



THE SYSTEM OF REFERENCE AND COUNTER REFERENCE IN ATTENDING TEENAGERS: REALITY X COMPLETENESS

O SISTEMA DE REFERÊNCIA E CONTRARREFERÊNCIA NO ATENDIMENTO AO ADOLESCENTE: REALIDADE X INTEGRALIDADE

EL SYSTEMA DE REFERENCIA Y CONTRAREFERENCIA EN EL ATENDIMIENTO AL ADOLESCENTE: REALIDAD X INTEGRALIDAD

Fernanda Augusta Penacci Torralbo¹, Carmen Maria Casquel Monti Juliani²

ABSTRACT

Objective: understanding the perception of professionals who provide care to adolescent health that meets socio-educational measures on the functioning of the referral system and counter, in the state Southwest region of São Paulo / SP. **Method:** qualitative study, whose methodological framework used was phenomenology. The production data was performed with doctors, nurses and owned nursing assistants who worked in inpatient-UI units, inpatient units and Internment Provisional-UI / UIP and Socio-Educational Service Centers for Adolescents (CASA). **Results:** emerged in the category << Access to care in the health system >>, composed of themes: << The operation of the system >> and << Regionalization and Completeness of attention >> need for better organization of care network. **Conclusion:** local and regional planning, a process that respects the capacity of services, combined with the agreement and accountability of the actors are valuable tools to meet the health needs in the various regions. **Descriptors:** Adolescent Health; Nursing Public Health; Health System and Comprehensive Health Care.

RESUMO

Objetivo: compreender a percepção dos profissionais que prestam assistência à saúde do adolescente que cumpre medida socioeducativa, sobre o funcionamento do sistema de referência e contrarreferência, na região Sudoeste do Estado de São Paulo/SP. **Método:** estudo qualitativo, cujo referencial metodológico utilizado foi a fenomenologia. A produção de dados foi realizada com médicos, enfermeiros e auxiliares de enfermagem pertencentes que atuavam nas Unidades de Internação-UI, Unidades de Internação e Internação Provisória-UI/UIP e nos Centros de Atendimento Socioeducativo ao Adolescente (CASA). **Resultados:** emergiu na categoria << O acesso ao atendimento no sistema de saúde >>, composta das temáticas: << O funcionamento do sistema >> e << Regionalização e Integralidade da atenção >> necessidade de melhor organização da rede de atenção. **Conclusão:** o planejamento local e regional, num processo que respeite a capacidade dos serviços, aliado à pactuação e responsabilização dos atores constituem instrumentos valiosos para atender as necessidades de saúde nas diversas regiões. **Descritores:** Saúde do Adolescente; Enfermagem em Saúde Pública; Sistema Único de Saúde e Assistência Integral à Saúde.

RESUMEN

Objetivo: comprender la percepción de los profesionales que prestan asistencia a la salud del adolescente que cumple medida socioeducativa, sobre el funcionamiento del sistema de referencia y contra referencia, en la región Sudoeste del Estado de São Paulo/SP. **Método:** estudio cualitativo, cuyo referencial metodológico utilizado fue la fenomenología. La producción de datos fue realizada con médicos, enfermeros y auxiliares de enfermería pertenecientes que actuaban en las Unidades de Internación-UI, Unidades de Internación e Internación Provisoria-UI/UIP y en los Centros de Atendimento Socioeducativo al Adolescente (CASA). **Resultados:** emergió en la categoría << El acceso al atendimento en el sistema de salud >>, composta de las temáticas: << El funcionamiento del sistema >> y << Regionalización e Integralidad de la atención >> necesidad de mejor organización de la red de atención. **Conclusión:** el planeamiento local y regional, en un proceso que respete la capacidad de los servicios, aliado a pactar y responsabilizar los actores constituyen instrumentos valiosos para atender a las necesidades de salud en las diversas regiones. **Descriptor:** Salud do Adolescente; Enfermaria en Salud Pública; Sistema Único de Salud y Asistencia Integral a la Salud.

¹RN, MSN, Regional Director of Health in a Public Foundation named Fundação CASA. Iaras (SP), Brazil. E-mail: ferpenacci@yahoo.com.br;

²RN, MSN, PhD, Faculty member of the Department of Nursing, Management area, Botucatu Medical School, Universidade Estadual Paulista UNESP. Botucatu (SP), Brazil. E-mail: cjuliani@fmb.unesp.br

INTRODUCTION

The teenager, in compliance with socio-educational measures, has the right to health, as well as all citizens. Noting the SUS health service integration necessities at the CASA Foundation in São Paulo / SP, developing this study became interesting, also considering the operation of the system of reference and counter reference, one of the critical points for ensuring communication and referrals between services aimed at the integral health care.

The Statute of Children and Adolescents-ECA, introduced by Law No. 8069 of July 13, 1990, in its Article 11 calls for *"It is ensured comprehensive care to the health of children and adolescents, through the National Health System, guaranteeing universal and equal access to actions and services for the promotion, protection and recovery of health"*.¹

Law 8.080 / 1990², regulated by Decree 7508/2011³, which regulates the actions of health services nationwide, determines the SUS principles: universal access, comprehensive care and equity.

Comprehensiveness means offering all types of healthcare services, serving promotion, protection and recovery of health. The cover of this whole range of actions requires an organization to optimize the available resources.⁴

An analysis of health care systems in international perspective shows the predominance of fragmented systems, focused on attention to acute conditions and acute exacerbations of chronic conditions. Fragmented health care systems are those that are organized through a set of health care marks isolated, incommunicado and unable to pay continuous attention to the population.⁵

Understood as mutual referral mechanism for patients between the different levels of complexity of services, the system of reference and counter reference (RCR) is recognized as an element for the integration of health networks.⁶

The health care offered to the adolescent who commits an infraction, in fulfillment of socio-educational measures in the CASA Foundation, the State of São Paulo, involves coordination with primary care. The action takes place in appropriate physical spaces within the Units and Youth Service Centers through a multidisciplinary team. As for the complementary actions, they should be carried out by reference units of SUS as pacts with municipal managers.

Health care networks are polyarchic

organizations of health care sets, with one mission, common goals and cooperative and interdependent action, so that, coordinated by primary care, they can offer comprehensive care to the population.⁶

When enumerating rights, establishing principles and guidelines of the assistance policy, defining general authorities and duties and providing for judicial proceedings involving children and adolescents, the Federal Constitution and the ECA set up a general system of protection of rights for children and adolescents, called Rights Guarantee System (SGD). Inside the SGD persists a subsystem with National System named Socio-Educational Services (SINASE). This constitutes a public policy, designed to include adolescents committing infractions, which correlates and demand initiatives of different fields of public and social policies⁽⁷⁾. Including ensuring access to all health care levels, through reference and counter reference, according to the SUS regulation, as well as inclusion, contemplating actions and services for the promotion, protection, disease prevention and health recovery.

The attendance of adolescents by the health system is hardly profound, in the sense of rights to health being effectuated. To overcome a superficial diagnosis of reality, we have raised a discussion about the attendance of teenage offenders, given the scarcity of similar studies.

One study found that the demand for primary care by adolescents occurs mainly before health problems or specific situations, as pregnancy, sexually transmitted diseases and immunity prevention, offering driven by demand. On the other hand, they were shy of health promotion activities as part of a routine service, pointing towards a structural gap in the dynamics of service for the care of adolescents.⁸

In this context, we proposed the research questions: Which is the CASA Foundation health team experience, regarding the functioning of the system of reference and counter reference in meeting the health needs of adolescents?

The objective of this study is to understand the professional's perception when attending to the health of the teenager under social-educational measures, of the system of reference and counter reference in the southwestern Region of São Paulo State.

METHODOLOGY

Article drawn from the dissertation << *The Reference and counter system in serving the*

Torralbo FAP, Juliani CMC.

Adolescent Offender: Health professionals' perception of the CASA Foundation >>, presented the Program of Graduate Studies in Nursing, Faculty of Medicine of Botucatu, Universidade Estadual Paulista / SP, Brazil. 2008

This qualitative study, on the phenomenological slope, uses the framework of the situated phenomenon⁹. It was authorized by the Ethics Committee of the Faculty of Medicine of Botucatu / UNESP (Letter No. 81/2007).

Production of data took place after obtaining the signed Informed Consent form. The subjects were health professionals working in inpatient-UI units, inpatient units and Internment Provisional-UI / UIP and Socio-Educational Service Centers for Adolescents (CASA), belonging to the South West Regional Division of the CASA Foundation / SP. They included all professionals: two doctors, two nurses (corresponding to all subjects in these professions) and eight nursing assistants from different services in the region, in order to obtain greater representation (for auxiliary when the researcher reached answers the research objectives and the phenomena begin to repeat, the interviews were stopped by the criterion of theoretical saturation).

The interviews were recorded and transcribed, taking care to safeguard the anonymity and safety of participants. The study used two key issues to obtain speeches. For nursing assistants the question was:

What is your experience in the referral system and the response to this referral when the teenager has a health need?

For doctors and nurses:

What is the answer obtained by the system of reference and counter reference when the teenager is redirected, before a health need?

After transcribing the interviews successive readings were conducted, followed by ideographic and nomothetic analysis.

At the stage of ideographic analysis, with the phenomenon in suspension and having themed what it is we try to understand and interpret from it, the essence or phenomenological structure was identified as manifest from the descriptions or speeches of the subjects. Once transcribed the descriptions, significance units emerged from this analysis, judged relevant by the researcher. After selection, these were transcribed into the language of the researcher. The *phenomenological reduction*, says Husserl, provides access to "*transcendental consideration mode*" that is, "*return to consciousness*". Thus, through the

The system of reference and counter reference...

phenomenological reduction, the objects have been shown in its constitution. Articulating the resulting insights, these were grouped into categories and themes through reductions⁹.

Finally, there was the nomothetic analysis, also called general psychological analysis, where we sought convergences and divergences between the different descriptions. The excerpts are presented with a number referring to the testimony of the number, followed by the section number in the respective testimony, between relatives, following some illustrative lines. Ex: (01:03) corresponds to statement one, meaning unit 3.

RESULTS

From the themes found, emerged the category "Access to care in the health system", resulting from the composition of two themes from the speeches units of meaning: "The operation of the system" and "Regionalization and Completeness of attention", presented below.

◆ **Functioning of the system**

Although the right to health is legitimate and must be guaranteed by the state, some challenges remain to be overcome, indicating a bottleneck in relation to vacancies within specialties, as pointed by some original lines:

[...] Specialty wait up to five months, it takes as much, until you leave. [...] It takes longer than if he'd gone elsewhere. (2:04)

[...] our medic, right, the medic from the unit makes referral necessary, but when you go to specialty, we can not get a vacancy, it takes a long time and sometimes even when a vacancy appears the child has already left the unit. (3:01).

Specialty schedule delays the most. The doctor makes the referral today, today we take the referral, try to schedule and that takes two to three months. (07:04)

In the case of specialties, scheduling appointments, most of the time are quite time consuming and unfortunately the next few references we have are insufficient to meet all the demand right!. (9:04)

[...] Here you see these cases of STDs that three months ago, we tried for consultation at least, and it is this difficulty. [...] and we have nowhere to go because this is our Basic Unit here, you know, but it serves the people here in town, which is already something! (11:05)

In response to the routing, the unit falls short because it's all very fast. It is an appointment a week [...] you usually have enough cases already waiting, then you take one, and do not solve it. Then you have to take it back and the other that's already

Torralbo FAP, Juliani CMC.

waiting a long time gets back, moreover, the service is very fast. (11:06)

(Note that the referred speed is at “flash” consults)

[...] Now it has to be a reference, we already have a reference station, right [...] Capão Alto, which is closer, right [...] But in Capão Alto has no doctor every day, the nurse comes once, twice a week too, and there is only one auxiliary. (3:06)

In the speech above, we see the difficulty faced when a reference unit does not have service at all times, for lack of professionals.

[...] We go to the hospital and come here sometimes to find the remedy lacking, there is no station, FEBEM lingers to buy. When you see all doors closed, I get very mad. I start to feel sick just talking. Because you can not do anything. (6:07)

The expression of an employee denotes the suffering caused by impotence when faced literally with the doors closed.

[...] Medicine that was expensive I was used to getting. Now, after I came to this region here, I joined a year to get a high cost of medication for a teenager who had respiratory problem, and fought a year and [...] not yet succeeded. I had to give up and the boy was liberated without medication. [...] While in my region all was much easier. [...]. (3:11)

The above statement points out differences between regions within the same State as the subject falls more difficult when moved from one region to another.

And every day here's the thing're getting worse. Shut two health clinics. We went so far as we be scheduling boy pro PS. [...] The boy has cough today, we can not afford to rule the day, because sometimes the escort does not come. It has nowhere to send patients. We handle agenda in PS and from fifteen days he's attended. [...] There no one understands. With cough, the PS? But has nowhere to send the boy. (2:06)

I think the system of reference and counter would be a very efficient system if it worked. [...] In fact this is not happening. [...] We have difficulty, yes. [...] Continuity of treatment mainly. (09:01)

The following explicates the theme related to the health regionalization process.

♦ Regionalization and health care

In the process of regionalization, one region may have more resources than others may, between the municipalities, depending on their size. This highlights the difficulty occurring with equitable distribution. The lack of medical professionals is also reported in the statements.

Health in service larger municipalities is reference to minors, reflecting on the

The system of reference and counter reference...

availability of vacancies to serve the greater municipal population. (2:07)

[...] Here in the unit where we work our major difficulty is the lack of doctor who does this region. 06. 01

We live in a location that has no hospital with emergency room, the Basic Unit has few doctors and there are days that has no doctor, so we depend on these other units, right. Hospital, emergency room, we depend on them. [...]. (6:04)

In my region, we took a few things to the head nurse because she was past for us and had freedom to take some actions, [...] It was our responsibility to turn in all the others, in all BHU and where had medical [...] we took action and the person came out of there with his problem solved. While not listed here. (11:04)

Issues related to management style and autonomy of team members can also interfere with the agility to solve the problems, as we extract the above statement.

[...] When we had the FHP, these more mundane cases they solved for us. I did not need much referral to outside the unit. We solved here. (11:08)

The speech above points to the solvability within the Family Health Unit attendance.

DISCUSSION

The category analyzed << Access to care in the health system >>, which brings together units of meaning about <<< >> The operation of the system and shows aspects of << >> Regionalization and Completeness of attention draws attention to the importance of effective regionalization of health services, pointing to the need for continuous evaluation of this process.

The decree 7508⁽³⁾ provides for the improvement of health care networks and, soon, the services should lay down Organizational Contract Public Health Action (COAP), which are still incipient in the state, despite the decree dating from 2011.

The health system functional aspects, as presented here may contribute alerting managers to the points that deserve special attention in these pacts recommended processes. For the COAP to be successful, we can not deny the deficiencies today in the system, in order to face them and seek to overcome them.

The World Health Organization (WHO) recognizes that some of the barriers faced by adolescents, related to health care are related to availability, accessibility, acceptability and equity.¹⁰

This WHO report states that teenagers belong to a heterogeneous group, with

Torralbo FAP, Juliani CMC.

expectations and preferences, however, despite the differences are identified common characteristics. They need to be treated with respect, security, confidentiality and protection.¹⁰

Dignity should never be forgotten or placed in the background. The practice of humanization should be observed continuously. Ethical behavior should be the principle of life and organization.¹¹

Similar to what occurs in health systems of many countries in the world, SUS presents still fragmented, with difficult access, assistance discontinuity, compromising the comprehensive care, so that does not respond adequately account the requirements before the health needs frame.¹²

Despite major challenges, the Ministry of Health has undertaken many initiatives including the humanization policy.

The Ministry of Health established the National Humanization Policy, including the need to improve organizational aspects of the system and health services, with the development of humanizing measures, including the expansion of communication and information and deal with the difficulties of user access¹³.

Progress in this policy in permanent construction will bring the SUS closer to its ideals. Integrating health through the establishment of regionalized and integrated networks of care is a condition for qualification and continuity of health care and assumes great importance in overcoming assistance gaps, rationalization and optimization of available care resources.¹⁴

CONCLUSION

The care for the adolescent health is critical. The teenager who commits an infraction, but deviated from the moral and social conduct is a citizen and in this case, the State assumes dual responsibility because health is a right of citizenship and, being institutionalized, is under the custody and state responsibility.

The presence of a multidisciplinary team to care for the adolescent who commits an infraction, within the Foundation Units configures a different standard, enabling the effective availability of supply and ensuring care and monitoring health, which is not always evident in the care the SUS. On the other hand, the systems are interdependent, in case the adolescent needs referral to specialized care.

We conclude that comprehensive care is still distant from its ideal, the difficulty of

The system of reference and counter reference...

continuity of care, jobs deficiency in specialties, delay in treatment, lack of medicine, factors as stress generators for the health care team, as highlighted in some testimonials.

To guarantee these rights, the participation of members of health teams of the Foundation's units is critical, which have the mission to create mechanisms for strengthening and assurance of health care in SUS, contributing to the process of fusion of teenager and society: a gathering of rights and duties.

Despite the limitations of the study, focused in a given region and given the lack of similar studies to expand the discussion it was possible to perceive that the political and institutional changes resulting from effective partnerships with health municipal services can cause significant changes.

The defense adolescent access to health services is the defense of citizenship, whereas it should not be a privilege for the adolescent offender, who in this condition can suffer prejudice, but ideally is considered to have solved the problems of access to it like any Brazilian citizen.

Acredita-se que os achados possam contribuir na discussão futura do COAP e nos processos de pactuação regional intergestores, uma vez que a defesa dos direitos de cidadania devem ser permanentes, rumo à consolidação de sistemas que desejamos encontrar na realidade e não apenas na avançada legislação brasileira, reconhecida internacionalmente.

REFERENCES

1. Ministério da Saúde. Estatuto da Criança e do Adolescente. 3rd ed. Brasília: Ministério da Saúde; 2006.

2. Brasil. Lei n.º 8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. Diário Oficial da União, Brasília, DF, 20 set. 1990. p. 018055.

3. Brasil. Presidência da República. Decreto 7508/11 - Regulamenta a Lei no 8080, de 19 de setembro de 1990, para dispor sobre a organização do Sistema Único de Saúde - SUS, o planejamento da saúde, a assistência à saúde e a articulação interfederativa, e dá outras providências. Diário Oficial da União, Brasília, 28 de junho de 2011.

Torralbo FAP, Juliani CMC.

The system of reference and counter reference...

4. Juliani CMC. Organização do sistema de referência e contra-referência no contexto do Sistema Único de Saúde: percepção de enfermeiros [dissertação]. São Paulo: Escola de Enfermagem/Universidade de São Paulo; 1996.

5. Mendes, EV. As redes de atenção à saúde. Ciênc. saúde coletiva. 2010;15(5):2297-305.

6. Serra C G, Rodrigues P H de A. Avaliação da referência e contrarreferência no Programa Saúde da Família na Região Metropolitana do Rio de Janeiro (RJ, Brasil). Ciênc saúde coletiva [Internet]. 2010 [cited 2014 Jan 25];15(Suppl 3):3579-86. Available from: http://www.scielo.br/scielo.php?pid=S1413-81232010000900033&script=sci_arttext

7. Conselho Nacional dos Direitos da Criança e do Adolescente. Sistema Nacional de Atendimento Sócioeducativo. 1st ed. Brasília: Secretaria Especial dos Direitos Humanos; 2006.

8. Queiroz MVO, Lucena NBF, Brasil EGM, Gomes ILV. Cuidado ao adolescente na atenção primária: discurso dos profissionais sobre o enfoque da integralidade. Rev Rene [Internet]. 2011 [cited 2014 Jan 25];12(spe):1036-44. Available from:

http://www.revistarene.ufc.br/vol12n4_esp_pdf/a20v12esp_n4.pdf

9. Martins J. Um enfoque fenomenológico do Currículo: Educação como Poiésis. São Paulo: Cortez; 1992.

10. World Health Organization. Department of Maternal, Newborn, Child and Adolescent Health. Making health services adolescent friendly: Developing national quality standards for adolescent-friendly health services; 2012.

11. Costa COM, Bigras M. Mecanismos pessoais e coletivos de proteção e promoção da qualidade de vida para a infância e a adolescência. Cienc Saúde Coletiva [Internet]. 2007 Sept/Oct [cited 2014 Jan 25];12(5):1101-09. Available from:

http://www.scielo.br/scielo.php?pid=S1413-81232007000500002&script=sci_arttext

12. Lavras C. Atenção primária à saúde e a organização de redes regionais de atenção à saúde no Brasil. Saude soc [Internet]. 2011 Dec [cited 2014 Jan 25];20(4):867-74. Available from:

http://www.scielo.br/scielo.php?pid=S0104-12902011000400005&script=sci_arttext.

13. Souza DJ, D'Innocenzo M. Desenvolvimento do Índice de Humanização dos serviços de saúde: etapa Delphi. J Nurs UFPE on line [Internet]. 2014 July [cited 2014 Jan 25];7(supl. 1):2365-74. Available from: <http://www.revista.ufpe.br/revistaenfermage>

m/index.php/revista/article/download/6154/10171.

14. Silva SF da. Organização de redes regionalizadas e integradas de atenção à saúde: desafios do Sistema Único de Saúde (Brasil). Ciênc saúde coletiva [Internet]. 2011 [cited 2014 Jan 25];16(6):2753-62. Available from:

<http://www.scielo.br/pdf/csc/v16n6/14.pdf>.

Submission: 2015/08/11

Accepted: 2016/01/10

Publishing: 2016/03/01

Corresponding Address

Carmen Maria Casquel Monti Juliani
Departamento de Enfermagem/FMB/UNESP -
Campus Universitário, s/n
Bairro Rubião Junior
CEP 18618-970 – Botucatu (SP), Brazil