FAMILIES' PERCEPTIONS REGARDING THE ORGANIZATION OF PRIMARY HEALTH CARE FOR THEIR CHILDREN

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ABSTRACT: This descriptive, qualitative research aimed to understand, based on the families' perception, the organization and the practices of care for the child in primary health care; the study was undertaken with 45 representatives of families of children aged from zero to five years old, enrolled in the programs of three health centers in a municipality in the metropolitan region of Curitiba, in the state of Paraná. The data was collected between September 2008 and February 2009, through three focus groups, and was analyzed using categorical thematic analysis. Three empirical categories emerged: *Access to the health services; Integrality;* and *Embracement*. In the perception of the families, there are issues which are favorable in relation to the reformulation of the practices of the programs for child health. However, they mention barriers to access, resulting from issues of organization of the services for the population not included in these programs. It is therefore considered essential for the families to participate in the planning of the health care actions for the child.
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INTRODUCTION

The Unified Health System is being restructured so as to meet the population's real health needs, Primary Care and the Family Health Strategy being indicated as examples of innovative strategies. This being so, it is essential to re-think the planning of the production of the health services, in relation to their logic of addressing only the pathological manifestations, which is characterized as fragmented, curativist and ad hoc.

It is necessary to work in a holistic perspective, that is, to reflect the health practices based on the widened reading of the context of the individuals' lives, ensuring that the interventions occur in line with each person's specific characteristics[1].

It is necessary to understand the form of the organization of the services based on the dialectic between the health requirements attended and the needs perceived by the families, in order to strengthen the intervention projects related to child development[2], as the family produces essential care for the health of its members[3]. For this, the service users have the right to participate in the decisions, even though it has been ascertained that this participative process is left to one side when the services are set up[4].

Therefore, this study's aim was to understand, based on the families' perception, the organization and the practices of care for the child in primary health care.

METHOD

This is descriptive research with a qualitative approach, undertaken in a municipality in the metropolitan region of Curitiba. The primary health care network in this region is made up of 21 Health Centers, of which 8 are centers with the Family Health Strategy and 13 are Primary Health Care Centers. Three centers with the Family Health Strategy were selected, suggested by the managers, the criteria being greater demand for the attendance of children.

All the members of the 45 families resident in the areas covered by the centers were invited to participate in the research, this being 15 families from each Health Center. However, only 15 mothers and two grandmothers from different families and areas of coverage accepted to participate in the study. The inclusion criteria for the families was to have children aged between zero and five years old, enrolled on one or more of the Health Center's programs.

The data was collected between the months of September 2008 and February 2009, through three focus group sessions with a semi-structured script which addressed the facilitating and hindering aspects in relation to the attendance of the children in the Primary Health Care Centers, and the improvements the families indicate for these services.

The statements were recorded and transcribed in full, being termed in the discourses as FG (focus group) followed by the numerical sequence in which they occurred (FG1, FG2 and FG3). For analysis of the data, categorical thematic analysis was used[5], which presupposes the stages of pre-analysis, exploration of the material or codification, treatment of the results, inference and interpretation.

The project respected Resolution 196/96 of the National Health Council. Agreement was obtained from the municipality's health managers, and the project was approved by the Research Ethics Committee of the Health Sciences Department of the Federal University of Paraná, under record N. CEP/SD: 376.056.07.07.

RESULTS

Based on the thematic analysis, the following categories and subcategories presented below.

Access to the health service

Subcategory – Access to the health service through the child health programs

The access to the service, represented by the child health programs, was considered satisfactory. The following were mentioned: the free child-rearing, immunization and milk programs, allowing the children priority of insertion in these programs and in the other services provided by the Health Center.

The immunization program was specifically mentioned by the families, with the mechanisms for access – such as the flexibilization of attendance times and the availability of the types of vaccines for childhood – indicated as positive points, as described in the account below:

The vaccine, I do it here [...]. *They always have the ones you need, at any time.* (FG 2)

Another program mentioned as facilitating the care for the child in the organization of the child health services was the milk program. Nevertheless, the families mentioned its operationalization as dissatisfactory, in

relation to the day and time proposed, which limit and conflict with the weighing of the child and the handing--over of the milk. The need to review this practice was suggested, as mentioned below:

Here, it's one day every two months [the weighing for the free milk program], and it turns into a ruckus. There's a load of mothers waiting, and sometimes there isn't time to go and get the milk, which is the same day, until 9 o'clock. Except, for you to get the milk there, you have to do the weighing. (FG 3)

Account FG3 makes clear that the organization of the service needs to be rethought, so as to meet the health needs. For this, the families pointed out that there needs to be a space for listening between service users and health workers and managers, regarding the difficulties confronted in using the service, as related below:

If we had a meeting with everybody here who has something to complain about, regarding the clinic, like we are doing now? Only the parents are here, but what if we were to do this with somebody from the local government? Look, we need a pediatrician, we need more medicines; we need this, we need that. (FG 3)

Subcategory – Access to the health service in the case of spontaneous demand.

The families mentioned spontaneous demand as one of the means of succeeding in being attended. However, this means of access is mentioned for children in the age range of over two years old, who are excluded from the municipality's child-rearing program, and is pervaded by descriptions of inefficiency, as – according to the accounts below - it does not succeed in meeting the needs of the service users who seek this service:

Sometimes there are only ten slots for being seen; we turn up, wait for ages and don't necessarily get seen at the time! (FG 1)

[...] *you have to pay for a consultation, there in the "X"* [private clinic]. *Because of that, if the baby gets ill* [...] *I'm paying to be attended better.* (FG 3).

One should emphasize that in the municipality, there is pre-scheduling of medical consultations and integration with other professionals, such as the dentist and nutritionist, only for those children who are inserted in the child health programs - causing the other children to have to rely on spontaneous demand.

Accounts FG1 and FG3 express the difficulties of accessing these health services, such as having to queue from extremely early in the morning ('dawn queues'), lack of slots for consultations, and the incompatibility of the Health Center's opening hours with the parents' working hours. These difficulties are mentioned as situations which contribute to the inversion of the logic of the model of care initially idealized in the system through primary care, and the proximity of the territory – the life space as the locus of the health care – as contributing to the distancing of the service of reference from people's area of residence, as they seek services for meeting their health needs.

The Integrality of the health services

When the focus is the system to integrate the primary, secondary and tertiary level services, in particular regarding referral and counter-referral in the municipality, the families perceived various difficulties, which are reflected in risks to the children's health, apart from the discrediting of these mechanisms, with shortcomings in the control of regulation of spaces, with long queues, as in the account below.

My son had a heart problem in 2001. I brought him here with a document for him to be referred. It arrived back last month. My son is 7 years old now, and it's less than one month since the document arrived [...]. *I had him seen privately, otherwise my son would have died* [...]. *They did tests and detected a blocked vein in the heart. They had to do an emergency operation.* (FG 4)

Embracement

Embracement, stipulated by the SUS, was recognized by and mentioned by the families as a quality practice, restricted to some professionals who use it as a tool in their work, as if by a family member:

Dr. X was a great doctor here, but he left [...] *He seeks what the child has, he doesn't request tests, he examines, he listens to us, he is patient in the consultation.* (FG 3)

The proposals for embracement must be articulated with the families, who suggested some measures in the focus groups, such as the pre-scheduling of the

consultations, the reserving of spaces, the flexibility of the opening hours, and even a more attentive, patient approach with co-responsibilization, as may be perceived in the discourse below:

[...] *arranging today for next week... Even if it took one or two weeks, so long as I didn't have to queue up in the early hours!* (FG 1)

DISCUSSION

The health programs which are adopted by the municipalities originate from clinical-epidemiological strategies which aim to reduce the rates of ill health in the population. In spite of the difficulties experienced, the municipalities are responsible for putting specific interventions – the actions for prevention of ill-health, and promotion of health - into practice in a decentralized way[6]. This decentralization allows the differentiated organization of the health services, so as to allow the attendance of the population's real needs.

The delimitation of the age range for attendance in the child-rearing program ends up causing the exclusion of those children who are not within this age range. One may reflect that for these families, the access to primary care may be considered focussed, but that this restricts the attendance to specific services or programs, establishing the universalization of the care in a segmented, de-articulated organizational chain of the public system as a whole[7].

A challenge is instituted to the local managers and workers: the expansion, or creation of, measures for greater access for the children in the age range which is outside this program. It is indicated that the monitoring practices for children in these Primary Health Care Centers may still be focussed in the model centered on the doctor, on the medical consultation, because the families did not mention care practices performed by other professionals in the Health Center for Child Development. It is necessary to make use of the Family Health Strategy team's skills so as to produce a culture of health promotion, prevention of ill-health, and treatment and rehabilitation.

The immunization program, mentioned by the families, aims to administer and monitor the child vaccine situation, working with types of vaccines standardized by the municipality based on the needs for epidemiological control. The Immunization Program's credibility may be owed to its effectiveness or to the fact that the service is free, as well as being the result of government investment with specific programs and goals for immunization, including the frequent publicity campaigns with the population and health workers[8].

The above-mentioned milk program, mentioned because it is an important means of accessing health care, was implanted in various municipalities in Paraná, with the aim of combatting malnutrition through the distribution of one liter of milk per day to those families with children aged between six months and three years old, and whose per capita income is of no more than half of a minimum salary[9]. Through this, the health centers monitor these children's growth and development, measuring and weighing them.

The families' participation in the conception and operationalization of the health services' practices is essential, and occurs in the municipality studied through the Municipal Health Council. Nevertheless, these wish or request to participate in the local planning of the centers and are concerned that the managers should be aware of these discussions so as to ensure the changes which they are to implement. It is noted that spaces for listening in the health centers must be established in an organized way and undertaken frequently, as with the evaluations of the health actions and activities undertaken for these families.

The local planning of the services is a collective project for integrating health care, in which workers, managers and service users are co-responsible in producing health[7].

For the changes in the organization of the service, it is also necessary for the authorities to be committed to establishing public policies for protecting and promoting child health, and thus to contribute to reducing the inequalities which condition the health-illness process. Therefore, the extent of investment which the State makes available for financing the actions for the attendance of children is related to the access to the health services and to the population's quality of life[10].

Access to the health service, in relation to spontaneous demand, is pervaded by the difficulties mentioned, being added to a biologicist and curativist culture, and to the limited number of spaces for medical consultations offered each day in the Health Center, concentrated in the morning period, which thus cause 'dawn queues' and, moreover, are determined by order of arrival at the services. This form of access does not make clear to the interviewees whether there is a logic of priorities in attendance by the health services.

As a result, offering the population means of accessing the health services with quality means minimizing

or breaking down barriers which permeate the process of obtaining care, and which may refer to the organization of the health services and to the institutions' work process, going beyond geographical, socio-economic and cultural aspects[11].

Based on the premise that health is a universal right, it falls to the State to offer the population the conditions for accessing the health services, so as to be able to live fully, covering the health-illness process, and its socio-economic causes[12].

The reorganization of the health service and of the professional practices becomes more complicated when the relationship between what is offered and the demand is not well-known, causing the actions to be undertaken in accordance with the demands in the services[13]. The need to prioritize groups for action, such as child-rearing, may cause another group of service users to be dissatisfied due to not receiving the same benefits and to considering that the services are not resolutive and that they seek equipment which does not have primary care characteristics. This practice demonstrates that the service users construct their own itinerary to relieve the health-illness problems, based on beliefs, knowledge and facilitating aspects which they find in the health services[11]. One may perceive an inversion of the logic of the gateway, which should be through the Health Center, which can cause discontinuity in the care of the service user.

So as to respond to the child's health needs, the families need to be able to rely on a hierarchized network of care, with professionals and services within and without the Health Center themselves, and even articulating services which pass outside the municipal boundaries. In this respect, the concept of integrality is linked to the organization of primary care, and its responsibility to provide continuous care to the population, as it consists of the service user's gateway to the different levels of care, affording the interpretation of the problems within the service user's historical-social context[14]. In order to promote integrated care, it is necessary for organizational structures to share ideas with network arrangements, management of processes, and management of the illness[15].

It is understood that the long wait for care at the secondary or tertiary level of health care is also a problem in other cities, as cited in a study undertaken in Fortaleza, which indicated that the service users can remain in this process for a year or longer. Among this difficulty's causes, the authors of the above-mentioned study refer to the lack of articulation between the primary level of health care and the other levels of the system, resulting in some service users being obliged to pay for private consultations with specialists[16].

It is valid to remember the Health Center's responsibility in relation to the counter-referral and monitoring of the cases. It is necessary to organize the attendance in line with the individual's needs and the seriousness of their condition. It is appropriate to act fairly, that is, the order of attendance and procedure must be equivalent to the harm to health, avoiding further compromising of people's health.

The lack of articulation between the services referring and counter-referring involves a lack of communication between the health services at their different levels of care and, in its turn, involves possible damage to the continuity of the care[17]. Therefore, in the organization of the health services, one must aim for integrality in the structuring of the services, with appropriate functioning of the system of referral/counter-referral, given that the resolution of the health problems often entails appropriate referral to specialized health services[17].

Here we return to the integrality of the services, so as to attend the different levels of care, perceiving the need to reorganize the institutions and their practices so as to promote access to a hierarchized network of integrated care, and with professionals whose focus is directed toward a care which covers the individual in all her dimensions, including considering the priorities necessary in each context.

Access and embracement are complementary in the implementation of the practices in the health services, in the search for integrated care[11]. In reflecting on the structuring of the Unified Health System as an offering of services, which has limits for attending the free demand, creating hierarchized and prioritary networks, the measures for embracement become essential in the routine relationship between service users and health service.

Embracement is understood through two aspects: one grounded in the stance taken by the health professionals for attending to and meeting the service users' expectations, intermediating the dimensions of the service's offers and possibilities with the needs expressed by the service users, and the other, covered by the organization of the health service as a mechanism planned and implemented for reorganizing the work and structure of the Health Center so as to meet demand whether spontaneous or organized in the programs, improving the conditions of access to the service as a

whole[18]. It stands out that both perspectives are effective and complementary for resolving the population's health problems.

In order to qualify the care, one incentivize the joint construction of the means of producing health within the institutions. In this regard, the organization of the service is influenced by this construction, which must be based on the real needs of those seeking the service, allied with the epidemiological information and with the use of the territory as a locus for the health practices. Thus, one must incorporate new strategies for qualifying and extending the actions, such as: unique therapeutic projects, expanded clinics, and matrix support[19].

The routine activities undertaken in primary care, when associated with the techniques of embracement, can bring about greater adherence on the part of the service user, as well as broadening the user-professional/health service bond, which is fundamental in the effective monitoring of children's health in the zero to five years old age range, and in the strengthening of their families.

Discussing embracement and access to health care goes beyond the singular dimension, requiring reflection on how the health team organizes its attendance to the population, and the understanding of how the State takes on the commitment to the population's health as expressed in the health policies, financing, and maintenance and strengthening of the democratic spaces collectively constructed so as to express and recognize the population's health needs.

It is emphasized that these professionals' work process needs to be known, as do the possibilities in their training for better understanding issues which may influence the service user-professional relationship. The pressure in a disorganized spontaneous demand can be one of these problems, and makes one think that the health professionals also need a welcoming in their work process, with appropriate training, incentives, listening, autonomy and strategies of care for the caregiver[11].

FINAL CONSIDERATIONS

The families indicated both favorable and negative points in relation to the organization of primary care. It is understood that there are needs for restructuring the practices and organizations of the health services which permeate the local dimensions of the Health Center, as they are pervaded by socio-historical issues of primary care, and express political and structural competences of the municipal, state and federal spheres.

However, embracement's potential may be perceived as a valuable tool for minimizing the families' dissatisfactions with the organization of the services, especially regarding flexibilizing the issues of access to the service, and thus promoting the link between the US and the community, and opening spaces for dialog so as to capture the families' real needs for care for the child, seeking the empowerment of both parties. In this way, the families' participation in the primary care actions for promoting children's health is considered essential.

The undertaking of further studies may indicate reflections and new professional experiences regarding the work process of the health professionals in different contexts and the possibilities for interconnecting the families' health needs for the care of the child.

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