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ORIGINAL ARTICLE

LONGITUDINALITY IN CHILD HEALTH CARE IN THE CONTEXT OF PRIMARY CARE

A LONGITUDINALIDADE NO CUIDADO À SAÚDE DA CRIANÇA NO CONTEXTO DA ATENÇÃO PRIMÁRIA

LA LONGITUDINALIDAD EN EL CUIDADO A LA SALUD DEL NIÑO EN EL CONTEXTO DE LA ATENCIÓN PRIMARIA

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ABSTRACT

Objectives: to identify in the caregivers' view on the longitudinality of primary care to solve children's health problems. **Method:** this study is qualitative in which interviews and speaking maps were carried out with 16 caregivers. The data were grouped and analyzed in thematic categories. **Results:** it was demonstrated that longitudinality means establishing therapeutic relationships independent of diseases. However, in the primary care services sought, it was evidenced: lack of confidence; Non-accountability; Absence of reception; Bond established with a single professional, resulting in the choice of prompt care for the sick child's care. **Conclusion:** the fragility in longitudinality caused a low resolution to the health problems of children, implying the need for changes in the work process in primary care. **Descriptors:** Child Health; Primary Health Care; Continuity of Patient Care; Primary Care Nursing.

RESUMO

Objetivos: identificar na visão dos cuidadores a longitudinalidade da Atenção Primária para resolver problemas de saúde de crianças. **Método:** estudo de abordagem qualitativa, em que se realizaram entrevistas e mapas falantes com 16 cuidadores. Os dados foram agrupados e analisados em categorias temáticas. **Resultados:** demonstrou-se que longitudinalidade significa estabelecer relações terapêuticas independente de doenças. Todavia, evidenciou-se nos serviços de atenção primária procurados: falta de confiança; não responsabilização; ausência de acolhimento; vínculo estabelecido com um único profissional, resultando na escolha do pronto atendimento para assistência do filho doente. **Conclusão:** a fragilidade na longitudinalidade ocasionou baixa resolutividade aos problemas de saúde das crianças, implicando a necessidade de mudanças no processo de trabalho na atenção primária. **Descritores:** Saúde da Criança; Atenção Primária à Saúde; Continuidade da Assistência ao Paciente; Enfermagem de Atenção Primária.

RESUMEN

Objetivos: identificar em la visión de los cuidadores la longitudinalidad de la Atención Primaria para resolver problemas de salud de niños. **Método:** estudio de enfoque cualitativo, en que se realizaron entrevistas y mapas hablantes con 16 cuidadores. Los datos fueron agrupados y analizados en categorías temáticas. **Resultados:** se demostró que longitudinalidad significa establecer relaciones terapéuticas independiente de enfermedades. También, se evidenció en los servicios de atención primaria procurados: falta de confianza; no responsabilidad; ausencia de acogimiento; vínculo establecido con un único profesional, resultando en la elección del pronto atendimento para asistencia del hijo enfermo. **Conclusión:** la debilidad en la longitudinalidad ocasionó baja solución a los problemas de salud de los niños, implicando en la necesidad de cambios en el proceso de trabajo en la atención primaria. **Descriptor:** Salud del Niño; Atención Primaria de Salud; Continuidad de la Atención al Paciente; Enfermería de Atención Primaria.

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INTRODUCTION

Primary Health Care (PHC) is defined as a set of welfare proposals distributed in an equitable way to all population, aiming to solve numerous common health problems by offering preventive, curative, rehabilitative and palliative actions. There are four essential attributes as structural elements for its solidification: attention to first contact, longitudinality, completeness and coordination. It should be stressed that these attributes must be articulated and added to the complementary attributes: family focus, community orientation, and cultural competence to obtain a PHC resolution.¹

The attribute of longitudinality as a key concept of this study, refers to the support of care offered by the health team, regardless of the presence of problems, linked to patients and families over time, in an environment of responsibility, trust and humanization.² It encompasses the identification of health services, with the teams as direct sources of care, willing to assist people because they are considered as usual care units and for solving health problems, with care centered on the patient and his/her family.¹

Linking longitudinally with families and ensuring continuity of care for children means fulfilling three essential tasks of PHC, problem-solving, communication and accountability. Thus, the resolute, communicative and responsible PHC addresses the cognitive, physical and social aspects of people with the scientific and technological aspects of health services resolving more than 85% of the health problems presented.²

By longitudinality, health care should be based on the observance of integrality, and it should be driven by specific elements as ways for subjects to receive continuous and responsible care in harmony with their needs. In this sense, the elements that constitute integral care and strengthen longitudinality, in the focus of this study are: movement - construction of care for the living; Interaction - establishing relationships; Otherness - construction and reconstruction of family identity and social interactions; Plasticity - transformation; Design - care creator; Desire - creation of free choice projects; Temporality - way of being cared; Non-causality - human formation through cause-effect aspects; Responsibility - self-understanding and formative construction of the human being.³

Throughout the years, health teams have been working with their knowledge in isolation, with no interaction among the members of the team, as well as with the

other groups of the community social network to establish interdisciplinary relationships and cross-sectorial contexts.⁴ Consequently, interaction also does not occur with the subjects who need to be cared for, making it difficult to link with the user, characterized by care that is totally unrelated and unresponsive.⁵⁻⁶ This fragmented care mode makes it impossible to merge horizons, Which involves actions in health on a path of coming and going between professional and user, that is, perceives care as procedural, apprehended in the technoscientific conceptions and subjectivities.⁴

Although the fragmentation of care, Brazil has shown positive results in the health of the child, since the reduction in Infant Mortality (IM) indices, from 47.1/1000 live born (LB) in 1990 to 16/1000 LB in 2015. However, these results did not show relevance for children in the neonatal period, since 70% of the infant deaths in the country involved neonates, due to perinatal diseases and prematurity. Among these deaths, more than 70% could have been avoided by actions developed in the PHC.^{2,7-9}

Besides this scenario of neonatal mortality, another worrying factor refers to childhood morbidities, since they are responsible for hospitalizations that could often be avoided by actions in PHC by following essential attributes.^{2,8-9} Through a set of diagnoses and practices in reliable environments, the PHC seeks to promote health, prevent health problems for children and subsidize healthy conditions for child growth and development.^{2,8}

In this context, there are gaps in the care of children, related to the absence of extension and follow-up to the attributes of PHC. In this, the attribute of longitudinality is highlighted, since it refers to the central characteristic of PHC, for accompanying the child over time by a health team, through community actions, home visits, and social participation.^{1,10} From the above, the objective was:

To identify the longitudinality of Primary Care in the caregivers' view to solve children's health problems.

METHOD

This is a study of qualitative approach, using the methodological reference of hermeneutic-dialectic as a proposal for analysis. Hermeneutics is characterized by the understanding and interpretation of events, in which phenomena are analyzed and apprehended from the whole, in a movement of going and coming between the parts and

the whole, followed by the apprehension of the stranger open to change, and finally by the understanding and dialogue through the mediation between concepts and language.¹¹ In contrast to this conception, the dialectic emerges as a process to argue the contexts of solving the child's illness.

It was sought to understand the itinerary of the families in search of attention to the child's health to identify the longitudinality, from the emergency care units. This study integrates research funded by the CNPq Universal Announcement, whose purpose was to characterize child care in emergency care units, outlining the profile of these services. Among these subjects, the participants of the qualitative step of the research were chosen by lot. There were 16 caregivers of children under one year old who were attended at Emergency Care Units (UPA) of Cascavel (PR), Brazil interviewed. Families who lived in the urban area of the municipality and with telephone contact to schedule the interview were included.

For the selection of the participants, it was sought to homogeneously contemplate families from the four geographic regions of the municipality, North, South, East and West. Children who were attended throughout the year in the PAU, obtaining a heterogeneous seasonal distribution of the attendances were selected. The documentary collection to clinically characterize the child and type of care were performed in the UPA files through the observation of care records.

The collection of data with the families happened in the following sequence: construction of the Speaking Maps (SM) and a semi-structured interview. The technique considered by SM refers to the graphic representation of the paths traveled by the families in search of care to the child's health. Because of simple drawings, this moment became pleasant and relaxed during the interviews,¹² allowing for greater interaction between interviewee-interviewer. From the SM, the interview began with the following question: Explain to me, please, this path traced in the SM. The dialogue during the interview was permeated by a guiding script developed from questions adapted from the Primary Care Assessment Tool (PCATool).¹³

The data collection took place in 2012 and ended when answers were obtained to the initial questions contemplating the proposed objectives. The quantification of the interviews was not objected of data collection since it is a qualitative approach.¹⁴

The data were submitted to the analysis of thematic content, allowing its organization,

outlining a horizontal map of the material.¹⁵ From this map and based on the longitudinal reference in the APS,¹ continuous readings of the content establishing a connection between them to assimilate the structures of relevance were carried out. This process allowed to construct a classification using transversal reading, and, finally, thematic categorization.¹⁵

The research project was submitted to the Ethics and Research Committee of the State University of the West of Paraná/Unioeste, being approved under Opinion N° 495/2010, complying with the norms of Resolution 466/2012 involving research with human beings.

RESULTS

The central theme category was: Longitudinal fragility for solving children's health problems in the context of primary care, delineated from the following themes: longitudinality means establishing therapeutic relationships independent of diseases; Lack of trust weakens the bond; Non-accountability hampers longitudinality; Lack of reception prevents the link; The bond is established with a single professional.

♦ Longitudinal fragility for solving children's health problems in the context of primary care

Caregivers recognize that it is necessary to establish therapeutic relationships independent of diseases for longitudinality, as the report below shows.

[...] whenever he [son] was or was not ill, I would take him there at the health clinic, and there, she [pediatrician] said what was to bring [...]. (Subject 16).

They also understand that access can be considered a prerequisite for longitudinality, through a facilitating and coordinated service.

The consultation [childcare] ... is good to do it... they [health professionals] are going to know the problem... it is easier for you to get the consultation [...]. (Subject 14)

In contrast to this scenario, the weaknesses identified for the establishment of therapeutic relationships have also emerged, such as the rotation of services and professionals, preventing family and professional interaction. This rotation generates an irregular source of attention and prevents longitudinality from happening, leading to an increase in the families' dissatisfaction with the care received,

[...] if he had a pediatrician in the neighborhood, who monitor the [grandson] since he was born and, whatever problem

we took at the clinic and consulted, he [pediatrician] would realize if he had a problem, that he needed a psychologist, a neurologist, of any other doctor [...]. We jumped from doctor to doctor, [...] and no doctor ever monitor [...] us different doctors. (Subject 6)

Illustrating the previous report, figure 1 shows that, when there is no link with the

health service, the care given by various services does not allow longitudinal and resolute care, causing discontent among families when they need to move between different health units, as well as seeking health care in emergency and emergency services, represented by PAC (UPA).

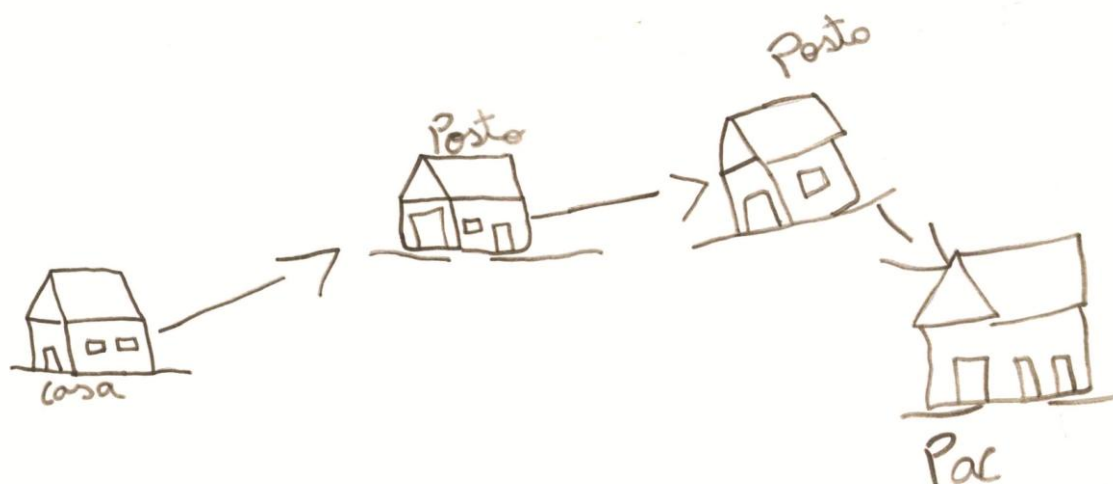


Figure 1. Speaker map constructed by subject 6. Cascavel (PR), Brazil, 2012.

Caption: Health unit (PHC Unit); PAC (Continuous Attendance - an old denomination used in the municipality to refer to UPA).

For a family to remain faithful to a regular source of attention, the relationship of trust between patients and professionals is fundamental, since its lack weakens the bond.

She examines, like, she does not have that touch of affection with the child, because to treat a child, to be a pediatrician, I think you have to have a contact with the children. (Subject 13)

Although dissatisfied with the care received and because they do not have other sources of attention in their children's illness, families, even distrustful of the professional's competence and living with a relationship without bond, end up seeking attention in this same service due to lack of choice:

[...] I end up risking [UBS pediatrician] again. But with all the medicine, I get one foot behind. [...] on the day she gave me the wrong medication, she was on her cell phone [...], talking and medicating another child over the phone. I was in doubt. I think she took it and prescribed the other child's medicine for me because she got confused, I guess. (Subject 12)

An environment without accountability like this one hampers longitudinality, and still, gives the caregiver some doubt when seeking care in health services. Because of the lack of opportunities for care, the family sees no other way out but to return to the service, although unsatisfied, or, first, look for the services of emergency care:

[...] the pediatrician asked to see the social worker [referring to milk without lactose].

[...] simply abandoned me. Of course, there are many consultations, but with a question like that, you need to talk to the social worker, and I kept waiting, I was nothing, I came home, she was already gone. [...] I do not trust her [pediatrician]. That is why I am not even looking for the health unit. I look in cases that I have to consult my child, measure, see their size, their weight, childcare [...], otherwise, I will not go straight to PAC (UPA). (Subject 13)

When the families of this study sought care to the child's health, they recognized that this way of acting of the professionals - without accountability - may be related to failures in their studies.

[...] there is an hour that people tire of complaining. Complain, complain; it is the same thing. If there is an attack [stress and fury at the UBS reception] on a person [...] that person has his limit, and when he reaches his limit, he thinks: My God since I am not treated him as people, It is because I have no college, because I do not have a diploma, [...] am I less than the others? I think, so many professionals should not be trained, but human people, who are there to meet others[...] (Subject 12)

In addition to non-accountability, the subjects of the study perceive the family's blame for the child's health problem by the professionals.

[...] The pediatrician blames me that he [son] had an acute, almost transfusive anemia. I was breastfeeding, wrong because I could give food and then breast. She

blamed me for that, but was that it? [...].
(Subject 12)

It should be emphasized that, for longitudinality to be present, health professionals should take responsibility for the integral care of the child, without blaming the families, but rather welcoming them in difficult times. The lack of reception prevents the bond from happening, a fact also observed in the research, as portrayed in the following statements:

[...] once, the baby was not well. I arrived [at UBS] and asked if I had a chance to make an appointment for her because it was not legal. She [receptionist] said, "Could not you have come sooner?" [But] if the girl got bad right now [...], that's the way it is, you need things and you never can. (Subject 8)

[...] they [receptionists] are so boring. We ask some information, and they treat us badly. [...] they do not treat you with patience. (Subject 9)

In these situations, care relationships happen in a one-way street, in which the patient is not even heard by health professionals.

[...] I told a pediatrician: Would not it be good to give her a little vitamin, something like that, she did not even answer me. He looked at me but did not answer me. (Subject 12)

[...] this milk I had to buy, for example, she [pediatrician] did not let me a question. He simply said that my son was allergic to lactose, and he needs to give the milk. He asked for tests, but before the exams, he asked me to give milk. (Subject 13)

The lack of attentive listening by the professional also expresses disinterest in establishing the bond with the children and their families, according to the testimony:

[...] I have the impression that they [caregivers] care about the child only when she is from the door in, out the door is our problem. (Subject 15)

When entering family experiences, it is possible to verify that the bond often happens, but with a single professional and not with the health service, as observed in the following reports:

[...] when he arrives there with the child, the doctor will not let him go home. There, the doctor is good, that is why I ran there. [...] he [the doctor] never lets in [at the health facility] and returns home [without consulting]. (Subject 10)

[...] I got used to that pediatrician [UBS from another neighborhood], [...] I already know him, so instead of bringing here [UBS from his neighborhood], I did not sympathize with the doctor at the neighborhood, then I take it there. [...] he

is playful, [...] I think he beats [...].
(Subject 14)

According to the above reports, although there are geographical barriers to health care for children, they do not prevent the search for the professional, once the bond is present and established to trust.

DISCUSSION

The study shows that the bond with the family cannot be based only on the continuity of care in the presence of diseases but in therapeutic relationships of promotion and health surveillance and disease prevention.^{1,10,16-7}

For the caregivers, it is essential for families to be included in this regular source of care, linking to health services for therapeutic relationships. Access to health services will be facilitated to know the history of health and illness of children, as well as care, will be efficient and resolution will be achieved.¹⁶⁻⁸ These perspectives involve elements such as alterity and interaction³ built over time, indispensable to strengthen the bond and obtain resoluteness.^{1,18}

The turnover of services and professionals found in the scenario studied may trigger irregular sources of care, impeding the presence of longitudinality, leading to family dissatisfaction, as well as obstacles to completeness.^{1-2,10,16} Such considerations demonstrate the absence of a project for care.³

Care should be offered to the child promptly, with access to the necessary technological services and resources, through a coordinated PHC service, resulting in comprehensive actions and practices for the child and his/her relatives.^{1-2,17} Thus, a therapeutic relationship is established by the long-term relationship, and it enables us to achieve, beyond technical success, practical success in health actions.¹⁰ These presuppositions lead to a reduction in the demand for light-hard technologies, the technologies of relationships¹⁹ as described by the subjects, and, the interaction between families and health services should assume relevance in the care developed, as well as non-causality and temporality in the process of caring for the child segment.³

For a family to remain faithful to a regular source of attention, it is essential to have a relationship of trust between users and the health service,^{2,10} because the lack of trust weakens the bond. The environment with confidence makes families aware that when they need it, there will always be a service

that will provide them with support until they can be solved.¹ From the moment this relationship does not happen, it will be difficult to achieve full care and resolve.^{1,16}

Considering that health work is relational, the technologies that are present in the productive process in health should be understood as essential elements for longitudinal care. In this way, the technical know-how that constitutes the light-hard technology, together with the light technology, that is, of the relations, should be anchors of health care in PHC. However, they can translate into a non-allied to the principle of longitudinality when presented in an incipient way, generating distrust by the patient about care.

Little accountability in research is fundamental to strengthen longitudinality and achieve full care,^{1,3,10,16} because its absence reflects situations that create environments of abandonment and distrust.¹⁰ These issues of respect and accountability must be initiated during the training of health professionals. However, contemporary training still shows to be fragile in this theme, since the hegemonic model of biologically focused care and medicalization remains evident in its guidelines. A differentiated look at the training should be superimposed on biological issues and involve looking at subjects as individuals with subjectivities and rights, who belong to a family and a community that equally require care, regardless of their socioeconomic conditions.^{1-2, 20}

Another aggravating factor regarding the non-accountability of professionals and services related to child care refers to the blame of families for the health problem of their children. It should be emphasized that families are victims of a weakened health system, allowing health professionals to remain unprepared and not responsible for persons seeking care.²

This way of thinking and doing health centered on the lack of responsibility by the professionals and the blame of the families for the children's health problems characterizes the lack of plasticity and movement in the form of care. Demonstrating that health care emphasizes the physical problem, the cure of the current disease. It is essential to reflect and change in health organization and practices to reverse this situation, pointing to reception and bonding as summing the accountability of the subjects.^{3-4,21}

Thus, to broaden the view and understand health care, it is necessary to include the extended and shared clinic in the daily life of the health work process, in which

professionals must learn to articulate and insert in care the different approaches and disciplines that make up the complex health-disease process. It is necessary to work as a team and to share knowledge,⁵ but above all, it is necessary to welcome families who need care, because the lack of reception prevents the bond from happening. This is a notorious condition to establish longitudinality, since it involves the polite, ethical, human, and resolute response. This treatment for patients should be initiated in the reception of PHC services and be extended to the resolution of the problems that afflict them.^{1-2,21} Attitudes such as these can be a potentiator of the attribute of longitudinality by emphasizing the formation of links personal and durable, aiming the identification and mutual accountability between families and professionals.^{1,22}

For people to feel welcomed and to create an environment of trust that enables the formation of the bond, these must be heard by professionals. However, this listening needs to be attentive to establish a therapeutic relationship between users and professionals, in a two-way street, which the person who needs to be cared for can participate with autonomy in the proposal of care.^{2,4,23} However, given the lack of care and, consequently, lack of resolving in seeking care for their children in PHC, caregivers perceived that professionals did not show an interest in being related to children and their families, revealing the lack of interaction in building the care.³

It is noted that the organizational structure of the health services reflects in the resolution of health care since the health units studied refer to the traditional UBS, and that the proposed implementation of the Family Health Strategy (ESF) would be an important way. It should be noted that the ESF is a reference for the care of children according to their health needs; Strengthens the bond between families and teams; Allows the knowledge of children's health problems by being close to families and knowing their health and illness history.^{1-2,16,23}

In this sense, it is understood that the ESF would strengthen the attribute of longitudinality, which would be achieved by receiving the families, at the same time the host could increase the use of ESF as a gateway to the health system, which would certainly influence positively in the How to use the health services, and also potentiate organizational issues, such as: improving horizontal relationships between professionals and users; Increase the availability of

professionals in response to demands; To offer care according to the real needs of the people; Expand service schedules; Among others.^{1-2,22}

The bond must happen between family and health service to have excellence to follow the longitudinality attribute, but another problem outlined in the research, is that when this happened it was with a single professional, making difficult the search for integral actions and resolution.¹⁻² However, individual actions such as those mentioned should happen, indicating the presence of alterity,³ but to transform health into daily life, these attitudes must be recognized by the services so that they can work as a team, in order to create a connection with the user. In an expanded context, evidencing the movement and the plasticity, that is, transforming the care.²⁻³ With the effective link, the user recognizes the health unit as a place of regular care delivery over time.

It should be noted that this study refers to the caregivers' view of children under one year old in their child's health care in PHC services. However, this aspect may be limiting to understand the complexity of the issue, suggesting to capture the same focus on the perception of health professionals and managers.

CONCLUSION

The results showed that, for caregivers, there are weaknesses related to longitudinality in primary care services, because, although they understand that longitudinality means are establishing therapeutic relationships independent of diseases, there are aspects such as lack of confidence; Non-accountability; Lack of reception; Established with a single professional. In this way, it was verified that due to lack of longitudinality, the resolution to the health problems of the child in the scenario studied was not achieved.

The elements of integral care were also not uttered in their fullness, although non-causality, temporality, and otherness emerged in some accounts. The way to care for the partial presence or absence of these elements reinforces the lack of longitudinality in the care of the child.

It is necessary to transform the work process to reach the magnitude of PHC services for child care. For this, health teams must understand it as a practice of innovation and restructuring, as well as rescue the expanded concept of health and disease,

Interdisciplinary relationships, theorizing care and longitudinality of health care.

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