Assessment of attributes for family and community guidance in the child health

Avaliação dos atributos de orientação familiar e comunitária na saúde da criança

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Abstract

Objective: To identify the extension in primary health services of attributes for family and community guidance about the health of children health.

Methods: This was a quantitative, cross-sectional and evaluation study. We administered 548 questionnaires (Brazilian Primary Care Assessment Tool, child version) to families and/or legal guardians of children younger than 12 years of age who were received care in 24 health units. Data were analyzed using SPSS software, version 17.0.

Results: The basic public health services of the studied municipality were below what is considered ideal for primary health care with regard to the attributes of family and community guidance. Score of these attributes were 4.4 and 5.1, respectively. Scores considered satisfactory were ≥6.6.

Conclusion: We found that it was difficult for services to integrate families and the community in the care process. This finding reinforces the healing care culture and individual-centered care.

Resumo

Objetivo: Identificar a extensão dos atributos da orientação familiar e orientação comunitária na atenção à saúde da criança nos serviços de atenção primária.

Métodos: Estudo quantitativo, transversal, do tipo avaliativo. Foram aplicados 548 questionários PCATool - Instrumento de Avaliação da Atenção Primária - Brasil versão criança aos familiares e/ou cuidadores de crianças menores de 12 anos atendidas em 24 unidades de saúde, sendo os dados analisados no programa SPSS 17.0.

Resultados: Os serviços básicos de saúde pública do município estudado possuem um percentual abaixo do considerado ideal para a atenção primária à saúde nos atributos de orientação familiar e orientação comunitária. O escore desses atributos foram 4,4 e 5,1, respectivamente, sendo considerados satisfatórios valores de escore ≥ 6,6.

Conclusão: Identificou-se a dificuldade dos serviços em integrarem a família e a comunidade no processo de cuidado, fortalecendo a cultura de assistência curativa e centrada no indivíduo.

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Introduction

Building and reorganization of public health policies in Brazil and around the world make up a long process that requires reflection to determine gaps in current care models. To reorganize the health system and strengthen clinical practice, investments in and changes to Primary Health Care (PHC) are needed.

In Brazil, the main proposal for PHC organization centers on the family health strategy (FHS). including basic care services characterized by continuity and integrality of care in a population from a specific area.[1] However, in the current Brazilian health system FHS coexists with the traditional basic health units (BHU), the characteristic of which is assistance with spontaneous demand.

In the context of PHC, child health care presents some weaknesses. A recent literature review[2] reported that PHC for children does not effectively distinguish between this point of attention and the other parts of the current health system. This lack of articulation shows the lack of effective coordination in PHC; it also implies that not all possibilities for pediatric health care are being addressed, thereby leading to unresolved care.[3]

To establish that the health units (BHU and FHS) are the main entry points to the health system and to obtain better results for PHC services, the principles of these units must be operationalized; therefore, structured PHC in agreement with its essential attributes (family and community guidance and cultural competence) would be more efficient and can improve resolution of care. Our study focused on attributes of family and community guidance.[4]

Family guidance considers the family as the object of care. The center of care is directed toward the knowledge of the multidisciplinary team and family members about the family health problems. [4,5]

Community guidance presupposes the knowledge of characteristics of community health and of local resources designated for cultural, leisure and other activities. Such knowledge provides a broader way to assess health needs than an approach based only on interactions with patients or their families.[4]

For pediatric health care, attributes of family and community guidance must be present because they strengthen the bond with health services and reflect the extension of further attributes, making health care for children more effective.

Assessment of health services in Brazil has become an increasing focus of scientific and institutional movements, indicating the need to include such assessment in planning and implementation of health programs. For this reason, a number of studies have been conducted to verify extension of essential attributes of an efficacious PHS. [6-8]

When considering the PHS as an attempt to reorganize health system, it is necessary to reflect, among other aspects, on characteristics of care delivery and the focus of attention. In this way, the development and broadening of studies on health services are needed, particularly because the reduction in child morbidity and mortality is directly related to the quality of care delivered. The objective of the current study was to identify to what extent family and community are involved in the pediatric care process in PHS.

Methods

This was a cross-sectional, descriptive and evaluation study with a quantitative approach of health care services models of FHS and traditional BHU in pediatric health care in Paraná in southern Paraná. This study is part of multicenter project involving the Universidade Estadual de Londrina and Universidade Federal da Paraíba. As part of this project, therefore, this research was developed in 24 health units (23 BHUs; 1 unit with 2 family health teams) in urban area of the municipality.

We estimated the sample size by probabilistic stratified sample causation with proportionated share by unit. The sample consisted of 548 caregivers of children younger than 12 years of age who were receiving care in the mentioned units.

Of this total, 17 were from an FHU and 531 from a BHU. To administer questionnaires, caregivers were selected by systematic sampling while they were waiting in line for nursing and medical consultations in the units. The following inclusion criteria were used: participants needed to be users of the service and have attended at least two consultations in the unit within the six months before data collection.

Data were collected from October 2012 to February 2013 using the Brazilian PCATool (Primary Care Assessment Tool), child version.[9] The questions concern all essential attributes and derivations; the attributes of family guidance are elicited in three questions that concern the family's opinion about the child's treatment, the history of family diseases and the encounter of the professional with the family. With regard to the attribute for community guidance, four questions addressed the use of home visits by the health team, the knowledge of professionals, community health problems, and participation of families in local health councils.[9]

Responses on the instrument were given by Likert scale with the following options: definitely yes (4); probably yes (3); probably not (2); definitely not (1). To obtain the score of each attribute, the mean of each element was calculated, thereby constituting a mean attribute. The mean of each attribute was transformed on a scale of 0-10 as follows: (score obtained-1) × 10/3.[9] For this transformed score, a cutoff point ≥ 6.6 is considered satisfactory for the extension of attribute in PHC. It is important to emphasize that this score is equivalent to a value of 3 or greater on the Likert scale because values < 6.6 were considered low.[10,11]

Questionnaire response were digitized into a database created in Excel 2010 with double entry.

Data were transferred to SPSS software, version 17.0, for analysis. Data are reported as mean, standard errors, minimum and maximum for each item of derivate attributes. Results described are presented with absolute and relative distribution.

Development of this study followed all national and international ethical and legal aspects of research on human subjects.

Results

Of 548 applied questionnaires, 440 (80.29%) indicated that the main caregiver of the child was the mother; 272 parents (49.6%) were married. Of children participating in the study, 228 (41.61%) were an only child. A total of 434 (60.94%) families had income equal to as high as two times the minimum wages. With regard to water and wastewater, 526 (95.99%) and 310 (56.57%) of respondents had treatment by official network, respectively.

The regular source of care for PHC services was the nurse for 6.4% of respondents and physician for 41.1%; both types of professionals were employed in the health service (Table 1).

Table 1. Professional or health service mentioned by the caregiver in relation to affiliation degree

Professional / service	n(%)
Nurse	35(6.4)
Physician	225(41.1)
PHC Service	288(52.5)
Total	548(100.0)

n – 548; PHC - Primary Health Care

Table 2 presents results related to each element that makes up the attribute of family guidance in PHC services.

Table 2. Attribute of family guidance

Variables	PHC Services Indicator(n=548)			
	$\bar{X}$	SE	Minimum	Maximum
The health professional asked your opinion on the child's treatment and care	2.2	0.677	1	4
The health professional asked about the family history of diseases	2.4	0.720	1	4
The health professional organized a meeting with child's relatives	2.3	0.563	1	4
Total	2.3	0.471	1	4
Mean score	4.4*	3.168	0	10

SE – standard error; * Transformed mean (0-10); PHC - Primary Health Care

Table 3. Attribute of community guidance

Variables	PHC Services Indicator (n=548)			
	X̄	SE	Minimum	Maximum
Somebody in the service made home visits	2.9	0.666	1	4
The service is aware of local community health problems	2.5	0.623	1	4
Services conduct surveys within the community to identify problems	2.4	0.606	1	4
Service invite family members to participate in health councils	2.2	0.631	1	4
Total	2.5	0.487	1	4
Mean Score	5.1*	0.162	0	10

SE – standard error; * Transformed Mean (0-10); PHC - Primary Health Care

Table 3 emphasizes results of each component of attribute community guidance.

The mean scores for family and community guidance in the health services investigated were 4.4 and 5.1, respectively. These values are below what is considered satisfactory (6.6).

Discussion

This assessment of health services used a validated instrument that enabled us to identify to what extent the attributes of family and community guidance are present in pediatric health care in PHC services according to the perspective of caregivers. It is important to emphasize that these results presented must be interpreted with caution because they reflect only the users' vision. It will also be necessary to know the opinions of the PHC professionals.

Health service geared toward PHC that include family and community guidance favor actions in plan and act, enabling nursing and other health professionals to provide care that is more effective and improves pediatric health indicators. However, in this study, caregivers mentioned that they received care from physicians (41.1%) more than nurses (6.4%). For this reason, this study emphasizes the need to broaden nurses' clinical practice in pediatric care in PHC services and in a broader clinical context because no isolated knowledge can resolve complex population health problems. A broader clinical aim may help overcome the barriers with traditional clinic care by modifying the work process from individual-centered care in a collective environment[12] to a care focus that is heterogeneous, medically centered, and pragmatic.

In this study, the predominant care model in the urban area of the studied municipality is of traditional health (91.6%). Until the data collection period, only two active PHS teams existed in this area, both located in the same physical structure. Transformation of the care model must begin by implementation of new PHS teams in such a way that reflects an understanding of local needs and characteristics for development of actions and that is oriented by national rules, such as consolidation of care networks focused on social health determinants.

Changes in the work process of health teams still produce tension because these changes propose alterations in conventional clinical practice and health management; more democratic relations between health professionals and relations with assisted population must be respected.[13] Part of the challenge that PHC proposes is unstrained labor relations and incorporation of children and their families as protagonists of the care process. This dichotomy between daily practice and the goals of PHC resulted in weakened presence and extension of attributes of family guidance, which contribute to the lack of resolution of pediatric health care.

A broader view of the role of the child and his/her family favors the construction of integrative and resolution care. It also helps reinforce the characteristics that PHC espouses, including attempts to reduce pediatric morbidity and mortality from avoidable causes.

To address the needs for family guidance, health services must present other character-

istics related to the PHC, such as longitudinal aspects. For the service to be identified as the regular source of medical attention, the family' knowledge of the origin and diseases care is essential. To address this assumption, one of the survey questions related to existing diseases in the child's family. In the evaluated health service, the mean score for this element was less than 3.0 (Table 2), which demonstrate that the service did not integrate family care. This finding also shows the weakness of other characteristics of PHC, besides family guidance, such as longitudinal care and community guidance. In this sense, family participation in the decisions concerning child care is critical so that the care focus is not fragmented and that the needs of the child and his/her family group are addressed.

Family integration in child health care, as well as the integration of health service and its professionals in family care broaden the relationship among the participants, remodeling the focus of health care. Despite that, in the studied municipality, individual-centered care was highlighted; care focused mainly on family was not evident throughout the follow-up of life cycle of children aged 0 to 12 years (Table 2). The attribute of family guidance in the PHC was not seen as part of the daily routine for delivering care to the child.

A mean score of 4.4 was identified in the assessment of the attribute of family guidance. This attribute also had unsatisfactory value in any of the services evaluated by users of BHU and FHS in previous studies conducted in Minas Gerais and São Paulo, as well as in Santander, Colombia.[7,14,15] However, research carried out in FHS units[6] with children younger than 1 year of age in the countryside of São Paulo reported a high score for this attribute; this finding diverged from previous studies. This discrepancy can be explained by the fact that participants in the latter study[6] were from a single family health unit; the study did not involve all units of the municipality or the selected health district.

In the municipality of the current study, the territorial process was concluded in 2012; however, according to data reported by interviewers, gaps

remained in diagnoses among the enrolled community, especially because services are not close enough to the community. We emphasize that the mean was unsatisfactory for all of the assessed elements (Table 3), which indicates the weakness in other attributes of PHC, such longitudinal care, access, integration of care, and family guidance.

One of the tools that PHC uses to understand the community is the home visit. This activity should be done by all health professionals. However, in this study, the mean score for this requisite was 2.9. Although home visits are an important tool, this practice is not conducted effectively and often is not integrated into the services care plan. Our study highlights that professional education in directions not compatible with those proposed by PHS and the massive presence of biomedical technology favor this negative aspect. Related to this aspect is the organizational environment of health services, which has a very complex dynamic involving users, health professionals, and their self-governors and the service administration. For this reason, focus on changes in the working process in health care led to several reflections concerning macro and micro policies.

In this context, the FHS is a care model that progresses slowly because it is based on broad objectives and involves community agents. In addition, little attention has focused on work conducted within these teams, particularly interdisciplinary practice in the daily routine of health care in such services.[14] Continuing education in health can be a strategy to generate new knowledge and broaden discussions in working environment, integrating the health team to identify strong and weak points of the service, reflecting the integral care to the child.

To improve the performance of services with relation to community guidance, it is imperative to understand the role of the service in community health problems. The assessed services had a mean score that was lower than ideal (Table 3), which showed a weakness of services concerning integration with the community. An approach oriented to the community links the clinic, epidemiology, and

social sciences, so that programs can be changed based on needs and the efficacy of such changes can be evaluated.[16]

The survey in the community to identify its problems also showed an unsatisfactory mean score. Listening to the population is important because health professionals often act as if they know the needs of the population and take for granted the way they should to act; they also assume interventions involving only technical knowledge are sufficient for effective care. Health problems or needs of the population must be take into account based on social health determinants.[17]

The scores of the other studies[7,8,14,15] on assessment of attribute of community were also considered unsatisfactory. It is evident that the score of attributes of family and community guidance (4.4 and 5.1, respectively) did not address the PHC goals of including the family and community in pediatric care, strengthening the culture of individual-centered care. The need to broaden PHC is clear in the municipality where this study was conducted based on the working process centered on such clinical widening, which emphasize the focus on family and children in their cultural context and in the community needs. For this reason, this broadened focus will entail the reformulation of public policies in the municipality, as well as in some aspects related to the structure and care process for an effective implementation of high-quality PHC services.

Conclusion

Attributes of family and community guidance had lower score in child health care based on assessment of users of primary care services. The service did not reach its total extension, which compromised the affiliation degree to the service and resolution of child health care in the PHC.

Collaborations

Araujo JP; Viera CS and Toso BRGO contributed with project design, data analyses and interpretation; Araujo JP; Viera CS; Toso BRGO; Collet N and Nassar PO contributed to critical revision of important intellectual content , drafting the manuscript and final approval of the version to be published.

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