GM/MS and 587/SAS/MS. However, the accredited Hearing Health Services had not adhered to the CER they are continue being prevailed for Ordinance 587/SAS/MG.

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The SUS's door is the basic care entrance. The qualification is necessary; therefore it must guarantee the universal[2] access, for the integral care coordination, and also taking care of 85% cases resolution reaching an ample practice. That means, none of the basic attention health care network will be strong enough if don't get any resolution.

However, a health network cannot be structuralized by a regionalism, hierarchically and organize, following a rigid flow, not taking care of the people necessities who search the service. The north axle of the actions must be integrity, surpassing the organized and hierarchically structure to act in a fragmented and articulated[3] health.

This way, this research appeared beyond necessity of knowing the professionals who compose the health network, as well as the services and actions taken, aiming to the process improvement of contra reference of the user, as well as the knowledge concerning the same will find the basic attention support.

In the present article, the manager profile will be presented, professionals and services which compose the Santa Catarina regional health network. The research objective was to characterize the municipal and regional professionals for the Basic hearing health network service and the Specialized Attention.

METHODS

The present study is the analysis from 11 cities data which the total is based on a qualitative research. It was used the involved people universe from the hearing health management, the analyses and collection came from Santa Catarina Health Regional studied, and belongs to the Hearing Health Attention Service – SASA. The ethical dimensions had followed the Resolution 196/96/CNS, being this research approved by the University Ethics Committee in Research of Valley of the Itajaí-SC, under the number 466. A assent of free term and clarified to the citizens was presented, explaining the objectives. The citizens had signed two different terms of assent: one was presented at the moment for data collection questionnaire and the other in the workshop, where an authorization was requested for recording.

The research process foresaw an electronic questionnaire application for professionals and/or the user's responsible leading for basic attention who receives the hearing health attendance from the reference service. It had the purpose to identify the involved authors from the hearing health network organization regional which guides the users to the Hearing Health Service of – SASA, beyond mapping and analyzing the network structure. However, as it didn't have any reply for the questionnaires sent, a telephonic contact was made with the cities, identifying the hearing health responsible, and the instrument personally was applied. The participation and reply came from all cities. The Health Hearing Service Management Representatives – SASA and speech therapists had participated on the research.

The inclusion criteria had been: to act in the SUS, Accept the research participation, have at least three months of attendance experience and guiding the SASA users.

The first questionnaire research stage contained multiple choice questions and open questions. It was related to the number of speech therapists and otolaryngologists in the cities; the programs that involve hearing in the different populations question; the hearing health organization network; the hearing health reference and against reference and the basic attention accompaniment users.

It is important to clarify the citizens that had been part of the research, and those who were the city hearing health responsible for the moment, or those that felt more prepared to answer the questionnaire and, later, they had participate the workshop. It is important to stand out, not only the people who had answered the questionnaire were participating at the workshop.

The second composed stage was for the workshop accomplishment, where they had been presented, findings and improvements arguments for that regional of the network Hearing Health organization. Seven cities had appeared, represented for managers and/or speech therapists.

The workshop was organized from the following form: initially the reasons had been presented by taken the study accomplishment. Later, the questionnaires analysis was presented, in descriptive way, not being the results collated with literature. In the sequence, it had a time for reflection, discussion of the findings and qualifying questionnaires information.

The workshop was recorded, transcribing and categorized from content speech and analysis proposal: pre-analysis, material exploration, results and interpretation treatment. The results were been argued and based from the National Politics of Hearing Health theoretic and referential and also from the Networks Health Attention document

In the following, will be show the Results and Quarrels. The following form organization: the speeches and quarrels questionnaires results and exhibition which was generated during the workshop presentation data.

The interviewed, speech therapists and managing professionals had been identified in their

speech by their profession initial letters and numbers (F1, G1, F2, G2…). The cities had been identified by M and numbers (M1, M2, M3, M4, M5….). The researcher was identified by (p). For researcher request others two speech therapists was participating , one involved with the basic attention and the other was from the Hearing Health Service management – SASA, so that they could assist in the quarrel and problems findings involved . These had been identified by C1 and C2.

RESULTS AND DISCUSSION

Hearing Health Structure Attention in to the Cities

The first question was to know how long time the citizen occupied the hearing health manager position. It was verified that 45.5% of them occupied the position for less than one year; 9% were in the position between one to three years; 9% between three and five years; and 36.5% was in the position for five years or more.

It can be observed, that great part of the citizens occupies the manager position for less than one year, what could be one of the hearing health network problem; the people's function rotation compromises the service course. We believed that the new manager finds difficulties to adjust, to understand the network and even though to consider improvements.

A recent study, considered that the current managers possess a simplistic vision for operation health services, also an unpreparedness of these professionals to assume the position which influence directly to the network operation, the public[4] service critical part is unprepared management.

Another question refer the existence for programs that must contemplate the hearing health referring actions in the cities, amongst them, are cited: neonatal hearing selection, individual school health, the worker health, the aged health, among others. These programs are the basic attention part and had been considered by the Government Health department in order to prevent hearing problems still in the basic attention. The fact preoccupation is that the population attendant from them can develop some hearing deficiency and these programs; it should propose strategies to the basic attention to evaluate and prevent such problems.

As it points Table 1 in the basic attention programs the biggest attendance are the hearing neonatal selection and aged health. Already the health program of the pertaining to school, worker's health and the Worker's Health Center of Reference – CEREST appear in lesser percentage.

Table 1 – Programs directed toward hearing health in the basic attention

	Hearing selection		School Pertaining Health Program		Worker Health Program		Aged Health Program		CEREST	
	N	%	N	%	n	%	n	%	N	%
City possess	7	63,5	4	36,5	4	36,5	7	63,5	4	36,5
City does not possess	3	27,5	4	36,5	4	36,5	3	27,5	6	54,5
It didn't know To inform	1	9	3	27	3	27	1	9	1	9

* CEREST = State center of Reference in the Worker's Health

The hearing selection relation is observed that only 63.5% of the cities carry through the examination, although the existence of Federal Law 12,303/10 that compels all the maternities and hospitals to carry through the examination for the just-been born before lives the hospital[5]. However, some cities affirm that they carry through the examination; some cities affirm that don't have the necessary equipment.

There are biggest cities partnerships which possess the equipment, for the exam accomplishment. 18.5% only carry through the examination in the city hospital. Others 9% direct for the Hearing Health Service Attention – SASA and 9% didn't know how to answer the question. However, this result is that only 18.5% of the cities possess maternity.

Regarding to the program Pertaining School Health, was observed that 36.5% of the cities affirm to have the program implanted, but only 27% give directed actions toward hearing health, amongst them the school hearing selection. And 36.5% do not possess the program and also 27% of the citizens didn't know how to answer.

When questioned about the Worker's Health implantation program only 36.5% of the cities affirm to have it, but none possess speech therapists acting. From this total, 18.5% give to the population audiometric tests, for the specialized attention; 9% carry through the audiometric tests in credential clinic to the SUS and 9% do not carry through the workers occupational audiometric tests. Another deserves quarrel point is the way the cities placed these professionals, as shows Table 2.

Table 2 – Distribution of the professionals in the cities

Cities	possess		do not possess		NASF		Specialized attention		Hospitals	
	n	%	n	%	n	%	n	%	n	%
Speech Therapits	11	100	0	0	3	27,3	9	81,9	1	9
Otolaryngologists doctors	4	36,5	7	63,5	0	0	4	100	0	0

* NASF = Nucleus of Family Health Support

It is verified that 100% of the cities possess speech therapists. The biggest number of professionals in a city was seven and the index population was above 184 thousand inhabitants. Others five cities, with population between 10 and 63 thousand, possess only one speech therapist acting in the specialized health. From this total, 81.9% of speech therapists and 100% of the doctors are concentrated in the specialized attention. Some speech therapists of these cities, beyond acting in the specialized attention, carry through concomitant work with two or more places, and also in the Nucleus of Health of Family Support – NASF (27.3%) and in the hospital (9%). The biggest part of these professionals act in their specialty at most of cases so this way the access to these services for the population becomes more restricted. The health services access is inequality and one of the main problems to be faced for the SUS[6] effectiveness. It is possible to guarantee universal access and equitable by the compromise between politics formulators and with a pact with the instances of power. It is necessary to consider the economic-social dimension, analyzing the public network investments from different attention levels, fortifying the basic attention, organizing the appointments flow, for the demands of social and sanitary epidemiologist. Moreover, it is necessary the access facilitating inside the geographic limits of each social territory, integrating practical services and also the SUS[6] network for reference and against reference. These dimensions are the efficiency base and resolution effectiveness for the population health necessities, having as objective image a resolute attention, responsible, integral, and more quality[6] equal.

One of the challenges, beyond the access, seems to be the proper city[7] integration services. The completeness can assign for too many dimensions and directions, sometimes as the axle services integrator, sometimes as citizen holistic vision, for care or demands for necessities as integral attendance action, among others.

The hearing health for professionals Performance front

Another aspect raised from the questionnaire mentions was cleaning the patient's ear wax, since the hearing device use tends to increase the wax production. The evidenced is 63,5% of the cities are the general physician who carries through such procedure; 18,25% is the otolaryngologists; 18,25% the general physician does not directs the patient to another city where have a otolaryngologists. The observation is follow from a conversation below and also more quarrels are observed from questions:

> G3: *"This I can say, in our city the physicians I don't do this anymore! They say that they cannot do it any more".*
>
> F5: *"Back in the M5, our otolaryngologists, people have 3 vacant for otolaryngologists here of M6, the general physicians they refused, but now the general physician of the health center is making, because people have few vacant for otolaryngologists, and if people bean direct alone just to make wax*

removal so will be no vacant. Is there a Doctor who does this?"

G3: *"This is all cities problematic"!*

However, the question of the removing the ear wax is a preoccupying factor, because not all doctors are carrying through the procedure or they don't feel secure to do it. The removing the ear wax problem gives the impression to the citizens for them to start reflecting regarding the lack of otolaryngologists doctors in the cities and, in turn, a long queue for consultation with this professional, as it can be observe on the speech below:

P: *"Then we have to think how long they have to stay in the queue to remove the wax and know how is the queue in some other city where there is a doctor who does do the removing wax"!*

G3: *"My God! It is taking too long; we do have a lot waiting in line for otolaryngologists, separate from the hearing health and that is when the speech therapist or doctor requests separate audiometric tests, understood? The queue for otolaryngologists is one! And for hearing health is another."*

The health services recurrent question is lack of doctors and otolaryngologists. When searching the southwestern region of São Paulo[8],on the health services the resolutely is the authors had detached the biggest problems ratio decided in the basic attention is not the nervous system referring ones and the directions of agencies were they found ear infections. Still with regard to health[8] services resolutely the authors affirm that the same one can be evaluated by two aspects: **the proper inside service** – the capacity is mentioned to take care of the demand and only direct the cases that need inside specialists and **the health inside system** – that for the basic attention the first consultation extends until the problem solution. For other levels attention, according to the authors, the resolutely involves aspects as: the demand, satisfaction of the customer, a technologies services, a preset reference system, accessibility, the human resources formation, the population health necessities, the adhesion treatment, the clients cultural and social-economics aspects, among others.

Beyond the otolaryngologist's doctor difficulty access for consultation, the cities representatives had identified the regional discrepancies, characterized for the difference for medical access services, as we can observe in speech below:

G2: *"We are here trying to decide for the hearing device but the pour ones do not have even an otolaryngologist"! "Just look at! People see here the difference inside of the proper region, people came here, because they have the biggest problem of the hearing health which is the device, but also we can see here there are cities which don't even have an otolaryngologists"!*

G4: *"Probably the city that has otolaryngologists and make the examination also will have a well bigger queue from doe's cities which even can take the wax out.*

The G2 speech deserves attention, since that the ordinance hearing health foresees to the basic attention should must have the accompaniment for the users and, we understands, the removable ear wax also must be done by the cities.

In the east region of São Paulo, authors[9] had found the same citizens access difficulty pointed at present research. They affirm that many users needed to dislocate themselves to other city regions for otolaryngologist's specialty to be taking care. In this case the hearing health service patient a very long queue would be necessary in order to get entrance,

The influence for other factors for health service access are: the good medical attendance and general attendance, the marking consultations easiness and housing proximity, the friends indication aspects, neighbors, or bond with the professional and reducing the expense with tickets that's what the users[10] had been pointed.

Still the professional's regarding the performance front the hearing health evidenced, that only 54.5% the cities possess the NASF implanted or are in the implantation phase, the others 45.5% cities do not possess. It is important to add, the NASF none implantation reason was not questioned to the citizens. However, from this article's speeches, also observing when the NASF exists in the cities they are not giving the right support as it would. Observe in the following speeches:

G3: *"Doesn't exist against reference, for example, I do make a reference to SASA, you send back to me and I would not have to return or reply a response from this patient back to you. So this doesn't exist, it doesn't happen"!*

According to the Health Family Nucleus Support – NASF Ordinance Nº 154, from 24 of January of 2008, has as objective to extend the basic attention coverage and finishing the actions, as its resolutely,

supporting the Health Family Strategy insertion in to service network. It must act in partnership with Health Family Strategy Teams – ESF professionals, sharing with responsibility for health practical and territories, working directly to the ESF support, extending the process actions for the Basic Attention with a longitudinal responsible team accompaniment, acting in the strengthening of its attributes and care for the SUS[11]coordination.

Another question searched was how long is the existence of the Health Family Strategy – ESF in the cities or if there are none. The Health Family Strategy can be a way for SUS consolidation; investments are necessary for the team's instrumentation, to act for the health[12] system logic new organization.

It was observed that 100% of the cities possess ESF, but concerning its covering was not questioned. During the presentation of the questionnaires manager's results a citizen raised, the investigation importance for the ESF covering in the cities, as it follow:

> G2: *"Perhaps it was interesting to consider in its work, the cities with family health covering or not, from there it will be a little, for example, back in our city the covering is 70%".*
>
> F1: *"But, example, M1, our covering is low because we are in downtown neighbor hood, then it is not possible to have ESF therefore we do not have the opportunity to have the NASF because we don't have strategy and space for building in that neighbor hood".*
>
> P: *"Really, I didn't approach in the questionnaire about this question related to ESF covering!"*

The importance to know the covering also becomes related with the NASF existence, the necessity for a bigger covering is 50% which is half of the system implantation, thus justify the existence of only 54.5% of NASF.

Network Labor organization

The Government Health department brings decentralized performance form as proposal for the networks, a way to articulate the work processes and relations between the different professionals for the population care. The Humanization should be as a deep cloth of the actions but the teams should be prepared to deal with the subjective dimension for practical and daily professional. The health organizations must be the production spaces for the user's goods and services, as well as potential valuation services spaces for diverse actors: managers, workers and users[13].

In relation to the hearing health access the evidenced that 90% of the cities queue exists. In relation to the priority in the organization and referrals to the hearing health it was verified that 46% of the cities obey the state operative plan deliberation, prioritizing the children, 59 years active workers and up according to place and aged. 9% of the cities affirm to always prioritize the children and 9% always prioritize the indicated doctor as urgent cases.

With the Brazilian increasing aging population, it is evident the necessity of bigger preparation and planning for the aged health services care. These users need bigger health system completeness and agility, because they do have difficulties in the use, on the health services access and displacement, the inadequately view of the attention model that they are deeply living, verifies the public politics necessity take a population specifics account, reducing these inequalities [14-16] and facilitating the access.

The regulation in the hearing health access is tied with the organization and control flows in order to prioritize the services access, on the protocols basis or risk classification. The inherent actions between these regulations are distinguished along construction and fulfillment for the reference and against reference, physical and financial control limits on the services[9].

Regarding the basic attention for patient accompaniment who receives the hearing deficiency diagnosis from reference service, that 82% of evidenced shows that they do not receive accompaniment form basic attention; and 9% affirm the otolaryngologist's doctor makes the patient's accompaniment in the specialized attention; 9% affirms that only the children receive the basic attention accompaniment.

What can be observe during the hearing health network quarrel data that is not organized and/or articulated to supply the accompaniment, as is demonstrated by the dialogue as follow.

> F7: *"Well let me understand! Can you make this, do you install the prosthesis and are they making a guiding for me".*
>
> G5: *"A against reference?".*
>
> F7: *"Yes, an against reference, Can you make this for me? That's what we were talking about! Do you make this for me? Can you send that aged man, a look! Just go to that speech therapist from M7! Can you do this for me?*
>
> P: *"Yes! Those cities that we have, as I can say, this bigger contact, of this support, the speech therapist already has updated, hour and place to take care of this demand of*

AASI users, then people already make this guiding".

F7: *"Ah! Oh! That is nice"!*

G2: *"Heim! (it nominates the researcher) there is any way for the city request the speech therapist receives some more training, or something like, the devices that are being used, what can be move and what cannot".*

P: *"Yes, certainty, this is the idea, some cities already had requested, it comes with the patients and little by little some already had been enabled, right? But the idea is that it happens for all".*

For the speeches above it is possible to verify that the basic attention professionals do have interest to give the hearing deficient's accompaniment, they request one against reference from the Hearing Health Service – SASA the user returns to the city for the accompaniment. The companying ship of the patient with hearing deficiency must be give as close as possible of the residence and also for basic attention from speech therapist. Moreover, to guarantee the effectiveness of the user's devices, the most efficient method is accompaniment, and it has been a great challenge for managers and executores[17]. The basic attention teams, as well as NASF, can appeal to executores[17] the technician teams support for services and attention from average hearing health complex ability, requesting the technician qualification of the basic attention professionals support, the way it should be use, and also the hearing device doubts, among others.

The users of hearing device accompaniment must be carried through in the basic attention, as Ordinance GM/MS, nº 2,073/200, nº 587/2004, and nº 589/2004[18]. However, the present study demonstrated that only 18% of the patients receive accompaniment basic attention; 27.5% of the cities make the children basic attention accompaniment; 36.5% do not receive basic attention accompaniment; 9% didn't know how to inform and 9% had affirmed they don't do it, but if the family looks for, the city will supply the accompaniment.

Another reason rose from the citizens, the basic attention accompaniment lack from the users, and seems to be related for low adhesion, as it can be observed in the speeches below:

C1: *"That's when the accompaniment importance, this stage comes to have the accompaniment, they had said right?*

G3: *"the accompaniment right?".*

C1: *"Then, he made the diagnosis and already made the contact but from what you are saying the adhesion is low, right? Well, they are not looking for? Or perhaps they have the idea from prosthesis which will resolve everything, right? They don't come back, they don't go to the speech therapist, is that right?*

C2: *"it has little adhesion?".*

F5: *"ooh! Few come back, we direct 10, 4 or 5 returns, the remained, we....."*

C2: *"Yes, but I think this is good 10, 4 or 5 it is very good, because from our experience with other cities, as well another regional's are very good, You know! For example we have a city that follows 250 patients.*

F5: *"ooh"!*

C2: *"Is that so, they have register, they had made a system group, right? It is not the way that it appears to be, the 250 people don't come here every week, right? But these 250 had passed the accompaniment groups; they become reference for these patients. So when they come to the service here for the monthly accompaniment, which is a monthly meeting, first, the group and then later just an individual. For this monthly return, it has one speech therapist, a psychologist and a social assistant and then they ask the citizens, Oh! People who are from that city go find the speech therapist back in the central office, which is their unit, it is their reference. The adhesion is very good, so it works this way! The adhesion delays a little, sometimes takes little time until create a bond, but it comes!"*

C2 (it continues): *"a research is being made here, what is happening, they believe the device doesn't have anything to do with the health unit, understood? This is in the SASA, they don't even talk of the health unit who use the device, the unit is one thing and the device is another, the UBS is for one thing and the SASA is to another, understood? Perhaps this can justify".*

The stories above demonstrate the users' bond with the Hearing Health Attention Service – SASA this way they don't even look for the basic attention to get a solution, or even the necessary accompaniments. To guarantee the hearing[4] health accompaniment effectiveness, some factors can be facilitated at the origin city for the user they will have a professional speech therapist with responsible reference for shelter, therapies and guidance. We believed the user access for the basic attention professional will be easier comparing to the SASA access, making it possible, for service reference for small problems or guiding resolution when necessary.

With the SUS construction process the cities have assumed the responsibility for townspeople health attention. The access as the possibility of the continuity care in accordance with the necessities, it has interrelation with the resolutely and surpasses the geographic dimension, enclosing aspects of economic order, cultural and services functional offers. But for this, qualification access becomes important, including aspects of organization and dynamics for the work process, considering the contribution and analyses importance of some aspects. Access and shelter are articulated for implantation practical and complement, with sights in completeness[19].

CONCLUSION

With the hearing health network characterization for Santa Catarinas' health regional it was possible to verify that most part of the speech therapists and otolaryngologists doctors is centered in the specialized attention, making the population access difficult for these professionals. the users relation accompaniment who receive the diagnosis from hearing deficiency, as well those who had received from the service reference hearing prosthesis, there is an evidenced that 82% do not receive basic attention accompaniment, the hearing health network is not well organized and/or articulated to promote such action. That means a rigid and vertical flow exists. The hearing complaints from patients are directed to the service reference. However, we believe the service reference and basic attention research contributed for a bigger approach and organization.

RESUMO

Objetivo: caracterizar os serviços e os profissionais que compõem a rede da saúde auditiva no âmbito municipal e regional em relação à Atenção Básica e Especializada. **Métodos:** pesquisa qualitativa que utilizou o universo de pessoas envolvidas com a saúde auditiva. Foi aplicado questionário em gestores e/ou fonoaudiólogos a fim de identificar os sujeitos e ações desenvolvidas com os deficientes auditivos nos municípios. Os critérios de inclusão foram: atuar no Sistema Único de Saúde, aceitar participar da pesquisa, ter pelo menos três meses de experiência com atendimento e encaminhamento de usuários ao Serviço de Saúde Auditiva. Posteriormente, foram convidados a participar de uma oficina de devolutiva dos questionários e discussão dos dados. O método utilizado para o tratamento dos dados obtidos nas discussões geradas nas oficinas foi análise de conteúdo das falas, identificando-se as seguintes categorias: estrutura de Atenção a Saúde Auditiva nos municípios; atuação dos profissionais frente à saúde auditiva; organização do trabalho em rede. **Resultados:** identificou-se que 45,5% dos gestores está há menos de um ano na função, 82% dos pacientes não recebem acompanhamento na atenção básica, 81,9% dos fonoaudiólogos estão centralizados na atenção especializada. **Conclusão:** a maior parte dos fonoaudiólogos e médicos otorrinolaringologistas estão centralizados na atenção especializada. Na maioria dos municípios não há ações voltadas para o acompanhamento dos deficientes auditivos, desta forma, não existe uma rede articulada para fornecer o acompanhamento dos usuários na atenção básica. Existe um fluxo rígido e vertical. O paciente com queixas auditivas é encaminhado para o serviço de referência.

DESCRITORES: Gestão em Saúde; Atenção Primaria à Saúde; Audição

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