DOI: 10.4025/cienccuidsaude.v13i4.20869

PROBLEM SOLVING OF CHILDREN HEALTH IN THE HEALTH CARE NETWORK

Cláudia Siveira Viera*
Fabíula Dos Santos Toso**
Beatriz Rosana Gonçalves De Oliveira Toso***
Eliane Tatsch Neves****
Kellen Cervo Zamberlan*****
Maristela Salete Maraschin******

ABSTRACT
The aim of this study was to describe the problem solving in health care for children under five in two southern Brazilian cities, based on the perspective of caregivers. A total of 25 family members of children assisted in Urgent Care Units in 2010 were the participants of this research. Data collection was carried out through semi-structured interviews at the families' homes. Data were subjected to thematic analysis and the outcomes showed that families seek Urgent Care to immediately solve their problems, considering Primary Health Care as having a low problem solving, and search for services with higher technological density to solve their children's problems. According to the families' comprehension, problem solving occurs when the service is fast and the child's symptoms disappear. Finally, access to the health service in the Basic Unit/Family Health Unit is hindered due to how services are organized.

Keywords: Child Health. Health Service Accessibility. Primary Health Care. Pediatric Nursing.

INTRODUCTION

Child health care must be regarded as a priority field when caring for the population's health. Basic health care services, such as immunizations, breastfeeding support, monitoring growth and development, and prevention of common childhood diseases contribute to the development of strategies against child morbidity, mortality and poor quality of life. In that regard, public social and health policies implemented over the years have promoted actions that resulted in lower child mortality rates since the early 20th century, when mortality rates stood around 100/1000 Live Births (LB); by 2010, that number had fallen to 16/1000 LB [1], with Brazil's southern region having the lowest rate in the country (11.6/1000 LB) [2]. Despite all efforts and advances in the health sector, certain indicators of child health, such as child mortality, point towards problems that require actions, practices and interventions that can result in significant changes in this scenario.

Although the child mortality rate is declining in Brazil, children under five contribute to an increase in the mortality and morbidity rates within that group, particularly in the age range below one year of age [3]. It should be highlighted that most deaths of children under one year in Brazil are due to diseases that originate in the perinatal period (61.5%) and poorly defined causes (24.4%), followed by infectious intestinal and parasite illnesses (5.7%) and respiratory diseases (5.4%). In the age group between one and four years of age, there has been an increase in external causes (23.0%), followed by respiratory diseases (17.1%) and infectious and parasite illnesses (13.9%)[2]. Also, respiratory and gastrointestinal problems are main causes of hospitalization among these children[3].

[1]Results of monograph of a Specialization course in Public Health at State University of Western Parana, it is part of a bicentrico research Project named "Children under five years old profile who was attended in two cities of south of Brazil", approved in the Universal Edital 014/2010 – CNPq.

*Neonatologist Nurse. Ph D. in Public Health Nursing. Professor of Nursing Course and Bioscience and Health Master Courser at State University of Western Parana (Unioeste), Cascavel Campus. E-mail: clausviera@gmail.com
**Nurse of Health Secretary of Cascavel City, PR. Public Health Specialist. E-mail:fabitoso@hotmail.com
***Nurse. Ph D. in Health Science. Professor of Nursing Course and Bioscience and Health Master Courser at State University of Western Parana (Unioeste), Cascavel Campus. E-mail: lb.toso@certto.com.br
****Pediatric Nurse. Ph D. in Nursing. Professor in the Nursing graduation course and Post Graduation in Nursing at federal university of santa Maria (UFSM/RS). Member of the Research Group People and Family Care, Society– PEFAS. E-mail: elianeves03@gmail.com
*****Nurse. Master in Nursing of the post graduation course of Federal University of Santa Maria (UFSM/RS). Member of the Research Group People and Family Care, Society– PEFAS. E-mail: kellencz@hotmail.com
******Nurse. Master in Nursing. Assistent Professor of Nursing Course Unioeste – Cascavel Campus. E-mail: maraschin@certto.com.br

It is then observed that children under five are being hospitalized or assisted in Emergency Care (EC) and Urgent care (UC) for childhood diseases, which could be resolved in Primary Health Care (PHC) units, starting during perinatal care. According to the World Health Report[4], PHC aims to guarantee universal health access for the population, reducing exclusion in assistance and social disparities in health, guaranteeing higher quality of services, organized around personal needs and expectations, guided by integrality in all care levels.

Nevertheless, although there are guidelines for child health care in Brazil – such as: priority agenda for child health[5]; integral care for childhood diseases – AIDPI[6]; pregnancy assistance[7], among others – some gaps have been identified in PHC assistance to this group, such as fragmented cared, centered on the pathology and featuring a reductionist character, instead of considering the different determinant factors of health. Assistance is provided according to demand, using narrow, reactive actions, without continuity of care over time and not focused on proactive actions or on the different contexts in which children are included, diverging from health policies recommended for this age group, contributing for lower resolution rates of health problems in these children.

To change this scenario, the structure of the Family Health Strategy (FHS) as a broad mechanism of PHC availability to the population is a viable alternative for child care in this scope of assistance, focused on integral care, longitudinality, coordinated actions and expanded access, using health surveillance and health promotion resources [8].

New studies are required on the problem solving rate of child primary health care in order to better understand this gap in care – from a type of care that could be solve at the first level of access to health care and which has failed as shown in several studies that indicate that predominant hospitalizations[3] and the search for emergency care by children and their families are due to causes that can be dealt by primary care[9].

Considering the care model in effect in PHC and epidemiological data, the question becomes: how are health problems in children solved in primary health care? Thus, the objective was to describe the problem solving in health assistance to children under five years of age in two Brazilian municipalities, under the standpoint of caregivers.

METHOD

This is a qualitative, descriptive and exploratory research, consisting of a cross-section of the study "Characterization of children under five assisted at urgent care units of two municipalities in southern Brazil", financed by the National Council for Scientific and Technological Knowledge – CNPq (Universal Notice 14/2010). That study is characterized as double centric, carried out in conjunction by Western Paraná State University (Unioeste), Cascavel Campus, Paraná; and the Federal University of Santa Maria – UFSM, Rio Grande do Sul.

The city of Cascavel is located in western Paraná state and has an estimated population of 286,205 [10]. The city's health care system at the time of data collection featured 22 Basic Care Units (BCU) and 10 Family Health Units (FHU), with two teams in the urban area covering 9.0% of the population, and two Urgent Care Units (UCU). In that city, UCU totaled 167,226 visits in 2010, with an average of 6,968 at each UCU; of those, approximately 2,300 to 3,300 monthly visits were by children between zero and 13 years of age. Of those, 50 to 63% consisted of children under five[11], the age range of the present study.

Santa Maria is located in central Rio Grande do Sul state and features a population of approximately 274,070, 3,138 of whom are under one year of age [11]. The health system consists of 32 BCU, distributed in six health regions, of which 16 are FHS covering 21.45% of the city's population. At the time of data collection, Santa Maria did not have a UCU, but instead two child urgent care units – one linked to the city and the other belonging to Santa Maria University Hospital (HUSM/UFSM). The city's child urgent care unit features a pediatrician on duty 24 hours, is located in a neighborhood near the city center and serves on average 150 children a day. The child urgent care unit at HUSM is known as Pediatric Emergency Care, has a pediatrician on duty 24 hours and serves an average of 30 children/day[12].

Study subjects were sampled from a survey of appointment records in the UCU, considering that the objective of the double centric study was to characterize the children assisted by these services. The study was developed to understand the reason for such a high demand for this service by the children's caregivers. Therefore, the subjects of this stage of the double centric study were family members/caregivers of children under five, who had taken their children for care at the pediatric urgent care services of the cities under study in 2010. Subjects were selected from the database of the double centric study, with a sample of the qualitative analysis of 1372 subjects – 648 in Cascavel and 724 in Santa Maria. From that total, subjects were selected to take part in the qualitative stage of the research, at random. From this selection, family members/caregivers were contacted by phone, inquired about their interest in participating in the study and scheduling a home visit for data collection. The exclusion criteria were address not found, changed or nonexistent phone number.

The data collection technique consisted of a semi-structured interview, defined as a method of collecting data reported by the interviewed subjects to obtain information on a given topic. Semi-structured or semi-guided interviews serve as a script for conversation, featuring a number of questions designed to guide the dialogue, but without predetermining the entire interview [13].

The interviews were conducted at the homes of the families, and were guided by the following question: "Tell me about your search for assistance for your child until you reached the urgent care unit?" The interviews were recorded and transcribed in full, right after the home visits, which began only after the interviewed subjects had read and signed the Informed Consent Form.

Because it was a qualitative study, the suspension of inclusion new participants in the study took place by a continuous process of data analysis, which began during data collection. With regard to the number of participants in the study, it is best to keep conducting interviews until the obtained result allows an analysis to comprehend the ideas and thoughts presented. Thus, the possible theoretical density was supposedly achieved, based on the empirical data available and on the analytical and interpretative attributes of the researchers [14]. This resulted in 25 interviews, totaling 15 subjects in Cascavel and 10 in Santa Maria. The data of the double centric study were analyzed on two occasions: first, the total research sample was characterized by quantitative analysis of the data from the documental research, with the results presented as descriptive statistics in another document. In the second occasion, the dados were subjected to thematic content analysis[13], presented herein, following the guidelines: pre-analysis (initial reading of the data set, building the corpus and reformulating assumptions and objectives); exploring the material (analyze the text systematically); identification of thematic lines and establish their respective centers of meaning, arriving at a description of themes, as broader classifications and use of an analysis script; treatment of results, inference and interpretation according to a theoretical framework.

This study was approved by the Research Ethics Committee (CEP) of Western Paraná State University - UNIOESTE in decision no. 011/2010 – CEP and by the CEP at UFSM under number 0378.1.243.000-10. In order to maintain the confidentiality of participants, interview fragments are identified in parentheses by the letter E, followed by a sequence number according to the order in which the interviews were carried out in both scenarios, as well as the city of origin of the interviewed subject.

RESULTS AND DISCUSSION

Of the children whose families took part in the study, 40% (10) were one year old, and respiratory diseases were responsible for 48%[12] of consultations. The following analysis categories emerged from the thematic analysis: Primary Health Care and problem solving; and the problem solving rate under the viewpoint of caregivers.

Primary Health Care and problem solving

This category discusses the problem solving rate, which is understood as the ability of the service to meet the health needs of the population in their work environment or at any care location of the service network, as long as it belongs to the health care network, coordinated

by the PHC and referred by it and monitored until the health problem is solved [7].

As the following interview fragments indicate, the families understand that the PHC is considered to have a low problem solving.

> Well, depending on the situation, on how she is, I'll decide where to go, whether to the PAC {continued urgent care} or to the unit. [...] They {at the BCU} give out medicine, but for home use, cough syrup, antibiotics they give out at the unit, but sometimes it's not necessary, but sometimes I have to buy it at the drugstore, and at the PAC the first dose is given there, so it's something immediate. [...] if I see it's serious, that they'll request that exam, an x-ray, then I'll go to the PAC, unless it's something like anemia, blood work, then I'll go to the unit...[...] (E6, Cascavel, PR).

> [...] When the fever rises quickly, then I have to rush him, I go to the UCU. I don't go to the unit, because it's an emergency, and the unit does not solve it. I usually take him {BCU}, just yesterday I took him to the unit, to get deworming medicine, for a referral to an ENT {Otolaryngologist}, then I take him to the unit, when the fever starts, then I take him to the PAC (Interview subject 15, Cascavel, PR).

> I had taken him here to the PA {municipal urgent care}, then they medicated him and after that, it was no use, then I took him to the university {university hospital} (E2, Santa Maria, RS).

It is understood that the search for urgent care services by family members/caregivers is due to the health state of the child or even by the worsening of their condition, leading them to seek resolution for their problems without going through BCU or FHU. According to the previous statements, when exams or urgent assistance are required, there was no need to first go to the health unit. Moreover, the immediate start of treatment by administering the first dose of medication is another aspect cited as a reason for seeking the UCU.

It is observed that in the public's perception, BCUs are places to seek for low-tech needs, such as treatments for worms, as cited above. PHCs must work to demystify this reasoning for seeking the service, creating a culture of filiation to the unit for all needs [7], and referral when a more acute situation emerges, as a responsibility of the unit and not of the family itself, which decides what is urgent or not based especially on the child's fever.

Difficult the access to the health unit is one of the aspects that make families seek assistance at the PA.

> [...] it's hard to go to the unit, I usually go to the PAC, it's easier. [...] Because at the unit we get there, schedule an appointment and there are no time slots left, at the PAC we know it's a sure thing, they'll help us. [...] I work all day and have no time to go to the unit, sometimes I even have to schedule an appointment and all, at the PA we don't, we go and we get help (E 12, Cascavel, PR).

> I always went there {UCU} because I thought that every time I needed – Saturdays, Sundays, holidays, when the fever is running high, sore throat, or diarrhea, I get help, while at the unit I have to schedule an appointment. The units don't open on weekends, the doctor arrives at 8:30, sees patients until 9 and then leaves, and if you come with your child running a fever, in pain, there is no doctor (E7, Santa Maria, RS).

> I usually come here to the PA {municipal urgent care}, which is closer, I always come here (E9, Santa Maria, RS).

Family members report difficulties in assistance at basic health, leading them to seek urgent care services directly. The severity of the child's clinical state, long lines and low number of available consultations, and lack of service on weekends were the main justifications for family members not seeking PHC services.

The Commitment Agenda for Integral Child Health and Child mortality Reduction, in 2005[5], indicated the existence a health network to which the PHC should guarantee quality, integral assistance to children, following principles such as universal access, support and responsibility for care. Currently, these guidelines are reinforced by the Stork Network[7], a proposal by the Ministry of Health to make operational the Health Care Network for Women and Children. Despite these guidelines, it was observed that child health at the study locations is centered on assisting acute causes and in meeting demand, proposing reactive actions.

When the attributes of PHC such as access; longitudinality of care, which assumes the presence of a bond between families and

professionals; coordination and integrality are present in the daily routine of health services, as well as organization of the healthcare workflow, meets the needs of the population through adequate flow and actions integrated with the other services of the health system, families may continue to mention PHC as they care unit. In that sense, specialized care, such as PA and hospitals, would be used only in those cases when the PHC did not solve the problem, or due to technological requirements or need for specialty [7,8].

The problem solving under the perspective of caregivers

This category shows the problem solving rate under the perspective of family members/caregivers. They understand that aspects that contribute to solve their child's problem include the speed of assistance to the child, combined with effective action by the professional towards the needs of the child at the adequate moment, and also the possibility of continuing treatment through admission.

> Service was good, they treated her well, especially the consultation which was fast at the PAC, she stayed there, she was medicated there, everything. Whenever the child has an emergency, I have no complaints [...]. The doctor helped her well, the nurse care well for her, they took her temperature, she was admitted, she was on an IV [...] (E4, Cascavel, PR).

> Care was quick, too [...]. It was actually fast, because there weren't many people, many kids, practically only two families with children there, that was it (E3, Santa Maria, RS).

This concept of problem solving is founded on the care model offered at the PA, centered on medicating, on serving acute cases; however, users do not understand that this point of care within health services cannot act on determinant factors of the child's health, and is inefficient for chronic conditions and does not offer continuity of care [15].

Another important aspect to solve child health problems that was identified by the families is when symptoms disappear, as they believe that the problem is solved with the exams and adequate medication or with admission to the PA, as follows:

> [...] as soon as she took the medication she never had allergies again. At least every time I took her there {UCU} it was solved, never did I leave there without medication, with nothing, every time I took her there, they admitted her there for two days (E1, Cascavel, PR).

> [...] the immediately ask for an x-ray and blood work, then she stays in observation, does all types of exams, even to release him, he never leaves without blood work, x-ray and medication. [...] of all the times I took him there, {UCU}, he always left with his problems solved, if he stays in observation he is cared for well, and if he comes home to take medication he gets better, if they see he is not well they send him to the hospital, then it's solved. (E15, Cascavel, PR).

> Actually I just walked in, barged in, didn't ask, didn't questionbecause when your son is there practically dying, you go in and don't care, right... I asked for a doctor urgently, and they saw he was in bad shape... didn't even speak... So then they medicated him, and admitted him... (E6, Santa Maria, RS).

The administration of medication was an aspect highlighted by families, giving them a certain security and giving them a sense of resolution. This type of care can be performed at the PHC units as evidenced in a study[16], which indicated that giving medication at the health unit improves the performance of the health team and increased compliance of the child's health care at the unit. This strategyof offering the first dose of the medicationat the unit is set in the guidelines of the strategy for Integral Care for Childhood Diseases, based on the understanding that families have difficulty administering the medications, and that this compromises the resolution of the clinical condition [6].

The need to medicate or perform more complex exams as an essential aspect for solving health problems is cultural trait of users, reinforced by the biologic-centered training health professionals, in which for both the "cure" (emphasis ours) of health problems takes place exclusively with medication and, consequently, with the disappearance of signs and symptoms[16]. Therefore, a need is observed for changes not only in the care model at health services, but also in the fragmented actions at traditional BCUs, towards integral care, in a care network [17], starting at the PHC, through FHS. This is

complemented by professional training and by the understanding that the health-illness process has other determinant factors than the biological aspect.

The subjects indicated challenges in accessing PHC services, translated by the lack of medications; lack of available appointments, and by the form of service by scheduling; delays in getting an appointment for their child; service hours for the public at BCUs/FHUs, and the distance to the health unit. These aspects show that access goes beyond the geographical issue, which was also mentioned by the subjects. It refers particularly to how the service is organized, centered on medical appointments, making it so the work process is based on a professional and not a team. As such, it is detected that the current model of organization of the PHC through the health care network, access in the sense of offering accessibility to services and its use at each new problem or service for the same problem again, as well as proposing that first care for urgencies and emergencies be made at the PHC[8], is still presented in restricted for to users.

Similar data were discussed in a study [9]on access and support in health services, in which the cited aspects were considered to be conditions that hinder the problem solving of health care. Access to health services is inter-related to the problem solving and goes beyond the geographically dimension, comprising economic, cultural and functional aspects [8].

With regard to the service of referral and counter-referral, subjects reported a discontinuity in child assistance.

> They told me {HU} to return to the PAC, if during the week take him to the unit, for exams, plus a follow-up, that was the instruction, verbally only, it was a doctor that saw me at the office who told me (E5, Cascavel, PR).

> [...] then if it doesn't improve, the fever they talk about, if the fever doesn't go down with the drugs, then you go back to the PAC. [...] then they tell me to go back there {UCU} if necessary, or to the health unit. So there was one time when I took my daughter and the doctor said she had anemia, then he told me to go to the unit, so the doctor there could do the procedures, to see if any exam was necessary, which they don't do there {UCU}, then he just told me, I came and had an appointment here {BCU}, that's what they told me, come to the unit, but did not refer me (E6, Cascavel, PR).

This minimal understanding of the health-illness process causes fragmented care, which has no continuity and accountability for the user's health in the service of origin, which would be the BCU/FHU. There is no referral and counter-referral between one service and another, resulting in local and narrow care. When the user enters another segment of the health service, he must start again to report his problem, as there is no referral from the previous service. This demonstrates that the PHC is still not the heart of the health care system as proposed in Health Care Networks (RAS)[7].

The verbal referral reported ultimately becomes only an advice to the user, as there is guarantee he will be seen, as if the responsibility was transferred to the actual user, without fulfilling the obligation to refer the patient to the adequate service. Support as an obligation of the team when referring the user would be a way to solve this problem of lack of referral and counter-referral [16]. Poor communication is observed, without unified records, showing vulnerability in the coordination of the PHC. The computerization of health services proposed in the Health Care Network should be a strategy to solve this problem of lack of communication among the services.

The resolving PHC, modeled on the Health Care Network model, in addition to organizing itself from the health problems of the population within its territory, shows lower costs and emphasizes proactive (and not reactive) actions, solving most health problems of the population; coordinating, organizing referral and counter-referral flows over the network; and taking responsibility for care, wherever the user is served [17].

The complaints by the families in this study showed that there is no bond between them and PHC services, as they report even having to take their children to routine check-ups at the BCU/FHU to prevent complications, but end up not taking them. Other studies [9;16] have shown similar data in which promotion and preventive actions against health complications are not priorities, weakening the focus on integral health care.

Promoting integral child health and developing actions to prevent complications and assistance are objectives indicated by child health care policies;

however, that is not what is seen in the actions developed at the PHC in the cities where the study took place. Even though government guidelines indicate that assistance actions for children should be based on integral care, this is still a distant reality, due to the vulnerability and fragmentation of health care offered by the professionals of the health service network[18].

When seeking assistance for their children's health, the families under study trace a peculiar itinerary that varies between seeking the BCU as a reference point until entering the UCU service. It is observed that the subjects under study use direct access to UCU as their first contact with the health service; in this context, the BCU/FHU, which would be the preferred entry point into the health system, is not so. In their health care itinerary, families seek a service that can provide immediate problem solving of their health problem. This likely occurs because the BCU/FHU has not represented an easily accessible entry point, resulting in inadequate care, which can generate additional costs and low problem solving at PHC[17].

In this situation, it is seen that the population tends to access the health system through easier ways, and that the BCU/FHU is not always the entry point, as indicate in the poly arch network of health assistance[19], precisely because it is not accessible and has a low problem solving, leading users to access health services by seeking other locations of assistance, such as the PA.

FINAL CONSIDERATION

Families seek the PA for immediate resolution to their problems, and regard the PHC as having a low problem solving, seeking a service with higher technological density to serve their children – understanding problem solving as the speed of service, quickly-performed exams, as well as the disappearance of symptoms manifested by the child at the time the UCU was sought.

Medicalization was a mentioned aspect with regard to the cure and solution of health problems in children. It was also mentioned that the difficulties in accessing the health service in the BCU/FHU are a result of how the services are organized. There is no observed integrality in the care given, much less a network of service, which would provide integrated care, understood as the means to make access feasible, user satisfaction and efficiency within a proposal of improved equity.

This form of caregiving lacks a bond between the health team at the PHC and the families under their care, in order to enable security in the service provided by the unit, thus favoring an understanding of the duties of the PHC and the knowledge of the existence of levels of complexity in assistance, thus leading to improved comprehension of the adequate functioning of services.

If the units had the attributes of the PHC throughout – that is, if they provided continuity of care; access to medication during the first contact; bond between team, user and family; action as a regular source of care used over time; accountability for offering services and acknowledgment of the different causal factors of pathologies in actions towards the community, the family would feel safe to first seek the PHC for assistance with their child, and, if necessary, a referral to the PA.

This study highlights the importance of the role of managers, assuming their function in reorganizing the PHC and Health Care Networks, aiming for adequate functioning of the health system, making it possible to satisfy user demands, solving their health problems or referring them to the other points of care in the network, organizing the flow of care. Thus, it should be emphasized that the PHC must make efforts to fulfill its duties from a network of care, seeking resolution, coordination and accountability for the health care of the population, seeking integral and humanized care for child health.

RESOLUÇÃO DE PROBLEMAS DE SAÚDE DE CRIANÇAS NA REDE DE ATENÇÃO À SAÚDE

RESUMO

Objetivou-se descrever a resolutividade na atenção à saúde de crianças menores de cinco anos em dois municípios do sul do Brasil, na percepção dos cuidadores. Participaram desta pesquisa 25 familiares de crianças atendidas nas Unidades de Pronto Atendimento, em 2010. A coleta de dados foi realizada por meio de

entrevistas semiestruturadas no domicílio das famílias. Os dados foram submetidos à análise temática de conteúdo e os resultados apontaram que as famílias procuram as Unidades de Pronto Atendimento para a resolução imediata de seus problemas, considerando a Atenção Primária à Saúde como de baixa resolutividade, procuram um serviço de maior densidade tecnológica, para resolução dos problemas dos filhos. Na compreensão dos familiares, a resolutividade existe quando há agilidade no atendimento e desaparecimento dos sintomas apresentados pela criança. Conclui-se que o acesso ao serviço de saúde na Unidade Básica de Saúde/Unidade de Saúde da Família é dificultado devido à forma de organização dos serviços.

Palavras-chave: Saúde da criança. Acesso aos serviços de saúde. Atenção primária à saúde. Enfermagem pediátrica.

RESOLUCIÓN DE PROBLEMAS DE SALUD DE NIÑOS EN LA RED DE ATENCIÓN A LA SALUD

RESUMEN

El objetivo de este estudio fue describir la solución de problemas en la atención a la salud de niños menores de cinco años en dos ciudades del sur de Brasil, en la percepción de los cuidadores. Participaron del estudio 25 familiares de niños cuidados en la Unidad de Pronta Atención en 2010. La recolección de los datos fue realizada por medio de entrevistas semiestructuradas en el hogar de las familias. Los datos fueron sometidos al análisis temático de contenido y los resultados mostraron que las familias buscan las Unidades de Pronta Atención para la resolución inmediata de sus problemas, considerando la Atención Primaria a la Salud como de baja resolutividad, buscan un servicio de mayor densidad tecnológica, para resolución de los problemas de sus hijos. Para los familiares, la resolutividad ocurre cuando la atención es ágil y los síntomas del niño desaparecen. Se concluye que el acceso a servicios de salud en la Unidad Básica de Salud/Unidad de Salud de la Familia es dificultado debido a la forma que se organizan los servicios.

Palabras clave: Salud del niño. Accesibilidad a los servicios de salud. Atención primaria de salud. Enfermería pediátrica.

REFERENCES

1. United Nations Children's Fund -UNICEF. Committing to child survival: a promise renewed. [on-line]. 2012 [citado 2012 Dez 20]; 44p. Disponível em: http://www.unicef.org/videoaudio/PDFs/APR_Progress_Report_2012_final.pdf

2. Ministério da Saúde (BR). Data SUS. Indicadores de mortalidade. [citado 2012 dez 16]. Brasília (DF): Editora Ministério da Saúde; 2011. Disponível em: http://tabnet.datasus.gov.br/cgi/deftohtm.exe?idb2011/c04.def

3. Victora C, Aquino EML, Leal MC, Monteiro CA, Barros FC, Szwarcwald CL. Saúde de mães e crianças no Brasil: progressos e desafios. Lancet. Series Saúde no Brasil 2. [on-line]. 2011. [citado 2014fev 25]:32-46. Disponível em: http://download.thelancet.com/flatcontentassets/pdfs/brazil/brazilpor2.pdf

4. Organização Mundial da Saúde-OMS. Relatório Mundial de Saúde 2008. Atenção Primária em Saúde: Agora mais do que nunca**.** Tradução: Ministério da Saúde (BR); 2010.

5. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Agenda de Compromissos para a Saúde Integral da Criança e Redução da Mortalidade Infantil. [on-line] Brasília (BR): Editora do Ministério da Saúde; 2004. [citado 2013 mar 12]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/agenda_compro_crianca.pdf

6. Ministério da Saúde (BR). AIDIPI. Atenção Integrada às Doenças Prevalentes na Infância: curso de capacitação tratar a criança: módulo 4. [on-line]. Ministério da Saúde, Organização Mundial da Saúde. 2a ed. [citado 2013 maio 12]. Brasília (DF): Editora do Ministério da Saúde; 2003. Disponível em: http://dtr2001.saude.gov.br/editora/produtos/livros/pdf/03_0471_M.pdf

7. Ministério da Saúde (BR). Portaria nº 4.279 de 30 de dezembro de 2010. Redes de atenção a saúde. [on-line]. 2010. [citado 2012 set 10]. Disponível em: <http://conselho.saude.gov.br/ultimas_noticias/2011/img/07_jan_portaria4279_301210.pdf>

8. Starfield B. Atenção primária. Equilíbrio entre necessidades de saúde, serviços e tecnologias. Brasília (DF): Editora do Ministério da Saúde; 2002.

9. Silva RMM, Viera CS, Toso BRGO, Neves ET, Rodrigues RM. Resolutividade na atenção à saúde da criança: percepção de pais e cuidadores. Acta Paul Enferm. 2013. [citado 2014 fev 26]; 26(4):382-88. Disponível em: http://www.scielo.br/pdf/ape/v26n4/v26n4a13.pdf

10. Instituto Brasileiro de Geografia e Estatística-IBGE. [citado 2012 dez 20]. Censo 2010. Dados básicos. Disponível em: http://www.ibge.gov.br/cidadesat/painel/painel.php?codmun=410480

11. Cascavel. Prefeitura municipal de Cascavel. Portal do Município de Cascavel**.** Unidades especiais de saúde. [citado 2013 jan 04]. Disponível em: http://www.cascavel.pr.gov.br/secretarias/saude/pagina.php?id=139

12. Ministério da Educação (BR). Hospital Universitário de Santa Maria. Dimensionamento de serviços assistenciais e da gerência de ensino e pesquisa. Santa Maria; 2013.

13. Minayo MCS. O desafio do conhecimento: Pesquisa Qualitativa em saúde. 12a ed. São Paulo: Hucitec; 2010. 410p.

14. Fontanella BJB, Ricas J, Turato ER. Amostragem por saturação em pesquisas qualitativas em saúde: contribuições teóricas. Cad saúde pública. 2008. [citado

2012 nov 11]; 1(24):17-27. Disponível em: http://www.scielo.br/pdf/csp/v24n1/02.pdf

15. Tesser CD, Poli Neto P, Campos GWS. Acolhimento e (des)medicalização social: um desafio para as equipes de saúde da família. Ciênc saude colet. 2010. [citado 2013 maio 10]; 15 supl. 3:3615-3624. Disponível em: http://www.scielo.br/pdf/csc/v15s3/v15s3a36.pdf

16. Costa GD, Cotta RMM, Reis IR, Ferreira MLSM, Reis RS, Franceschini SCC. Avaliação da atenção à saúde da criança no contexto da Saúde da Família no município de Teixeiras, Minas Gerais (MG, Brasil). Ciênc saúde colet. 2011. [citado 2014 fev 25]; 16(7):3229-3240. Disponível em: http://www.redalyc.org/pdf/2814/281421953027.pdf.

17. Mendes EV. As Redes de Atenção à Saúde. 2a ed. Brasília (DF): Organização Pan-Americana da Saúde, Editora do Ministério da Saúde; 2011. .

18. Novaczyk AB, Gaíva MAM. As tecnologias inter-relacionais na assistência à criança na atenção básica: análise de documentos oficiais. Ciênc cuid saúde. 2010 jul-set. [citado 2012 Nov 12]; 9(3):560-8. Disponível em: http://periodicos.uem.br/ojs/index.php/CiencCuidSaude/article/view/12560/6652

19. Ribeiro LCC, Rocha RL, Ramos-Jorge ML. Acolhimento às crianças na atenção primária à saúde: um estudo sobre a postura dos profissionais das equipes de saúde da família. Cad saúde pública. 2010 dez [citado 2013 maio 08]; 26(12):2316-2322. Disponível em: http://www.scielosp.org/pdf/csp/v26n12/10.pdf.

Corresponding author: Cláudia Silveira Viera. 124 Betula street, Zipcode: 85807240. Neighborhood Recanto tropical, Cascavel, Parana. E-mail: clausviera@gmail.com.

Submitted: 14/05/2013
Accepted: 26/05/2014