FAMILY HEALTH STRATEGY - THE POINT OF VIEW OF CHILDREN'S CAREGIVERS

ESTRATÉGIA SAÚDE DA FAMÍLIA - A ÓTICA DOS CUIDADORES DE CRIANÇAS ESTRATEGIA SALUD DE LA FAMILIA - LA ÓPTICA DE LOS CUIDADORES DE NIÑOS

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ABSTRACT

Objective: to assess whether the essential attributes and derivatives of primary health care were present and how they were being implemented in the Family Health Strategy from the point of view of caregivers of children under two years of age and adult users. **Method:** quantitative, descriptive and cross-sectional study conducted in three municipalities of the region of Presidente Prudente, State of São Paulo, Brazil. We used the child and adult versions of the Primary Care Assessment Tool (PCATool), and 176 caregivers of children under two years of age and 181 adult users participated in the research. **Results:** the attributes of primary health care were present in the Family Health Strategy in the region; however, some attributes, such as healthcare coordination-integration, access to initial contact-accessibility, and family guidance needed to have their implementation improved. **Conclusion:** the attributes of primary health care should be properly incorporated into the practice of health professionals through training and actions that characterize the Family Health Strategy as a model with a focus on the family. **Descriptors:** Health Assessment; Family Health Strategy; Primary Health Care; Public Health; Child Health; Adult Health.

RESUMO

Objetivo: avaliar sob a ótica dos cuidadores de crianças menores de dois anos e usuários adultos se os atributos essenciais e derivados da atenção primária à saúde estavam presentes e como estavam sendo operacionalizados na Estratégia Saúde da Família. **Método:** estudo quantitativo, descritivo e transversal realizado em três municípios da região de Presidente Prudente, Estado de São Paulo, Brasil. Utilizou-se o instrumento de avaliação da atenção primária à saúde (PCATool) na versão criança e adulto, em que 176 cuidadores de crianças menores de dois anos e 181 adultos usuários participaram da pesquisa. **Resultados:** os atributos da atenção primária à saúde estavam presentes na Estratégia Saúde da Família da região; porém, alguns atributos como Coordenação - Integração de Cuidados, Acesso de Primeiro Contato - Acessibilidade e Orientação Familiar precisavam melhorar sua operacionalização. **Conclusão:** os atributos da atenção primária à saúde devem estar adequadamente incorporados à prática dos profissionais da saúde por meio da capacitação e valorização das ações que caracterizam a Estratégia Saúde da Família como modelo com foco na família. **Descritores:** Avaliação em Saúde; Estratégia Saúde da Família; Atenção Primária à Saúde; Saúde Pública; Saúde da Criança; Saúde do Adulto.

RESUMEN

Objetivo: evaluar bajo la óptica de los cuidadores de niños menores de dos años y adultos usuarios si los atributos esenciales y derivados de la atención primaria de salud estaban presentes y cómo estaban siendo puestos en marcha en la Estrategia Salud de la Familia. **Método:** estudio cuantitativo, descriptivo y transversal realizado en tres municipios de la región de Presidente Prudente, Estado de São Paulo, Brasil. Se usaron las versiones niño y adulto del Instrumento de Evaluación de la Atención Primaria (PCATool) y 176 cuidadores de niños menores de dos años y 181 adultos participaron en la investigación. **Resultados:** los atributos de la atención primaria de salud estaban presentes en la Estrategia Salud de la Familia en la región; sin embargo, algunos atributos tales como coordinación-integración de los cuidados, acceso a primer contacto-accesibilidad y asesoramiento familiar necesitaban mejorar su puesta en marcha. **Conclusión:** los atributos de la atención primaria de salud deben ser debidamente incorporados a la práctica de profesionales de la salud a través de capacitación y desarrollo de acciones que caracterizan la Estrategia Salud de la Familia como un modelo con enfoque en la familia. **Descriptores:** Evaluación De La Salud; Estrategia Salud de la Familia; Atención Primaria de Salud; Salud Pública; Salud Del Niño; Salud del Adulto.

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INTRODUCTION

Health actions in Brazil have not always met the population's demands. There have been various stages and transitions being modeled according to the socioeconomic and political rules over time. It is worth mentioning that health fragility in some historical moments has been more evident and linked to accessibility only available to the elitist classes and privileged groups. Governmental priorities have been determined according to the political and economic needs.¹ The social security crisis and population movements were determining factors for reshaping the health systems that had been deployed until the current system.²

An important milestone for the implementation of the Unified Health System in Brazil was the First International Conference on Primary Health Care held in 1978. This conference argued that health actions and policies should take into consideration the main health problems of the population, providing the promotion of health services, disease prevention, cure, and rehabilitation.³

Due to the 1988 Federal Constitution of Brazil, there were changes in all sectors of the country, including health services. In Article 196, the Constitution states that health is a right of all and duty of the State.⁴ Sequentially, the Organic Law No. 8080/90, highlights the importance of health promotion, prevention and protection. This new text states that, since the creation of the Unified Health System, health does not only mean being free of disease, but should be interpreted as the welfare between the environment and the individual in all vital situations.⁵

As the reorganization of the health system evolved, innovative policies were created to expand and strengthen accessibility and social participation in the health context. In addition, these policies sought to adapt healthcare to individuals' evolution and transformations in the way of life, culture, and socioeconomic conditions.¹

The Family Health Strategy (FHS), formerly known as the Family Health Program, was one of the Brazilian proposals for the consolidation of primary health care (PHC). It seeks to decentralize, regionalize, reorganize, and strengthen primary healthcare, in order to reorient the health practices with a focus on the families and the community, targeting their needs and vulnerabilities.⁶ The FHS is based on the National Basic Care Policy, approved by Ordinance No. 2,488 of 21st

October 2011, which defines the FHS as a priority strategy for reorganization of PHC in Brazil and reaffirms its role as the healthcare network operator.⁷

From this point of view, thinking about the great importance of PHC in the world, Starfield defines four essential and three derivative attributes that, according to the author, should be present in PHC, so that this level of healthcare can be considered decisive and efficient. The essential attributes include:⁸

- **Access to initial contact:** provides access from the first time that the individuals' need a service and always that they come to the health units.

- **Longitudinality:** services provided to users are assured in a continuous manner over time.

- **Integrity:** services provided to the population should be available in order to meet the population's health needs in an integral manner.

- **Coordination:** management of healthcare integrality in all services, thus assuring its continuity.

The derivative attributes include:⁸

- **Family guidance:** detect health needs, i.e., potential diseases and cure in the family context.

- **Community guidance:** results from the diagnosis of the population's health needs and vulnerabilities present in each group based in the relationship between the community and health services.

- **Cultural aspects:** based on the relationship established, the health teams take into consideration the cultural characteristics of the population to make understanding and communication flow easier.

The present study is based on the relevance of PHC in Brazil, and the importance of researching and assessing its functioning in several Brazilian scenarios. From this point of view, we assessed the FHS, a strategy that has been collaborating during 23 years to the expansion of collective healthcare. The FHS, which is a technological innovation in the health system, has achieved many positive outcomes, such as decrease in infant mortality, increased distribution of medicines, increased number of examinations (such as oncotic colpocytology), increased number of pregnant women followed-up during the pre-natal period, and decline in the indicators of admissions due to cerebral vascular accident and congestive heart failure in the population aged over 40 years.⁸

OBJECTIVE

• To assess whether the essential attributes and derivatives of primary health care were present and how they were being implemented in the Family Health Strategy from the point of view of caregivers of children under two years of age and adult users.

METHOD

This quantitative, descriptive and cross-sectional study sought to clarify the essential and derivative attributes of PHC and contribute to the field of health assessment with a focus on the FHS in the region of Presidente Prudente, State of São Paulo, Brazil. It was conducted in three small-sized municipalities of the mentioned region, namely: Junqueirópolis, with 19,918 inhabitants and eight FHS teams; Mirante do Paranapanema, with 17,901 inhabitants and seven FHS teams; and Presidente Epitácio, with 43,348 inhabitants and eight FHS teams.¹⁰

To evaluate the FHS in the three municipalities, we assessed the PHC using the child and adult versions of the Primary Care Assessment Tool (PCATool) validated in Brazil. The PCATool was prepared by Starfield and allows assessing the essential attributes: access to initial contact of the individuals with the health system; longitudinality; integrality; healthcare coordination. The derivative attributes are: healthcare focused on the family (family guidance); and community guidance. For Starfield, the essential and derivative attributes should be present, so that PHC can be considered effective.⁸

The participants of the study were 176 adult caregivers of children under the age of two years, who responded to the child version of the PCATool, and 181 adults who responded to the adult version of the PCATool. The exclusion and inclusion criteria included participants aged 18 years or over, and being users of the FHS and living in its area of coverage.

The study was submitted to Plataforma Brasil and to the Research Ethics Committee of the School of Nursing, University of São Paulo, under CAAE: 42499615.9.0000.5392 and approved under Opinion No. 1,024,138. Authorization was requested from the health departments of the municipalities of Junqueirópolis, Mirante do Paranapanema, and Presidente Epitácio by means of a document addressed to the professionals

working in 2015, who authorized the study in the FHS area.

The logistics of data collection was directed by the health manager of the municipalities, who previously provided the telephone numbers of the FHS nurses for planning data collection and to schedule the dates that the researcher could go to the units to carry out the interviews with the users (caregivers of children under two years of age and adult users). The participants of the study were randomly chosen.

The adult users and caregivers of children under two years of age who agreed to participate in the research signed two copies of an informed consent form, one for the participants and the other for the researcher. The data were collected in the physical space of the FHS units and at participants' homes with the help of health community agents. The data collection was carried out from May to July 2015.

Subsequently, the data collected were organized using Microsoft Excel for Windows. The analysis of the data was based on the PCATool manual of the Ministry of Health to obtain the scores or averages of the PHC attributes assessed. The author of the assessment instrument used in the present study considers a value of 6.6 or over to be a good average.⁸

RESULTS

♦ Analysis of the essential and derivative attributes of PHC from the point of view of caregivers of children under two years of age.

Of the 176 participants who responded to the child version of the PCATool, 76 (43.18%) were from Junqueirópolis, 60 (34.09%) from Mirante do Paranapanema, and 40 (22.73%) from Presidente Epitácio. The children cared for by the FHS of the municipalities had an average age of 12 months, 90 (51.14%) were male, and 82 (46.59%) were female.

Table 1. Essential and derivative attributes of primary health care, according to the participants who answered the child version of the Primary Care Assessment Tool. Region of Presidente Prudente, SP, Brazil, 2015.

Attributes	Average/Score	Standard deviation	Minimum	Maximum
Degree of affiliation (A)	9.51	1.42	3.33	10.00
Access to initial contact - Use (B)	8.63	2.01	0.00	10.00
Access to initial contact - Accessibility (C)	7.48	1.76	0.00	10.00
Longitudinality (D)	7.37	1.67	0.95	10.00
Healthcare coordination-integration (E)	6.80	3.37	0.00	10.00
Coordination-Information systems (F)	8.01	1.79	2.22	10.00
Integrity-Services available (G)	7.92	2.06	0.00	10.00
Integrity-Services provided (H)	7.49	2.84	0.00	10.00
Family guidance (I)	6.79	2.82	0.00	10.00
Community guidance (J)	8.04	2.24	0.00	10.00
Essential score	7.96	1.12	3.04	2.70
Overall score	7.84	1.18	9.85	9.88

Table 2 shows the averages of the indicators that compose the attributes healthcare coordination-integration (E), and

family guidance (I), which obtained the lowest values according to the point of view of caregivers of children under two years of age.

Table 2. Average scores of the indicators that compose the attributes healthcare coordination-integration (E) and family guidance (I), according to the point of view of caregivers of children under two years of age cared by the teams of the Family Health Strategy in the region of Presidente Prudente, SP, Brazil, 2015.

Indicators	Score
E2	7.84
E3	7.81
E4	6.67
E5	5.62
E6	6.05
I1	6.08
I2	6.93
I3	7.35

Note. E2 (Did the healthcare service/physician-nurse suggested/indicated [referred] that your child should consult a specialist or specialized service?); E3 (Did the physician/nurse of your child knows that he/she consulted a specialist or specialized service?; E4 (Did the physician/nurse of your child know the outcomes of that consultation?; E5 (After that consultation with the specialist or specialized service, did your physician/nurse talk about what happened during that consultation?); E6 (Was your "physician/nurse interested in the quality of healthcare provided to your child by the specialist or the specialized service?); I1 (Does your physician/nurse ask you about your ideas and opinions relating to the treatment and care of your child?); I2 (Has your physician/nurse already asked you about diseases or problems in your child's family (cancer, alcoholism, depression?); I3 (Would your physician/nurse" meet with other members of the child's family if you considered it necessary?).

♦ **Analysis of the essential and derivative attributes of PHC from the point of view of adult users of the FHS**

Of the 181 adult users who participated in the present study, 80 (44.20%) were from Junqueirópolis, 59 (32.60%) from Mirante do Paranapanema, and 42 (23.20%) from

President Epitácio. Their average age was 50 years and had lived in the FHS area for 17 years. In addition, 32 (18.23%) were male, whereas 148 (81.77%) were female. Table 3 shows the averages of essential and derivative attributes, essential score and overall score.

Table 3. Essential and derivative attributes of primary health care, according to the point of view of the participants who responded to the adult version of the Primary Care Assessment Tool. Region of Presidente Prudente, SP, Brazil, 2015.

Attributes	Average/score	Standard deviation	Minimum	Maximum
Degree of affiliation (A)	8.69	2.00	3.33	10.00
Access to initial contact-Use (B)	9.11	1.44	3.33	10.00
Access to initial contact-Accessibility (C)	5.25	1.54	1.94	8.61
Longitudinality (D)	7.71	1.55	1.19	10.00
Healthcare coordination-integration (E)	7.68	2.26	0.00	10.00
Coordination-information systems (F)	7.56	1.81	0.00	10.00
Integrity-services available (G)	7.45	1.61	1.06	10.00
Integrity-services provided (H)	7.46	1.61	1.06	10.00
Family guidance (I)	6.75	2.78	0.00	10.00
Community guidance (J)	7.89	2.26	0.00	10.00
Essential score	7.60	0.86	4.23	9.41
Overall score	7.35	1.14	3.34	9.45

Table 4 shows the indicators that compose the attributes access to initial contact-accessibility (C) and family guidance (I).

Table 4. Average scores of the indicators that compose the attributes access to initial contact-accessibility (C) and Family guidance (I), according to the point of view of adults cared by the teams of the Family Health Strategy in the region of Presidente Prudente, SP, Brazil, 2015.

Indicators	Score
C1	0.42
C2	0.74
C3	8.07
C4	7.26
C5	5.17
C6	2.41
C7	2.36
C8	9.13
C9	4.64
C10	8.25
C11	7.99
C12	6.56
I1	5.62
I2	6.91
I3	7.72

Note. C1 (Does the health service/physician/nurse provide care on Saturdays or Sundays?); C2 (Does the health service/physician/nurse provide care at least a few nights on working days up to 8:00 p.m.?); C3 (When your health service/physician/nurse is working and you become sick, does anyone there provide care to you on the same day?); C4 (When your health service/physician/nurse is working, are you guided over the phone if you need it?); C5 (When your health service/physician/nurse is not working, is there a phone number that you can call when you are sick?); C6 (When your health service/physician/nurse is not working on Saturdays and Sundays and you become sick, does anyone from this service provides care to you on the same day?); C7 (When your health service/physician/nurse is not working and you become sick during the night, does anyone from this service provides care to you on that night?); C8 (Is it easy to make an appointment (routine check-up) in this health service/with your physician/nurse?); C9 (When you arrive at your health service/or physician/nurse’s office, do you have to wait more than 30 minutes to be seen?); C10 (Do you have to wait for a long time, or talk to a lot of health professionals to make an appointment at your health service/or with your physician/nurse?); C11 (Is it difficult to obtain medical care from your health service/physician/nurse when you think it is necessary?); C12 (When you have to go to your physician/nurse/health unit, do you have to miss work or school?); I1 (Does your physician/nurse ask you about your ideas and opinions [about what you think] when planning the care and treatment for you or a family member?); I2 (Has your physician/nurse asked you about diseases or common problems that can occur in your family [cancer, alcoholism, depression]?); I3 (Would your physician/nurse meet with members of your family if you think it is necessary?).

DISCUSSION

In general terms, the essential and derivative attributes of PHC were present in the FHS of the three municipalities in the region of Presidente Prudente, according to the opinions of the caregivers of children under two years of age and adult users interviewed in the present study. However, some attributes, such as family guidance, healthcare coordination-integration, and access to initial contact-accessibility needed to be improved. In order to facilitate the explanation, the discussion was divided into two topics, namely: (a) Assessment of child health in the scope of the FHS from the point of view of caregivers of children under two years of age; and (b) Assessment of adult health in the scope of the FHS from the point of view of adult users.

◆ Assessment of child health in the scope of the FHS from the point of view of caregivers of children under two years of age

User perception is essential for the healthcare process, because the users

participate actively and experience the service. They can determine whether the aspects of the service are in compliance with healthcare standards.¹¹

The FHS context is a new pillar of support and remodeling for continuing PHC. This fact demonstrates the interest in the individuals, families, and integral healthcare. The prevention of disease aggravation and early identification are of utmost importance for the vital cycle of any individual and even to promote an effect on the community.

In 2012, the revision and readjustment of healthcare networks for the approval of the National Policy for Basic Healthcare highlighted the priority of integral child healthcare. This procedure focused on health promotion, and follow-up based on a new approach model.¹²

In the present study, the point of view of caregivers of children under two years of age interviewed indicated that, overall, the PHC attributes were present. However, the attributes healthcare coordination-integration and family guidance were close to the

reference average of 6.6, indicating that these attributes needed to be improved within the FHS scope.

Firstly, it is important to become aware of what healthcare coordination-integration means, in order to facilitate understanding and perform a good analysis of the topic. This is not just a matter of monitoring practices; coordination requires the active participation of both parties and health professionals' stimulus. This attribute is closely linked to the level of health quality that can be promoted taking into consideration user evolution on the part of health services. This concern is related to the vulnerability of the child throughout the health service network. This is a way of "mapping", following-up, confirming the effectiveness in clinical and social findings, which will promote actions and precise decisions, thus avoiding risks inherent to healthcare actions.¹¹

It is relevant that health professionals know the users assigned to their units, so that continuity of proper healthcare and/or problem-solving capacity can be promoted. It is essential that health professionals abandon the culture of using only the information provided by medical records. They should facilitate the bond and dialogue with the users in order to enrich the previous information with reports of the patients. The participation of users and their performance in self-care is also a feature of the new health model.

The attribute coordination obtained an acceptable value. However, when compared with the other attributes, it was possible to observe a numerical disparity, especially when interpreted by the indicators that compose this attribute (Table 2). This fact can be understood as a listening deficiency, lack of dialogue between patients and health professionals, hindering decision-making and actions targeted at meeting the needs of the population.

The results of the present study also indicated that there was little problem-solving capacity in the FHS. The indicator E1 (Has your child had an appointment with any specialist or specialized service during the period during which he/she was being followed-up by the FHS?), which composes the attribute healthcare coordination-integration, indicated that 60.79% of the caregivers interviewed reported that their children had been referred to specialists. This finding is not in line with the results obtained in a study conducted in the micro-region of Alfenas, State of Minas Gerais, Brazil, in which only 14.5% of the caregivers interviewed had

reported that their children had been referred to specialists.¹³

The scores of indicators E4 (questions whether the health professional was aware of the outcomes of the consultation with the specialist), E5 (whether the caregiver talked to the physician/nurse after the specialized consultation, and what happened during it), and E6 (whether the physician/nurse showed interest in the quality of care provided to the child during the specialized consultation/service), shown in Table 2, indicate the interest of health professionals in knowing the outcomes and the care provided by other services. This means that they are concerned about the improvement of the children, i.e., whether they were properly received after the contact and consultation in other services, or even whether the health professionals are aware of the guidelines and actions that should be taken, and what type of follow-up should be performed during the post-consultation period.

The recognition of the problems addressed in other services, as well as their integration, facilitates the provision of global patient healthcare.¹³ In 2009, in Pouso Alegre, State of Minas Gerais, Brazil, a study considered the migration of children to other services as a result of the increased rotation of medical professionals and their inadequate training for the function, and also assessed the average score of this low attribute.¹⁴

Family guidance is characterized by the capacity to involve the family in the health-disease process. It is worth mentioning that this disease process may be related to the family context. The profile that the family exhibits can be the clearest outline for the risks of acquiring a disease. The behavior of the members within the familiar environment, evidenced by the community experience, makes them responsible for providing care together with the health professionals.

Family members are a key to the quality and effectiveness of the actions. However, health professionals are able to identify health problems in a medical visit through dialogue and the combination of technical knowledge with the information obtained from the individuals. They transform the information into a healthcare and educational tool, involving the whole family in this process, especially when it comes to healthcare provided to children. It is known that, at present, mothers do not always spend the entire time with their children due to the need of seeking resources (especially financial) or several personal issues. Therefore, contact, knowledge, and

assessment are part of a previous approach planning. This factor enables the health team to get used to the cultural characteristics of the family, thus deepening the relationship between the two parties based on communication.¹³

The study conducted in the micro-region of Alfenas, State of Minas Gerais, Brazil, revealed the same difficulty in performing family guidance in the FHS, with an average score of 5.10. This result demonstrates the problem occurring in the basic care network.¹³ The low values for community guidance were also confirmed in a study conducted in Pouso Alegre, State of Minas Gerais, Brazil, with an average of 4.7.¹⁴

Regarding family guidance, it is often observed that the FHS has not focused its praxis on the family, and has scarcely valued the participation of the family in the health-disease process. This fact is a paradox, because the guidelines and principles governing this healthcare model establish the family as the focus of healthcare.

To this end, regarding the follow-up of children in the FHS, it is essential to value the family as a potential factor for health or disease. Child health depends on the family and the community in order to be actually effective.¹⁵

• Assessment of adult health in the scope of the FHS according to the point of view of adult users

The assessment of adult health in the FHS of the three municipalities indicated that the attributes with the lowest scores were access to initial contact-accessibility and family guidance. The score of the first attribute was below average, with a value of 5.25 according to the point of view of adult users (Table 3). The term access to initial contact refers to the possibility that users have to be cared for by the service, or even receive guidelines from the moment they need healthcare for the first time or every time that the service is necessary. Health professionals are the gateway for users and responsible for user embracement targeting the individual and collective peculiarities.

It is very important that the professionals/services are aware of the profile of their population and the lifestyle of the individuals in the region of coverage, so that they can meet the demands in an equitable and humane way.

A study conducted in São Luiz, State of Maranhão, Brazil, indicated the difficulty and the lack of interest on the part of health professionals according to users' point of

view, the lack of knowledge about social and health risks, and lack of knowledge about social, life, and family conditions. On the other hand, the health professionals and managers responded differently from the information collected. In addition, these findings show that home visits are a common practice of the service and did not receive a good assessment by users.⁶ The visits should be an opportunity for health professional to offer the service as a gateway or provide access to users, i.e., promotion of active accessibility in their area of coverage.

In the present study, access to initial contact-accessibility was fragmented by the working hours in the health units assessed and the patient waiting times, which may have resulted from poor organization and management deficiency confirmed by the accessibility indicators shown in Table 4, namely: C1 (Does the health service/physician/nurse provide health care on Saturdays or Sundays?); C2 (Does the health service/physician/nurse provide healthcare at least a few nights on working days up to 8:00 p.m.); C5 (When your health service/physician/nurse is not working, is there a phone number that you can call when you are sick?); C6 (When your health service/physician/nurse is not working on Saturdays and Sundays and you become sick, does anyone from this service provides healthcare to you on the same day?); C7 (When your health service/physician/nurse is not working and you become sick during the night, does anyone from this service provides healthcare to you on that night?); C9 (When you arrive at your health service/physician or nurse's office, do you have to wait more than 30 minutes to be seen? [without considering patient screening or user embracement]); and C12 (When you have to go to your physician or nurse's office/health unit, do you miss work or school?).

The comparison of the statement above with the assessment of adult health in a municipality of Vale do Jequitinhonha, State of Minas Gerais, Brazil, indicates that there is a need to reformulate the work process on the part of health managers and professionals.¹⁶ The hours of operation in the units could be made more flexible to provide better healthcare to users. Due to Nurses' ability in management, they can change the shifts to obtain a better adhesion of the community to the service.

A study conducted in Rio de Janeiro, Brazil, to assess PHC from the point of view of adult and children also showed that accessibility was a problem in different primary health

care units.¹⁷ The studies conducted in São Paulo and Montes Claros, State of Minas Gerais, Brazil, found that the difficulty of access was a reality, which contributed to a negative rating of the services. In Chapecó, State of Santa Catarina, Brazil, there we also problems of accessibility related to the demand and the small number of medical appointments.²⁰

Unlike the studies cited above, the assessment of PHC in Vale do Jequitinhonha determined a better projection of accessibility in one of the areas studied. However, there were conflicting results in other areas with respect to the same attribute, thus revealing the concern with the difficulty of access due to geographical barriers.¹⁶ In the other studies mentioned above, the central idea was attributed to shortage and user dissatisfaction regarding the hours of operation, interpersonal relationship, and user embracement. This fact was confirmed by a study conducted in the FHS of Serra, State of Espírito Santo, Brazil, stating that the main tool is user embracement, which is firstly based on listening.²¹

"The first impression is what counts"; therefore, this popular saying with its empiricism calls attention to the profile that the new healthcare model should build together with users. From the ambiguity of senses, this saying can also be interpreted through what the figure—in this case the professional in whom the users put their confidence—can improve by giving emphasis on popular knowledge associated with scientific knowledge. This way, user embracement will make basic healthcare be the main pillar of support for the collective and individual needs. Even without using hard technologies, the individuals will be able to acknowledge the service by considering user embracement a source of prevention and a favorable environment to sit back, be safe, and protect their health. However, it is through the impression of the initial contact, appreciation, and exchange of knowledge that the user will feel free to use the service as soon as necessary.

Family guidance, from the point of view of adult users, had an average score that showed its proximity to the result obtained from the point of view of caregivers of children. This fact clarifies the fragility of this attribute for users of different ages in their stages of life, as revealed by the indicator I1 (service and space for the individuals' healthcare process and/or the family being directly involved in the healthcare plans). This attribute, characterized by negative responses at

different ages, consolidates the operating failure of the units of the three municipalities in the region of Presidente Prudente and, in addition, reveals that this issue can affect other units of the national territory.

With respect to the relationship between families and users, the bond is the best way to establish and enhance what the individuals are willing to offer and, this way, solidify the quality of well-being, be it physical, mental or spiritual. The studies conducted in Vale do Jequitinhonha and Serra indicated that family guidance was underrated, which shows that the families were not being benefited with the proposal of the National Policy for Basic Healthcare addressed to the FHS.^{7,16,21}

Another result that confirms the findings of the present study is the low score of family scope in Sao Paulo, which demonstrates that low scores were present in cities with different population, cultural, and geographic dimensions. According to users, health professionals did not value the living conditions of users and information about their families. Few users reported that the professionals knew their families.¹⁸

The crucial aspect of the problem is that the families should not only be approached when requested but on a daily basis. As mentioned earlier, this is an action promoted through dialogue and professionals' interest based on action, because family guidance consists of assisting the individuals and, above all, bringing the families to be protagonists of control and participation in continuous healthcare within their own clan.

Managers are responsible for planning and professionals' training, so that they can assimilate the principles and guidelines of the FHS. This assistive model aims to incorporate knowledge and practices built in conjunction with families and communities. The goal is to recognize the real health needs and groups in a situation of social exclusion and vulnerability. This way, it will be possible to strengthen the fulfillment of accessibility principles, integrality and equity of the Unified Health System, quality of the services provided, and the solution of the main problems of the population.

CONCLUSION

The present study showed that, according to the opinion of the caregivers of children under the age of two years and adult users, the FHS in the three municipalities of the region of Presidente Prudente, State of São Paulo, Brazil, exhibited the attributes of PHC. However, some attributes, such as healthcare coordination-integration, access to initial

contact-accessibility, and family guidance, needed to be improved in accordance to the principles of the Unified Health System. Given that the attributes are related to each other, the absence of some of them implies healthcare fragmentation. This way, the practice of the FHS is mischaracterized and affects the actions for disease prevention, health promotion, early detection of chronic diseases and their complications, identification of the needs and situations of vulnerability of the population, and the functioning of the healthcare network.

Child healthcare in the municipalities needs to strengthen healthcare coordination-integration, which is an attribute that promotes the integrality and the resolution of more complex health problems. Another important aspect is that the principle of regionalization does not occur without healthcare coordination. On the other hand, adult health needs to include and strengthen access to initial contact-accessibility in the daily practice of FHS professionals. Without accessibility, it is difficult to think about health, given that there will not be actions targeted at users' health. The lack of accessibility mischaracterizes the FHS as a gateway to the health system. From this point of view, it is necessary to join efforts and actions performed by health managers, professionals, and users in order to find solutions for the existing barriers.

Family guidance needed to be improved in the scope of adult and child health in the three municipalities studied. This attribute is one of the FHS assumptions to work with a focus on the family. Without the incorporation of this attribute in professional practice, the FHS loses its differential.

From this point of view, it is suggested that the essential and derivative attributes of PHC should be adequately incorporated into the practice of health professionals through training and valorization of the actions that characterize the FHS as a model with a focus on the family, which is the starting point and coordinates the health services network in a resolute manner. The re-assessment and re-adjustment of the FHS primary functions should be performed by health managers, health professionals and users, in order to regain the important role of the FHS for the reorientation of PHC in Brazil.

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