ORIGINAL ARTICLE

Brazilian Breast Cancer Care Network: the perspective of health managers

Rede de Atenção ao Câncer de Mama: perspectiva de gestores da saúde

Red de Atención al Cáncer de Mama: perspectiva de gestores de la salud

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ABSTRACT

Objective: To analyze the organization of the Brazilian Breast Cancer Care Network, according to the perspective of managers of the *Coordenadoria Regional de Saúde Sudeste* (Southeast Regional Coordination of Health) of the city of São Paulo. **Method:** A descriptive study, with a qualitative approach, carried out with seven managers of this Coordination. The interview data were analyzed based on the components of the operational structure of the Brazilian Health Care Network: Communication Center; Secondary and Tertiary Care Points; Support Systems; Logistic Systems; and Network Governance System. **Results:** There is heterogeneity in the operationalization of the Care Network and the obstacles to its integration and comprehensiveness were: fragility of the bond with the users; high turnover of professionals in Primary Health Care; lack of standardization of the reference system and counter-referral, and low cooperation between municipal and state health services. **Final considerations:** The organization of the Brazilian Breast Cancer Care Network is fragmented, thus compromising the comprehensiveness of care.
Descriptors: Breast Neoplasms; Primary Health Care; Health Management; Women's Health; Health Evaluation.

RESUMO

Objetivo: Analisar a organização da Rede de Atenção ao Câncer de Mama, segundo a perspectiva de gestores da Coordenadoria Regional de Saúde Sudeste do município de São Paulo. **Método:** Estudo descritivo, com abordagem qualitativa, realizado com sete gestores dessa Coordenadoria. Os dados da entrevista foram analisados com base nos componentes da estrutura operacional da Rede de Atenção à Saúde: centro de comunicação; pontos de atenção secundários e terciários; sistemas de apoio; sistemas logísticos; e sistema de governança. **Resultados:** Há heterogeneidade na operacionalização da Rede de Atenção e os obstáculos para sua integração e integralidade foram: fragilidade do vínculo com as usuárias; alta rotatividade de profissionais na Atenção Primária à Saúde; ausência de padronização do sistema de referência e contrarreferência, e baixa cooperação entre serviços de saúde municipais e estaduais. **Considerações finais:** A organização da Rede de Atenção ao Câncer de Mama se apresenta fragmentada, comprometendo, desse modo a integralidade do atendimento.
Descritores: Neoplasias da Mama; Atenção Primária à Saúde; Gestão em Saúde; Saúde da Mulher; Avaliação em Saúde.

RESUMEN

Objetivo: Analizar la organización de la red de atención al cáncer de mama, según la perspectiva de gestores de la Coordinadora Regional de Salud Sudeste del municipio de São Paulo. **Método:** Estudio descriptivo, con abordaje cualitativo, realizado con siete gestores de esa Coordinadora. Los datos de la entrevista fueron analizados con base en los componentes de la estructura operativa de la Red de Atención a la Salud (*Rede de Atenção à Saúde*): centro de comunicación; puntos de atención secundarios y terciarios; sistemas de apoyo; sistemas logísticos y sistema de gobernanza. **Resultados:** Hay heterogeneidad en la operacionalización de la red de atención y los obstáculos para su integración e integralidad fueron: fragilidad del vínculo con las usuarias; alta rotación de profesionales en la Atención Primaria a la Salud; ausencia de estandarización del sistema de referencia y contrarreferencia y baja cooperación entre servicios de salud municipales y estatales. **Consideraciónes finales:** A la organización de la red de atención al cáncer de mama se presenta fragmentada, comprometiendo, de ese modo la integralidad de la atención.
Descriptores: Neoplasias de la Mama; Atención Primaria de Salud; Gestión en Salud; Salud de la Mujer; Evaluación en Salud.

INTRODUCTION

The World Health Organization estimated that by the year 2030, there will be 27 million new cases of cancer and 17 million deaths from this disease, with the largest increase occurring in low- and middle-income countries[1-2]. It also states that low-cost actions currently available may interfere with the course of the disease in 1/3 of cases, but the lack of investments, especially in these countries, favors their increase with worse prognoses[2].

In Brazil, breast cancer shows an increase in its incidence and mortality[3]. Without considering non-melanoma skin tumors, it is the most frequent type, with a forecast of 57,960 new cases, and an estimated risk of 56.20 cases per 100,000 women in the years 2016 - 2017. In the Southeast region, which home to two global metropolises: São Paulo and Rio de Janeiro, the estimated risk is higher, corresponding to 68.08/100 thousand[2].

The high pattern in the mortality curve still occurs, among other factors, as a consequence of the late diagnosis of the disease[4]. The implementation of conduits that allow the early diagnosis interferes decisively in the mortality rate, with a reduction of up to 30% in some countries.

In analyzing the actions of early detection of breast cancer, one study concluded that women who depend exclusively on the public health system find greater barriers to access mammography screening. The proportion of women who underwent the examination was 79.5% among those with health insurance, compared to the coverage of 51% among users of the Brazilian Unified Health System (*Sistema Único de Saúde*)[5].

During the 26 years (1990-2016) of Brazil's health policy trajectory, it is observed that no national government has assumed as a priority in the political agenda the consolidation of a public health system that is effectively universal and egalitarian, o the concomitant expansion of the private, lucrative market, which intensifies social stratification and inequalities in health[6].

The emphasis on Primary Health Care (PHC) is considered to be one of the strongest predictors of cancer screening. According to the *Política Nacional para a Prevenção e Controle do Câncer* (*National Cancer Control* Programme), PHC is responsible for coordinating and maintaining the care of cancer users, when referenced elsewhere in the Health Care Network of people with chronic diseases under the SUS[7].

Currently, the organization of integrated health systems in the network represents an innovation in terms of the care model. The Brazilian Health Care Network (RAS - *Rede de Atenção à Saúde*) is defined as organizational arrangements of actions and health services, of different technological and interdependent densities, that seeks to promote the comprehensiveness of care and is organized in horizontal relations between the care points, whose center of communication and coordination is the PHC[8].

The analysis of the organization of the Brazilian Breast Cancer Care Network, with an emphasis on the health management component, can collaborate in the identification of fragmented points in the continuous provision of prevention, early detection, diagnosis, treatment and palliative care, in a timely and coordinated way between different points of Health Care. Thus, the guiding question of this research was: what are the possibilities and obstacles in the management of the operational structure of the Brazilian Breast Cancer Care Network, according to the *Política Nacional para a Prevenção e Controle do Câncer* (*National Cancer Control* Programme) within the scope of the Brazilian Unified Health System?

OBJECTIVE

This study aims to analyze the organization of the Brazilian Breast Cancer Care Network, according to the perspective of managers of the *Coordenadoria Regional de Saúde Sudeste* (Southeast Regional Coordination of Health) in the city of São Paulo.

METHOD

Ethical aspects

The development of the study met national and international standards of research ethics involving human livings. The project was approved by the Research Ethics Committee of the *Universidade Federal de São Paulo*.

Acceptance of the participants was obtained through the signing of the Informed Consent Form. Anonymity was maintained using alphanumeric identification (M- manager interviewed, followed by a numerical order from 1 to 7).

Theoretical-methodological framework and type of study

The methodological option that guided this study was a qualitative approach, of a descriptive nature, with content analysis as a proposal for discourse decomposition. The analysis of the organization of the Brazilian Breast Cancer Care Network was based on the framework proposed by Mendes[9], referring to RAS, considering the second element as the basis of analysis of this study within the triad population, operational structure and health model. The operational structure is composed of the nodes of the networks and the connections that communicate these different nodes, being constituted of five components: 1) Communication Center - Primary Health Care; 2) Secondary and Tertiary Care Points; 3) Support Systems; 4) Logistic Systems; and 5) Network Governance System. Each of these structures was established a priori as thematic categories[9].

The elaboration of the data analysis of the study took into account the services offered to the population, and the organization and management of health services aimed to this end, not having been addressed the organization and management of health work, which would need other complementary references, avoiding the objectives of this study.

Study setting

The study was developed at the *Coordenadoria Regional de Saúde Sudeste* (Southeast Regional Coordination of Health) in the city of São Paulo, Brazil. In this territory, the cancer care is organized in input flow, diagnosis, treatment, follow-up/clinical support and outflow, both for discharge and death.

Participants of the study and data source

As a data source, the possible participants in the study were: managers with prior knowledge about the *Política de Controle do*

Câncer de Mama (Breast Cancer Control Policy), structure of the network, with mastery over the flows constructed to access the different levels of care and with responsibility in the prediction and provision of resources for the execution of the proposed actions for the control of breast cancer. Thus, an intentional sample was composed of seven health managers, all female, with an average age of 35 years, two of whom were responsible for the Technical Assistance of the *Coordenadoria Regional de Saúde Sudeste* (Southeast Regional Coordination of Health, CRS), in the areas of Primary Health Care and Women's Health, and five technical advisors from the different *Supervisões Técnicas de Saúde* (Technical Health Supervisions) of the same coordinator.

Collection and organization of data and work steps

The initial invitation was made at the Southeast CRS and, later, a second contact was made directly with each manager, at which time the objectives of the research were explained, inviting them to participate in the study. After the acceptance by the indiviuals, the interviews were scheduled.

Data collection took place from August 2014 to April 2015, using a semi-structured interview technique, performed in a reserved space in the working environment, according to the availability of date and time of each of the participants. The interviews were audio recorded, with an average duration of 28 minutes. The collection of data was complemented by non-participant observation and documentary analysis.

A script was used consisting of three guiding questions, namely: (1) Does the current cancer care policy related to breast cancer control have favored the flow of actions in the Women's Health Care Network? (2) What are the main difficulties encountered in the implementation and/or implementation of these actions? (3) What are the possibilities and limits to implement, in the current conditions of the Women's Health Care Network, the actions proposed by the cancer care policy, specifically those related to the control of breast cancer? As the interviews were carried out, they were transcribed in full and assigned a number, according to the order in which they were made.

Data analysis

The interviews were submitted to content analysis[10] and, as previously mentioned, the registration and significance units from the empirical material were organized in the theoretical categories of the operational structure of the RAS, proposed by Eugênio Vilaça Mendes[8].

The speeches were transcribed in full and checked, and validated with the independent reading of another specialist researcher in the area. After the transcription, an exhaustive reading of the content was performed with the purpose of performing the pre-analysis, in order to establish registration units that corresponded to the pre-defined thematic categories, according to the adopted framework. Subsequently, representative clipping and aggregation of these categories were done, with data classification, treatment of results, inference and interpretation, in order to establish a critical and reflexive analysis of the results found, comparing them with the objectives outlined at the beginning of the research.

RESULTS

The results are presented in five charts that correspond to the thematic categories of the study and relate the subcategories and significant quotes of the individuals interviewed, allowing the apprehension of the object of study delimited.

In the first thematic category, communication center - Primary Health Care, study participants point out difficulties in scheduling consultations, compliance with care flows and protocols, adequate referral and counter-referral in the system, and high Health professionals.

Chart 1 – Description of the category "Communication Center", subcategories and registration units of scientific research

Thematic Category	Subcategories	Speeches of individuals
Communication center - Primary Health Care "*O centro de comunicação das Redes de Atenção à Saúde é o nó intercambiador no qual se coordenam os fluxos e contrafluxos do sistema de Atenção à Saúde, sendo constituído pela Atenção Primária à Saúde*" (The communication center of the Health Care Networks is the interchange node in which the flows and counterflows of the Health Care system are coordinated, being constituted by the Primary Health Care)[8].	First contact: accessibility and use of the service	[...] *for the person to make the first appointment at the Basic Health Unit can take from two to three months.* (M1)
		[...] *I know I have a three-month waiting line.* (M6)
	Coordination of flow and counterflow of the system	*The professional is oriented towards the protocol, but does not acquire the knowledge to make a correct flow. So often does not request the mammogram or referral, and this delays the start of treatment very much.* (M2)
		Another limitation would be the difficulty of dialogue with the secondary network, the lack of counter-referral. (M1)
		One obstacle that we have is the fragmentation of the network, because the hospital does not provide this response to Primary Care. (M3)
		When you go to the treatment service you lose that contact. It still needs to ensure this monitoring with Primary Care. (M5)
		In referral and conterreferral, the clinician talks to the mastologist who talks to the hospital and that user returns to the clinician. This turn is a big knot. The referral and counter-referral does not exist. (M2)
		Is there a flaw in communication between services, because while you are being treated you are being followed up and then, when you fall into the network, under what conditions? [...] So we started well and lost data on the way. (M3)
	Profissionals availability	[...] *we have a very large turnover of these professionals…* (M1)

Chart 2 – Description of the category "Secondary and Tertiary Care Points", subcategories and registration units of scientific research

Thematic Category	Subcategories	Speeches of individuals
Secondary and Tertiary Care Points "São pontos de atenção secundários e terciários, os nós da rede onde se ofertam determinados serviços especializados, gerados através de uma função de produção singular. Se diferenciam por suas respectivas densidades tecnológicas" (Secondary and tertiary attention points are the nodes of the network where certain specialized services are offered, generated through a singular production function. They differ by their respective technological densities)[8].	Secondary Care	*Every patient who is referred for breast or mammography ultrasonography has the offer of a specialized mastology service and, with an altered result, is automatically referred to the mastologist and within this service the puncture is already done and is already being sent to the care line and will follow-up the comprehensive care.* (M1) *Mammography and breast ultrasonography are not performed here. We always need to be forwarded and the result is a huge waiting line...* (M3).
	Tertiary Care	*The limit would be in the tertiary sector, especially the communication with this sector. I prioritize the marking and stay in the regulator every two days. It's as if I want to get my problem up front and the tertiary sector has difficulty. I can get the job because I'm insistent.* (M4) *What is certain is that when the patient is discharged from the hospital, he/she returns to the specialty outpatient clinic as a way to re-educate herself and then to the territory to follow up at the Basic Health Unit.* (M2)

Chart 3 – Description of the category "Support Systems", subcategories and registration units of scientific research

Thematic Category	Subcategories	Speeches of individuals
Support Systems "São lugares institucionais das redes onde se prestam serviços comuns a todos os pontos de Atenção à Saúde, quer seja no apoio diagnóstico e terapêutico, quer na assistência farmacêutica e sistemas de informação de saúde para obtenção de dados úteis à regulação, programação e ajuste na assistência à saúde da população" (They are institutional places of the networks where services are provided common to all points of Health Care, whether in the diagnostic and therapeutic support, or in the pharmaceutical assistance and health information systems to obtain useful data for regulation, programming and adjustment in the health care of the population)[8].	Diagnostic and therapeutic support	*We have a very large population and few equipment ... I do not know if [the solution] would increase the number of mammographs. Statistics show that the numbers of mammographers are more than adequate and are in adequate numbers, but would be a better redistribution of services.* (M5) *[...] I think we have two nodes: the maintenance of mammography equipment, because they break down and generate a waiting line, [...] and we still have absenteeism.* (M1) *[...] and absenteeism is high [...], almost 30% absenteeism and is complicated because the patient does not get out of line and harms the other patient who needs to get in line.* (M3)
	Information System	*[...] we do not have much related to that SISMAMA Program, I do not know what happened and I think I never implemented it here.* (M4) *Who does the mammograms for our region is [...] an outsourced company and what I have contact with them have never fed anything about SISMAMA and I do not receive any data.* (M6) *The SISMAMA system itself is not being used in everyday life for management and it is a discussion that we must make. Who feeds the bank are the services of reference and would be a good tool, but we are not performing this practice.* (M5)

Chart 4 – Description of the category "Logistic Systems", subcategories and registration units of scientific research

Thematic Category	Subcategories	Speeches of individuals
Logistic Systems "São soluções tecnológicas, fortemente ancoradas na tecnologia da informação, que garantem uma organização racional dos fluxos e contrafluxos da informação, produtos e pessoas na Rede de Atenção à Saúde, e deve contribuir para a efetiva coordenação entre os pontos da RAS" (These are technological solutions, strongly anchored in information technology, which ensure a rational organization of the flows and counterflows of information, products and people in the Network of Health Care, and should contribute to the effective coordination between the points of RAS)[8].	People flow	*[...] In our region we have no difficulty regarding referrals and our rear with regard to breast cancer is quite efficient and it works. Our cancer care network works.* (M2) *[...] anyone who is regulating tries to check a place near their residence, but the area is too large and can be scheduled too far.* (M7)
	Information flow	*[...] the information does not reach all women and the vast majority looks when it sees a palpable nodule or retraction and with that is already in a more advanced stage [...].* (M6) *There is a lack of awareness of the population to do the preventive exams, we know that the media is important and it may be necessary to disclose in the popular program, in a soap opera, the problem of breast cancer.* (M2) *The user or population is disbelieving that the danger lives next door and that they should do the preventive exams annually. [...] it would help if the media intervened with commercials and novel approach.* (M7)

Chart 2 shows the nodes found in secondary and tertiary care, with mammography, ultrasound and breast examination performed outside the unit, contributing to the delay in diagnosis and timely treatment, as there is a lack of articulation between the different levels of care.

Chart 3 shows the problem of the support system for the Cancer Care Network, in which managers report a shortage of devices in relation to the number of women who need to perform the mammography examination, lack of equipment maintenance, a significant number of patients' absences in the accomplishment of the examinations and the low use of information systems in the management of care in breast cancer.

In the description of the Logistic Systems, in Chart 4, the managers mentioned that some users do not have transportation to carry out exams at other care points, and that the workers in the regulation sector, sometimes in the scheduling, do not consider the distance between the residence of the user and the service that will offer the exam.

Chart 5 – Description of the category "Network Governance System", subcategories and units of registration of scientific research

Thematic Category	Subcategories	Speeches of individuals
Network Governance System "*A governança das Redes de Atenção à Saúde é o arranjo organizativo que permite a gestão de todos os componentes, de forma a gerar um excedente cooperativo entre os atores sociais em situação, aumentar a interdependência entre eles e obter resultados para a população adscrita*" (The governance of health care networks is the organizational arrangement that allows the management of all the components, so as to generate a cooperative surplus among the social actors in the situation, increase the interdependence between them and obtain results for the attached population)[8].	Formulation and strategic decision to organize and coordinate the interaction between the network components	*The Municipality is very large and ca not have a vision of a whole and we must work in partnerships...* (M2) *We have a special problem [...], because I have a set of Basic Health Units, being more than 50% municipalized, that is, no management contract.* (M5) *In our region we have no difficulty regarding referrals and our rear with regard to breast cancer is quite efficient and it works. Our cancer care network works.* (M2)

Chart 5 presents the difficulties that managers face in the organization of services, due to the size and complexity of the city of São Paulo, as well as problems arising from management contracts. On the other hand, some managers interviewed do not mention obstacles in the Cancer Care Network.

DISCUSSION

The PHC is an organization strategy aimed at responding regionally, continuously and systematically to most of the health needs of a population, through the integration of preventive and curative actions directed at individuals and communities[11]. However, some challenges compromise its performance as a communication center of the Health Care Network.

In this study, the reports of the participants, analyzed in the light of the operational structure of RAS, proposed by Vilaça Mendes[9], pointed to three problems in PHC as the center of the cancer Care Network. These are: (1) barriers in the first contact of users with the service, diverging from the principle of universality of care; (2) failures in the coordination of flows and counter-flows of the health system, compromising the articulation of primary, secondary and tertiary care points; and (3) the turnover of incomplete professionals and teams, implying the commitment of the performance of the actions, in quantitative and qualitative terms.

PHC is known as the "gateway" of users in health systems, an initial service that should function as a filter capable of organizing the flow of services in health networks, from the simplest to the most complex in technological density[12]. However, in practice, there are barriers to access to the network of comprehensive and continuous care, confirming results found in a study developed in the municipal health network of Recife-PE, which corroborate with this data[13].

The lack of professionals who make up the minimum staff of the PHC, as well as their high turnover, are management problems, however, the presence of the employee in the service alone does not imply quality of care, being fundamental the Permanent Education of the health teams, not only for the correct flow of actions in the Breast Cancer Control Network, but also for the provision of clear and complete information on the actions to be performed[14].

In the present study, it was observed that the conformation of the women's care line in the context of the fight against breast cancer starts from the diagnosis of alteration in the breast. Thus, it is inferred that the actions of disease prevention, health promotion and surveillance, through tracking, are not yet consolidated as actions of this line of care. Problems were also identified in the

communication of the result of the mammography to the user, in the bottleneck of the hospital demand and in the planning and operationalization of hospital discharge, with return to PHC[15].

The actions of early detection of breast cancer contribute to its diagnosis in the early stages, as well as to the reduction of morbidity and mortality rates. However, despite the efforts made by the Ministry of Health, in Brazil the high rate of late diagnosis of breast cancer is still persistent, corresponding to 60% of the cases[4-16]. Among the several factors that may be influencing this situation, studies show that there is a lack of compliance in the provision of screening and early detection of this condition with MoH recommendations, which may compromise its results and the expected impact[17-18]. It should also be considered that the drop in the flow of services or the lack of articulation between them causes delay in the implementation of the actions and delay in diagnosis and in the beginning of treatment[4].

Thus, the reference and counter-referral system, which should act as a mediator in the connection between the points of the care network, will, in many circumstances, work as a hindrance to the agility of the process. In addition, the most technologically dense health services often do not return the information to Primary Care, making the care network a tangle of disjointed and punctual practices. It is therefore emphasized that there is almost no counter-referral[13].

With regard to support systems for the Cancer Care Network, such as support for diagnosis and therapy and information systems, in this study, it was identified that the use of mammography devices is not efficient, since there are problems inadequate (re)distribution in the network, absenteeism of users and technical maintenance of the devices. On the other hand, failure to use the Breast Cancer Information System (SISMAMA - *Sistema de Informação do Câncer de Mama*) as a care management tool can make it difficult to access useful information to monitor the actions of early detection of breast cancer[18].

In the organization of the Health Care Network, logistics systems are solutions based on information technology to ensure the necessary flows and counterflows[9]. In this category, the present study pointed out problems and solutions related to the flow of people and information in the cancer network.

One of the main characteristics in PHC is the longitudinality in the care to the individual, encompassing actions promotion, protection and recovery of health, in a comprehensive and continuous way. The positive results intrinsically related to this service derive from the most appropriate diagnosis and treatment, reducing unnecessary referrals to other sectors of the network and the use of more complex procedures[19].

The existence of sanitary voids in Brazil may, in some respects, be reproduced in regional and even municipal territories. The discrepancy between supply and demand in health services directly interferes with the quality of care, determining obstacles to the community, especially when the topic is the timely prevention and identification of breast cancer, fundamental for the reduction of their morbidity and mortality rates. In this respect, geographic access assumes essential relevance[4,20].

It was identified from the managers' perspective that users find geographical barriers to the use of diagnostic support services and also that the dissemination of information on breast cancer in the community is ineffective in order to promote accountability and co -care management in the collective dimension.

The geographical barrier was also mentioned in a study that evaluated the capacity of municipal management to provide health care for the elderly, highlighting their repercussion on the accessibility and continuity of the Health Care of users of the system, signaling a common problem for users of the public health system[21].

The design of programs of dissemination and clarification promotes the production of knowledge in the population and favors the early search for health care, reducing the time between the search for care and the discovery of a symptom of breast disease[22].

The participation of the community in breast cancer control actions is fundamental and for users to be protagonists in their health-disease-care process, access to complete and clear information is indispensable[23].

The involvement of multiple actors in the shared and resolutive management of the Women with Breast Cancer Network implies the assumption of responsibilities and the establishment of relations of communication and interdependence[24].

In this context, the value of quality of health records is important. The ease in its consultation and availability in the so-called information continuity is a fundamental point for longitudinality in Health Care. The knowledge obtained, not only restricted to the clinical conditions of the person, but also to sociodemographic aspects, cultural values and family situation makes possible the formulation of programs and policies, facilitating the guidance of health professionals and the therapeutic adherence of the users[19].

The work of managing the components of the network requires managers to have an expanded vision, with formulation and strategic decision, to integrate and coordinate all the necessary flows. In this study, results on the network governance system indicate that, in some territories, the Cancer Care Network is efficient, mainly due to the diagnostic and therapeutic back-up available. However, in other experiments, the lack of partnerships, including management contracts, added to the breadth of the territory, make it difficult to manage this cancer network.

The development of policies based on geographically defined population characteristics facilitates the provision of services, adequate conduct, access, security and quality of care. An option in resource regulation may be the formulation of risk models for the pre-screening of breast cancer screening. These models can provide a better choice and adjust the available resources[1].

Managers have the ability to organize care networks in numerous possibilities of connection that can contribute or hamper the access of the population to the assistance. The governance system may, at its discretion, encourage cross-service connections, in addition to indicating possible centers with potential for expansion[18]. Successful actions in the control of breast cancer include a broad, multidimensional and multi-level implementation and effective location of the Basic Health Unit, as well as the necessary path for diagnostic and therapeutic exams, since the user should use them often throughout the treatment. In the optimization of the network, the position of the care services and place of housing of the population, the means of transport available, the distance, the time and the costs involved in the displacement need to be assessed during the composition of the network[25].

In this regard, it is understood that the continuous and increasing use of new information technologies by the governance system favors the decision making and the implementation of effective actions for the control of breast cancer. Among the various possibilities of using new information technologies, a study highlights the Health Observatories as an important "strategy for the expansion and availability of information and evidence for decision making in the health field, including the areas of surveillance, promotion, Primary Care and management of health education"[26].

In view of the above, it is agreed that successful cancer control programs generally involve comprehensive, multidimensional and multi-level efforts in the implementation and communication of public policies[25].

Study limitations

Uma das limitações que pode ser apontada diz respeito à análise restrita a região Sudeste do município de São Paulo que, embora extensa e populosa, pode não representar a realidade de outras regiões, sugerindo a necessidade de expansão, de modo a visualizar a realidade da Rede de Atenção na sua plenitude.

Contributions to the sector of Nursing, Health or Public Policy

The study made possible a critical reflection on the cancer network in the studied area, the demands and procedures involved in the early detection of breast cancer, as well as the need for adequate planning, continued education, sufficient material and human resources and political articulation for the implementation of the policies, offering adequate care services, with emphasis on Primary Care.

FINAL CONSIDERATIONS

The results of the study concerning the organization of the Brazilian Breast Cancer Care Network, according to the perspective of managers of the *Coordenadoria Regional de Saúde Sudeste* (Southeast Regional Coordination of Health) in the city of São Paulo, analyzed in the light of the five components of the operational structure of the Health Care Network, there are different realities in the Cancer Care Network of this Coordination, and the obstacles to its integration and comprehensiveness were: fragility of the

bond with the users; high turnover of professionals in Primary Health Care; lack of standardization of the referral system and counter-referral, and low cooperation between municipal and state health services. On the other hand, the results also indicate that, in some territories, the Cancer Care Network is efficient, mainly due to the diagnostic and therapeutic backside available.

It is concluded, therefore, that the asymmetry in the access of users to actions and services, in distinct points of the Cancer Care Network, as well as its fragmentation, shows that it is imperative to apply efficient and ethical methods of collaboration and coordination in the management of available resources and longitudinal care.

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