Problem-solving capacity in children health care: the perception of parents and caregivers

Resolutividade na atenção à saúde da criança: percepção de pais e cuidadores

Rosane Meire Munhak da Silva[1]
Cláudia Silveira Viera[2]
Beatriz Rosana Gonçalves de Oliveira Toso[2]
Eliane Tatsch Neves[3]
Rosa Maria Rodrigues[2]

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Abstract

Objective: Understand how the health problems of a child are solved in the perspective of parents and caregivers, based on the attributes of primary health care.
Methods: Qualitative study using a hermeneutic-dialectic approach involving 16 caregivers of children younger than one year old, assisted at an emergency unit.
Results: Lack of access, absence of bonding and coordination, and comprehensive care deprivation contribute to the lack of resolvability, leading to a search for alternatives to solve the health problems of children.
Conclusion: As observed, primary health care services demonstrate no problem-solving capacity in children's health problems, as the essential attributes for the effectiveness of such care were not present.

Resumo

Objetivo: Compreender como ocorre a resolutividade do problema de saúde do filho na visão de pais e cuidadores, a partir dos atributos da atenção primária à saúde.
Métodos: Pesquisa qualitativa com abordagem hermenêutico-dialética, envolvendo 16 cuidadores de crianças menores de um ano, atendidas em serviços de pronto atendimento.
Resultados: Falta de acesso, ausência de vínculo e coordenação, privação do cuidado integral contribui para não resolutividade, levando a busca por soluções alternativas para resolver os problemas de saúde das crianças.
Conclusão: Na apreensão do estudo observa-se que os serviços de atenção primária não se mostram resolutivos diante dos problemas de saúde das crianças, visto que, os atributos essenciais para efetividade nesse ponto de atenção não estiveram presentes.

Corresponding author
Rosane Meire Munhak da Silva
Tarquínio Joslin dos Santos Avenue, 1600, Foz do Iguaçu, PR, Brazil.
Zip Code: 85870-650
zanem2010@hotmail.com

[1]Universidade Estadual do Oeste do Paraná, Foz do Iguaçu, PR, Brazil.
[2]Universidade Estadual do Oeste do Paraná, Cascavel, PR, Brazil.
[3]Universidade Federal de Santa Maria, Santa Maria, RS, Brazil.
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Introduction

Government strategies implemented by public health policies towards children enable the reduction of the causes that lead to children sickness, allied to income distribution actions that empower social services policies.[1,2] This setting can be demonstrated, for example, by the results achieved in child mortality rates, since during the Brazilian colonization period, child mortality reached 700/1000 live newborns, and currently the country presents an index of 16/1000 live newborns.[3]

Mortality in the neonatal period is still high, for 60% of early deaths could have been avoided by timely access to quality and resolutive health care services.[1,2] In this setting, the existence of health policies aimed at children's health and the availability of primary health care services to the families and children are observed, however, they have no intense effect on the reduction of morbimortality for avoidable causes. The absence of actions for health prevention and promotion keeps the avoidable morbimortality occurring, in association with the vulnerability of primary health care services.[4]

A resolutive health care system is understood as a social response to health needs. Problem-solving capacity is defined as the capacity of solving health problems of people under social and biological vulnerability, for example, a child, regardless the complexity or level of care.[5] This capacity must be guided by primary health care, understood by following its attributes, namely, access, longitudinality, comprehensiveness and coordination, in addition to the complementary attributes: family, community and culture.[6]

Solving health problems in children under these conditions means the actions must be guided to a broad health context, conducted by comprehensive care and by following essential elements such as: movement, interaction, otherness, plasticity, project, desire, temporality, non-causality and responsibility.[7]

The objective of this study was to understand how the health problems of a child are solved in the perspective of parents and caregivers, based on the attributes of primary health care.

Methods

Qualitative study based on the hermeneutic-dialectic methodological framework. Hermeneutics is based on the concrete experience of the encounter or otherness, not limited to a logical repetition of the traditional method of thinking, aimed at broadening thinking horizons through comprehension and interpretation.[8] The dialectic emerges as a proposal to discuss perspectives for solving children's health problems.

The study sample was comprised of children one year or younger, and their families, assisted in the Emergency Services of the city of Cascavel, state of Paraná, in the south region of Brazil in 2010. Sixteen subjects were randomly selected from the urban area of the city. Subjects were contacted by telephone and, later received a home visit for the interview. Documental data collection was performed in the file department of the emergency service units and the interviews in the residence of families, during the period between March and May of 2012.

Being a study with qualitative approach, the sum of all interviews was not relevant for the methodological proposal, even though it was part of the comprehensive praxis. When results started to generate construct and to answer the initial questionnaires, data collection was concluded.[9] Three collection techniques were used: home survey; talking maps; semi-structured interview.[10]

The construction of results followed three steps, namely: reading of transcribed interviews, aimed at becoming familiar to the text and identifying meanings; identification of meaningful connections composing the interpretative reading; interpretation of the whole, reflecting on the initial reading and transferring to the interpretative reading, achieving a broad comprehension of data, describing themes and subthemes for discussion guided by the referential attributes of primary health care[6] and elements of comprehensive care.[7,8]

The development of the study followed the national and international ethical guidelines for studies involving human beings.

Results

Subsections that demonstrate difficulties and obstacles in solving children's health problems emerged from the study theme, described as follows.

Lack of access, absence of bonding and coordination in health services contributing to the non-capacity of solving problems

Despite the transformations in the current health thinking, in addition to technological progress, many people still face difficulties in accessing services to solve children's health problems.

"[...] starting the treatment is very complicated. Like my grandson […] he had adenoid disorders and underwent surgery, but the surgery took one year and three months to happen" (subject 10).

In addition to the access, primary health care services must be presented as an essential tool for health care and user embracement. In the absence of user embracement, the link between professionals and families will be hardly established.

"[...] sometimes the girls [receptionists] […] provide us with good service, sometimes they don't. Sometimes when you have to ask for something they are very rude" [referring to an aggressive service] (subject 8).

The lack of interest and non-responsibility were added as properties for non-capacity of solving problems in this reality.

"[...] the professional [physician] who provided me with the service, if she had more interest in caring for his [son] health, what would she have done? If she went any further, she would have done something more [...], but she simply prescribed paracetamol […]" (subject 4).

In order to achieve the problem-solving capacity, a coordinated primary health care service is needed, in other words, planned and organized with a view to provide people with service in an efficient, agile and effective manner, exhausting all possibilities of health care, before referring patients to other sectors.

"We should go through a consultation, if the child is feeling bad, have a consultation here [primary health care unit] which is closer […]" (subject 9).

Deficiency in comprehensive care generates the non-capacity of solving problems

It is fundamental to have a service guided by comprehensive care in order to achieve the problem-solving capacity in the health care of children. Hence, it is necessary that services consider social determinants for the care. The following report emphasizes that the understanding of comprehensiveness and the capacity of solving problems were not considered by public health services.

"In my case, I am a mother of five children, what does it solve? [...] What would 100% be for me? It would be a good service, having a place to leave them [children] […]. Because if he [son] was in a daycare and had a little problem, they [teachers] have means to take him there [primary health care unit], […] I have no resources" (subject 12).

In order to complement these conceptions regarding social determinants, the capacity of solving problems in health services guided to comprehensiveness must offer conditions for the families to care for their children.

"[...] I think the government had to send more medication, since there are many people who cannot buy them, so how do we do it? [...] How can the mother buy it without money, it is difficult. [...] This way, mothers will always be able to take care of their children" (subject 8).

The biologic view, which does not consider the family social context, will hardly propitiate happiness to people, as this view is summarized into the solution to the immediate problem not perceiving what made the children sick.

"[...] the physician was not good, and I never went to see her again. [...] Some physicians go beyond, they see what is going on […] let's find out what is going on, where it is, go beyond, and make the patient happy. He is already in pain, goes to see the doctor, goes there to get well. The physician must make efforts to act as if it was someone in his/her family […]. [...] They say [professionals] we want what is the best. It is not the best we want; we want the necessary […]" (subject 4).

Contrary to the previous report, the understanding that the capacity of solving problems is

a synonym of sickness treatment emerges, in other words, the care under the biological concept.

"[...] I consider consulting, prescribing a medication, seeing if everything is alright. [...] Like when they took an x-ray, I thought it was good […]" (subject 3).

The prescription of medication, performance of laboratorial and image exams were also appreciated for the capability of solving problems in health services for children's sickness.

"I think it must be faster, not taking it so long […]. I mean, the exams […] we have to wait for many days, if the person is not well, […] it gets even worse […]. And there can be no lack of medication, I take controlled medication […] But now the doctor told me this medication will not be provided anymore, I will have to buy it" (subject 10).

"[...] Taking someone to a consultation, receiving the service, does not take too long […] and receiving medication […]. And it does not take very long to have an exam […]" (subject 14).

For caregivers, health professionals are unprepared to provide comprehensive care to children.

"[...] I also think they [receptionists] need more organization, guidance. The physicians back there [offices] cannot see what is going on […] what if someone dies in the front" (subject 1).

Search for alternative solutions to solve health problems

In face of the non-capacity of solving children's health problems, the families search for alternatives that, often, may either aid or damage the care. As an auxiliary alternative, the search for help in religious entities was mentioned.

"She [pediatrician] gave me a lot of medication […], I told them I would turn to the children's pastoral. In the pastoral […] My son is currently treated with medication from the pastoral, I give him anemia medication, I give him everything" (subject 12).

In addition to the expectation of help in religious entities, spirituality and faith emerged as a way to solve health problems in children.

"[...] I didn't buy the milk [indicated by the pediatrician due to a possible allergy to lactose], I came home, prayed […]" (subject 13).

As a damaging alternative, the direct search for medication in pharmacies without prescriptions was described. Moreover, the requirement for medical prescriptions in buying antibiotics was perceived as an obstacle in the care of children.

"And now the pharmacies do not sell antibiotics anymore, only with a prescription […]" (subject 6).

This setting in public health services made and still makes families search for private services, demonstrating the absence of access, coordination, longitudinality and comprehensiveness.

"[...] I took him to the unit, the pediatrician saw many exams, […] a fever suddenly broke out […], I went to the lab, collected the exams, but the results showed nothing. He did not get better; I took the exams to a private doctor who prescribed the medication. [...] he got better […]" (subject 4).

"[...] When you need it, there are no resources [...] you have to wait and until you wait, you have to look for a private doctor. [...] If I go out now and want to book an appointment for my son I can do it […], but he doesn't need it now […]" (subject 13).

Therefore, families stop searching for care in public services because they show no capacity of solving health problems in the care of their children.

"[...] Now, I am not going there anymore, because when I go, I waste my time, so I don't go anymore" (subject 8).

Thus, given these difficulties, families preferred to search for health care for their children in the emergency services units, denominated Continuing Health Care Service.

This search occurred due to obstacles in accessing primary health care services; lack of organization of primary health care services; absence of user embracement and responsibility; slow services; among others.

Discussion

The present study offers resources so that active professionals and managers in primary health care will reflect on their practices and invest in the improvement of actions for empowering the problem-solving capacity in the care of children, as health ser-

vices in the studied city do not present the capacity to solve health questions that affect children under one year old.

The limitations of this study involved the perceptions of the families, since the implementation of the suggestions reported also require the view of active professionals in many health care positions, for example, in nursing.

The lack of problem-solving capacity was demonstrated by not following the primary health care attributes. Resolutive care may be obtained by accessing services, however, within this reality, this search was distant. The preferential access for health care is the primary health care, however, due to the slowness in these services, caregivers sought for alternatives they considered more accessible to solve their problems.[6]

The search for services that will not characterize a prioritized admission in the system results in a colossal demand in urgency and emergency services and discontent families for not receiving the necessary care, as they are not responsible for continuing the care.[4,7] This organization format with no care project due to the increase in spontaneous demands and the summarization of care to acute problems reflect the lack of problem-solving capacity.[4-6]

Another problem referred to the lack of user embracement to the families, which generated an environment of lack of trust.[1,11] Longitudinality occurs by means of a trusting environment built throughout time, only this way the care will be prosperous and achieve the capacity of solving problems.[4,6]

The lack of interest and non-responsibility mentioned by the families also led to the non-capacity of solving problems.[7,12] These perceptions demonstrated the absence of otherness and interaction among health professionals, including the absence of listening, essentially hindering the fusion of horizons.[13]

Regarding comprehensiveness, the view used as guide is the view of children rescuing subjectivity and considering themselves as social subjects with rights, belonging to a family that also requires care.[4,7,14] This conception is possible if social determinants for the care of children are considered, whether economic, locational, nutritional, educational, among others, characterizing a social response to children's problems.[4,14] This comprehension for establishing the problem-solving capacity was not present in this study, and the lack of minimum conditions for the families to care for their children, constructed by the movement of care was mentioned.[4,7]

The search for a care system with problem-solving capacity is built within a care beyond the biological and non-causality aspect.[7] It involves the understanding of human beings as individuals with subjectivity found under vulnerable conditions.[5,14] Notwithstanding, this momentary condition must not be interpreted as a state conditioned to the professional's decision, however, reflected in compound with the subject to receive care, in the case of children, the parents. Hence, practical success is achieved propitiating happiness. User embracement and responsibility are excellent ways of propitiating happiness.[11-13,15]

Opposing this argument, some families understand that problem-solving capacity is a synonym to treating diseases, signaling only the causalities. This argument demonstrates how families become the victims of a weakened health system. This reduced conception, centered in the fragmentation of the care propelled by the pharmaceutics-medical industry emerges among many professionals involved by the lack of otherness and plasticity.[7] It makes inappropriate information reach the families, making them vulnerable within our capitalist society.

In order to face these problems and solve health problems, coordination is needed to meet the needs in an agile and full format. Nevertheless, health services are fragile, with isolated and non-standardized working methods that result in fragmented actions with poor solving capacity.[6] The context denotes the conditions available in primary health care services, which makes them provide assistance rather than health care, mixing elements of the selective primary health care and as the first level of care in the Unified Health System (SUS, as per its acronym in Portuguese), characterizing the background of many problems faced by the primary health care in the country. Services with the presence of coordination

attributes provide services to children in a programmed format and not spontaneously.[4]

Primary health care services are presented as vulnerable due to the slowness and availability in the moments they are needed. Such vulnerability was related to the lack of support services to exhaust the possibilities of solutions before referring patients to other spheres of care.[4,6] Moreover, reference services are poorly functional and slow, proving the absence of longitudinality. This fact led families, even while having financial difficulties, to generate expenses in attempts to solve health problems of their children. The considerations denote the absence of desire, project and movement for care.[7]

Going beyond the economic situation, the absence of desire, project and movement also presupposed the lack of preparation of professionals in the care of children.[7] The present coordination in a service tends to develop its members in a competent and satisfying manner, involving all participants of the service. A prepared team embraces users and presents solutions for their health problems, even when the result is not a medical consultation. Sometimes, a dialogue is enough to solve the problems affecting them.[4,6,12,13,15]

Coordination also involves providing services within a precise period, reducing people's suffering to the least.[9] In addition to the agility in health care, the availability of technologies also enables reorganizing and transforming health practices guided to comprehensiveness and care with the capacity of solving children's health problems.[14]

Since they are presented with no problem-solving capacity, the families search for alternatives to solve health problems; even though sometimes, these alternatives can negatively affect them. The search for help in religious entities, spirituality and faith emerged as health care auxiliary; however, the direct search for medication was demonstrated as damaging. This search was understood as an immediate solution. Moreover, it also led families to search for care in private services,[6] even when they had no favorable conditions for this search, collaborating for empowering their precarious existing conditions.

This setting led many families to stop searching for these services, losing the trust that the public sector can or will be able to collaborate in the care of their children.

The value of public policies and professional practices are emphasized as a concrete horizon, the capacity of solving problems in primary health care, whether to avoid inherent iatrogenies to non-systematic or non-committed practices, whether to execute comprehensiveness exclusively to impossible cases treated under this care level. Distant from focusing the care to a primary level, offering poor care for poor people, the capacity of solving problems must be the foundation on which the SUS (Unified Health System) is based, implemented in its plenitude, focus of the battle of professionals and the population.

Conclusion

In the understanding of parents and caregivers, the studied service has no capacity of solving children's health problems, since essential attributes of primary health care were not present. Several problems were identified, such as lack of access and slowness in the care for children; lack of bonding triggered by the lack of interest and non-responsibility; lack of comprehensiveness; and lack of organization of services due to coordination deprivation.

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Collaborations

Silva RMM and Viera CS contributed to the execution of the project, analysis and interpretation of data. Silva RMM; Viera CS; Toso BRGO; Neves ET and Rodrigues RM collaborated in writing this article, in the relevant critical review of its intellectual content, and in the approval of the final version to be published.

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