

The access and the difficulty in resoluteness of the child care in primary health care

O acesso e a dificuldade na resolutividade do cuidado da criança na atenção primária à saúde

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Keywords

Primary health care; Child care; Health services accessibility; Nursing care; Pediatric nursing

Descritores

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Abstract

Objective: To learn how access is conducted in two primary care units, traditional and family health strategy, and assess whether there was resoluteness of assistance to child health.

Methods: This is a qualitative study, we used hermeneutic for understanding the data. The research instrument was non-participant observation technique; the data were analyzed using thematic analysis method.

Results: There are four sub-categories: children, their family members and the first contact in primary care; the service organization and its influence on access; the therapeutic itinerary of the family and child in search of health care; scheduled access to health care.

Conclusion: Access to health services showed weaknesses regarding the child health care and the proposed care service could build stable relationships and humanized care to child demand in primary health care.

Resumo

Objetivo: Apreender o acesso em duas unidades de atenção primária, tradicional e saúde da família e avaliar se houve resolutividade da assistência a saúde da criança.

Métodos: Trata-se de pesquisa qualitativa, utilizou-se a hermenêutica para compreensão dos dados. O instrumento de pesquisa a técnica de observação não participante, os dados foram analisados pelo método da análise temática.

Resultados: Estão apresentados em quatro sub-categorias: a criança, seus familiares e o primeiro contato na atenção primária; organização do serviço e sua influência no acesso; o itinerário terapêutico da família e sua criança em busca de cuidado em saúde; o acesso à atenção programada em saúde.

Conclusão: O acesso aos serviços de saúde apresentou fragilidades quanto ao cuidado à saúde da criança e que a proposta do acolhimento pode construir relações estáveis e cuidado humanizado à demanda infantil na atenção primária à saúde.

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Introduction

The care provided to children in Primary Health Care aims to promote health through priority actions of surveillance and monitoring of growth and child development. It is necessary to establish conditions for the provision of this care, strengthening the team through the provision of resources and subsidies to health teams, autonomy and accountability to users, so that the health work reach its purpose, which is solving the health needs of the child and family.⁽¹⁾

One of the requirements necessary to effective care is individuals' access to health services. Access of first contact is one of the essential attributes of primary health care and denotes the accessibility and use of these services in case of problems in which people seek health care.⁽²⁾

It can be said that an accessible service that is easy to approach, available to people in which there is no geographical, managerial, financial, cultural or communication barriers, enabling individuals to receive care, and that is resolute, ie, the problem is solved there or in another level of care, in the first contact with the health service.⁽³⁾

In this perspective, the study aimed to learn the access in two units of primary health care, one traditional and another with family health strategy, with different work processes and assess whether there was resoluteness in the health care of children in this context, the two models used in Brazil.

Methods

This is a descriptive qualitative study whose theoretical and methodological framework for data interpretation was the hermeneutic.⁽⁴⁻⁶⁾

Data collection was conducted in two primary care services that have primary care models distinct from one another. The study subjects were all professionals working in these two units.

For data collection, we used the technique of non-participant observation, with previously established script and for the observation record's a field diary was used. The period of data collection was

two months and ended due to saturation of information observed, providing the researcher enough information to respond the research question.

The information collected from the field diary from the observation were ordered, organized, categorized, contextualized and interpreted by the method of thematic analysis.⁽⁷⁾

In pre-analysis, we established the first contact with the material, identifying the units of meaning, then explored through units of representative parts of the texts of the field diary and finally the data were grouped and interpreted allowing the construction of a category that explained access to services in the health units investigated.

The development of the study met national and international standards of ethics in research involving human subjects.

Results

We chose to present the data in box format in which we can observe the systematic category: "The influence of the work process in access and resoluteness of the primary health care of children" with their sub-categories and the related reports of observation in each unit of analysis, according to chart 1.

Discussion

We understand the results as inserted in the observed reality, which is a limitation of qualitative method. Therefore, these results should not be generalized. Thus, we analyzed the information collected and systematized earlier around the difficulty of access to childcare in primary health care.

We highlight that the performance in primary health care is a fertile field of nursing work, looking at the data can reflect on their way to take care of children in the context of primary care and change their practice to expand access and improve the resoluteness for children and their families, this is the practical application of the study.

Regarding access to health services, we found that the reception is the first place for seeking in-

Chart 1. Systematic category

| | |
|--|---|
| The first contact in primary health care | Users come to the counter requesting information, the receptionists guide them or refer to the respective sectors that are ordered: dressings, vaccines, inhalation. The information given on reception are given in a timely manner, the user of this service depends on the orientation of the receptionist: "Where is the vaccination room? [asks the user] turn around and wait in the lobby [the receptionist responds]", "would you like to speak with the nurse? She is not here today; she is on sick leave, replies the receptionist and the woman go home. |
| The service organization and its influence on access | Before eight o'clock in the morning, Community Health Agents (CHA) is the one who work in the reception: meet the patients, take the charts, schedule specialties consultations, answer the telephone and give information requested by users. Patients need to stand in line all day to get a form, arrive around four or five o'clock in the morning. The security guard of the unit tells how many forms will be available that day. In the morning, about 30 individuals wait for the health unit open forming two lines, one for each physician in the area covered by the FHS. After opening the unit, the receptionists deliver the forms according to the order in the line, if there are no left over form the user goes home, or if he/she is very ill and wants to wait, an assessment is performed. [...] when there is no form or the pediatrician is on vacation, they contact another Health Unit to try a vacancy for the child. People who fail to get a form that day and want to wait to undergo an assessment, can wait. In this assessment, the pre-consultation (measures of vital signs) is made, if the person is not well, they speak [technicians and/or nursing assistants] to the patient go to the Emergency Unit (UPA). |
| Access to scheduled primary health care | The childcare Nurse agenda of Team 31, in the morning provides consultations to children in general and one afternoon for newborns at high risk. This organization aims to meet the return of discharged children from NICU and they could not schedule childcare. Every Thursdays afternoons are addressed to care for pregnant women and children 0-3 years through the open agenda, in which the team of dentistry teaches mothers preventive measures of oral health. For the rest of the age group, the agenda is open from time to time and patients come to leave their name on the waiting list. |

formation for users, which seeks care. In this place, patients are oriented according to their needs, questions or complaints.

The reception of both units, regardless of the care model adopted, whether traditional or family health strategy acted as a barrier and filtered users. The indication would be to care for them and change this moment, establishing a bond, in qualified listening, good care practices in order to ensure a humane, effective care, legitimizing this level of care as a preferential entrance to network of health care.⁽⁸⁾

These characteristics denote a care in child health, involving mothers and the family integrally. It assumes the adoption of an expanded concept of health, in which they are engaged in biological, psychosocial, cultural and subjective needs. In order to be effective, it is essential the interdisciplinary action of interdisciplinary teams of health, with longitudinal coordinates actions of multiple professionals.⁽⁹⁾

One way of interdisciplinary approach is to invest in the care, which can be developed through two dimensions: attitudinal, toward humane care, with qualified hearing of health problems, involving a positive response to the demands and the creation of bonds between the health team and the enrolled population. The other is organized to establish flows, references and count references, territorialization, overcoming the constraints or negative responses such as lack of forms and the establishment of an adequate initial assessment process.⁽¹⁰⁾

In other words, the reception is no longer a place of power, capable of deciding about the user access or not.

This tool can be implemented through the establishment of dialogue and can provide solutions to present difficulties, forming a mixture of technical knowledge with popular knowledge. In this perspective, knowledge sharing can occur since the health worker present sensitivity to listen, understand the health needs and thus integrate them with technical knowledge, providing the user a better care at the clinic.⁽¹¹⁾

We observed the existence of problems in the organization of work, in which many workers left their specific functions to do their work at different sectors of their competence, supplying a shortage of workers. Moreover, the excess of work and site conditions become hindering factors for the worker to develop their work in caring and humane manner with a view to solve the health problems of children.

Study with receptionist workers of a basic health unit described the work as fragmented, in which the focus of his/her work were addressed based on procedures offered, the health needs facing a biological view of the health-disease process, hard and soft-hard technologies. The purpose of this study proved to work as charity or undetermined, unknown to the worker.⁽¹²⁾

Another study that evaluated access to family health strategy in the view of users, obtained similar result, where users reported delay in consultations, helping to reduce the credibility of the

family health strategy, and thus hindering access, reinforcing disbelief in the health service provided by the public sector.⁽¹³⁾

This finding is also similar with the study cited, among other similar results, the (de) humanization of care, demonstrated by the presence of people at dawn waiting for being cared.⁽¹⁴⁾

Thus, instead of adopting the practice of risk classification, with the choice of an appropriate methodology for this, one of the units adopts the conduct called assessment. This practice should not be taken as care, since this is a device with the principle of managing new ways of doing care in any space and time to work with the use of conversation technology providing sensitive listening, ensuring universal access and giving a positive response with agility to services and users.⁽¹⁵⁾

This perspective could be present in a more expressive and consolidated family health strategy teams studied, however, the observed results showed no differences in the organization of services in the access of family health strategy at the traditional basic health unit. On the contrary, showed to offer better access and resolution of cases, compared to the family health strategy unit, who through “forms” and “assessments”, turned out to distance from principles that characterize as the preferred strategy for promoting health of the population.

Family Health is a strategy to actions to promote health through the empowerment of individuals and families for their care, since to be responsible for the health of the territory's population, teams should extend the curative/preventive practice, seeking to promote quality of life, which corresponds to one of the main foundations of the changing healthcare model.⁽¹⁶⁾

However, adopting only the family health strategy as practice without actually changing the model of care makes service users deviate, because the population is unaware and “lost”, they do not know which service trust to clarify their health needs.

One of the actions of the family health strategy is scheduled care, which describes itself as the clinical encounter initiated by the health professional who focuses on aspects of care that are not

considered an acute condition or an exacerbation of chronic condition. This encounter becomes the basis of a care plan drawn up, reviewed and agreed upon the health team and the users.⁽¹⁰⁾

In the observations, it was possible to detect that type of childcare for nurses in both units, the puerperal consultation associated with the first visit of a newborn with the team of physicians and the team of dentistry's from the family health strategy with oral health prevention for pregnant women and children up to three years.

Regarding access to these services, it was observed that changes in the form of scheduling occurred with childcare group of newborn at high risk coming from the neonatal intensive care unit, where learned by the nurse, the difficulty of scheduling and caring for this priority, which lacks meticulous care.

These findings complement the study of the care of preterm and low birth weight, discharged from neonatal intensive care unit, where families described their journey in health services in search of continued health care for their child after hospital discharge. Mothers are expressed that this itinerary is marked by barriers to access, fragile bond and institutional vulnerability of health services, generating insecurity, dissatisfaction and non-effectiveness in child monitoring.⁽¹⁷⁾

It was possible to observe that most of the care provided to children is through medical consultations, where access to care in child health is prioritized in acute situations of disease, ie, the focus of that care ends up being the disease, complaints and intervention for their healing, which indicates a physician-centered healthcare, which overestimates the biological aspects of individuals and soft-hard and hard technologies instruments use for care,⁽¹⁾ which ultimately do not reach the health needs of the child integrity.

Regarding health needs, study conducted based on perception of users, found that these needs are linked to production and social reproduction and accessibility to health actions and the related bond needs for autonomy and self-care, concluding that the relationship confidence allows strengthening the potential for addressing the health-disease process.⁽¹⁸⁾

Health care can become effective if care technologies be inverted, seeking to insert therapeutic projects in actions that transfer knowledge to the user, raise their self-esteem, making them able to incorporate experience in their unique therapeutic process, making it also subject of his/her health, having the opportunity to work with soft health technologies in a more relational process than instrumental, which means designing therapeutic projects focused on users' needs and having him/her as the protagonist of their health process.⁽¹⁹⁾

In this study there were no differences in programmatic care executed in the model of the family health strategy in contrast to the traditional health unit, both kept such care through weekly schedule. The largest portion of childcare was accomplished through spontaneous demand care, caused by the demand for care, cases of acute conditions of diseases and ailments, all resolvable within the primary health care.

Conclusion

Access to first contact demonstrated weaknesses concerning child in primary health care, it was evidenced the existence of organizational barriers, preventing or hindering access to care through imposed bureaucratically devices. Furthermore, it was noticed a fragmented and uncoordinated care in both primary care services, demonstrating that such services need to structuring and development of health care effectiveness for the child and his/her family.

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Collaborations

Finkler AL contributed to the project design, analysis, data interpretation and writing of the paper. Viera CS collaborated with the project design, analysis, interpretation of data, drafting the paper and critical revision of the important intellectual content. Tacla MTGM cooperated with writing and

critical revision of intellectual content and Toso BRGO participated in the project design, analysis, interpretation of data, drafting the paper and critical revision of the important intellectual content.

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