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THE PROCESS OF WORK IN PRIMARY HEALTH CARE TO CHILDREN

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ABSTRACT
In the Primary Health Care (PHC) services, the care provided by workers' team responds to the health needs of different social groups. The aim was understanding the PHC work process, in two units, a traditional Basic Health Unit and a Family Health Strategy unit. Descriptive study of qualitative approach. Data was obtained in two PHC units through observation technique during two months, one in each unit, with the notes taken in a field diary. The data was analyzed under the thematic of analysis principles. The results were discussed over two units: working time at PHC unit, and predominated working focus at PHC, thus leading to demonstrate that there is fragmented work, focused on the professional only, in both health care models. The problems in the organization of health work process tend to hinder the health care of children in PHC; it shows a negative impact in the health care resolution.

Keywords: Children health. Human resources. Child. Primary Health Care.

INTRODUCTION

The Primary Health Care (PHC) services provide users the first contact to the health system and are responsible to organize the caring to individuals and the community, as a whole. In this area of care, the proposal is to provide equal use of resources and integrity in caring through a wide concept of health service, guided by principles and character, searching for the inclusion in a perspective to support the health necessities of the population attended[1]. Among those health necessities to be attended through PHC, child health care is highlighted, therefore aiming to promote health, prevention of illnesses, and other possible harms, following up with the child's growth, development, immunization, and nutritional observation.

For an ideal and effective performance of such actions, it is indispensable the organization of health care teams with enough human resources to generate a caring process through the use of light and light-hard technologies, including listening, welcoming and accountability[2].

On the technological core of the working process, there are structured processes produced by dead labor together with live labor on the spot. It is under this core that the definition of the hegemony of the productive processes relies on: among the structured technologies given by the machinery used, provided under a market reasoning, and together with them, the relational technologies, based on other logical thinking such as the human necessity, which emerge from production of health aimed to support caregiving[3].

Hence, when the work process is conducted by live labor, workers feel more free and creative, bringing professionals and users closer together, with interactions that would insert the user in the process of production of his own health status, placing this individual as a protagonist in the process of health-disease. When such actions are focused on the dead labor, the instruments, limiting the acting of professionals programing machines and filling

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out reports, and having little or no interaction with the users, it becomes a series of proceedings[4].

This work process aims to produce caring, and has individual and collective subjective protagonists as main characters, which all have different intentions, objectives and goals. This scenario is also understood as the micropolitics of the working process[3]. Such individuals work according to a wide array of interests, corporations, directives, and devices. The behavior the laborer adopts throughout his day that may generate conflicts in the working process due to lack of articulation among other subjects, generating tensions in this environment as well as in the health care model adopted[5].

A health care model based on one's own interests and disconnected from other subjects can be interpreted as a fragmented health care labor, in which the user is required to go over a series of diagnoses and therapeutic procedures in order to find a resolution to the user's health issues. It is possible to understand that health is not an area in which reigns the logic to substitute technologies; in the contrary: the accumulation of new technologies and a broader diversity of services has given health care services a concept of fragmentation and consumption of those same services[6].

While the changes in the production are taking place, directives such as welcoming, bonding with accountability, and autonomy of the user as indicators of health care effectiveness are being developed, which can be observed and evaluates[3], especially among PHC, which is understood as nucleus that organizes the whole health care system in a more universal health system, wide and equalitarian, closer to the individuals and to the collectivity, aiming to solve health issues through users' and professionals' autonomy and participation, providing them with a high resolution capacity[7].

If PHC was built upon an interconnected structure linked to a qualified health care network, based on the principles such as first contact access, longitudinality (caring provided by the health team together with users and families through time), integrality (available services that support the population over the biological, psychological, and social aspects among the services network), caring organizational coordination (a guarantee in continuing the health care service), the focus on the family (family as the aim for health care), and community guidance (recognition of the necessities into the socioeconomic and cultural context under the perspective of collective health)[8] would achieve an 80% chance of effectiveness in health care demands.

In regards to the health care service provided in PHC, as seen mostly done by the Family Health Strategy (FHS) system, it is expected that they will be provided by a multi-professional team that welcome the individuals according to their health necessities. If the relationship professional-user is motivated through the use of live labor in act, with a higher autonomy of the individuals performing the tasks, with a broader view of the health-disease process, it will develop into a more holistic and articulated assistance of the health services that belong to the same network[7].

Therefore, the present study has an objective to understand the work of primary care teams of traditional basic health units and of family health strategy ones.

METHODOLOGY

This study is part of a multi-centered evaluation of services of PHC to child care, supported by the Paraná West State University (UNIOESTE, in Portuguese), Londrina State University (UEL, in Portuguese), and Paraíba Federal University (UFPB, in Portuguese). This investigation was approved by the Universal Notice of the Brazilian Nacional Council for Scientific and Technological Development (CNPq, in Portuguese), under protocol number 474743/2011-0. This article presents the data related to one stage of this research. This is a qualitative investigation, developed through a descriptive and evaluative approach. To support data analysis, the theoretical-methodological reference taken was the historical dialectical materialism.

To acquire the data it was used the non-participative observation technique in two PHC units: a traditional Basic Health Unit (BHU), and a FHS one, both located in urban areas of Cascavel, in the southern Brazilian state of Paraná. The subjects of this study were the

professionals of the two units. The data collection was between May and June 2013, in daily observations, from Monday to Friday, during the units' working hours.

A field diary was the instrument used to register the observations conducted through a script, which detailed the tasks performed by the teams in regards to child care, the intentionality of the roles takes, the object and the instruments used by the team. The notes used in this study were identified with the initials "P.S.", followed by the number corresponding to the day of the observation, and the initials BHU for the traditional health units or FHU for those related to the family health program.

The information gathered from observations were treated through the method of Thematic Analysis[9], described from the pre-analysis step (repeated reading and grouping data in categories), material exploration (identification of structures of textual relevance), treatment of the results found (regrouping, transversal and horizontal reading, and identification of the core of meanings), and interpretation (construction of the thematic categories for data presentation according to each one's analysis), thus leading to two categories: "the teamwork in primary health care" and "the focus of the predominant workload in primary health care".

The ethical aspects based on the present regulations were respected, and this research project was approved by the Committee of Ethics in Research with human beings of Paraná West State University, under protocol 044/2012.

RESULTS AND DISCUSSION

The characteristics of BHU and of FHS have gone apart, as in FHS one would find only general practitioners, while in BHU there will be also the presence of pediatricians. The number of nurses was constant in both models, with at least one nurse present at each unit. The traditional BHU had medical services in the areas of general practice, pediatricians, gynecologists, and obstetricians. The nursing systems included childcare, gynecological care, and nursing consultations. Besides that, general dentistry services, as well as social service were offered in this unit. The FHS offered appointments with general practitioners, nursing services, home visit of health care teams, dentistry services, social service, activities to promote the education of health with specific groups (Hiperdia and Family Planning), despite other procedures offered on a regular basis in a FHU unit (immunizations, banding, nebulization, pap smear collection of the cervix and other small surgeries).

The units had the minimum quorum of professional to function properly, even though they are different models of health care. Professionals are from the areas of Medicine, Nursing, Dentistry, and Social Service, according to the Brazilian National Policy in Basic Care[7].

THE TEAMWORK IN PRIMARY HEALTH CARE

The work in both units is seen as divided and portioned among the professional categories. Each professional works in a specific environment, usually without sharing or supporting the health care procedures with the rest of the team.

Certain characteristics of the work procedures seen at the FHU are highlighted below:

> The community health agents (CHA), when in the unit, are found in a closed room, not showing any sort of interaction with the rest of the team (P. S. 3 FHU).

> One of the physicians when he is not in an appointment, he locks himself in the office and only responds to an emergency if needed (P. S. 3 FHU).

> The nursing technicians have a daily schedule of tasks, switching every 15 days, divided in pairs (A and B), and work places (one and two) (P. S. 13 FHU).

> On the Dentistry Clinic, the afternoon appointments ended and it was possible to see dentists, technicians, and oral health assistants were in a room, chatting. During the period observed there was no interaction among them with the rest of the FHU team, which seemed to be two distinct teams (P. S. 12 FHU).

> The nurse was working in a pre-consultation, checking arterial blood pressure, weight, temperature, and there were mothers with their children waiting for child care from the nurse, and because the lack of available staff, this nurse was performing the pre-consultation together with a community health agent, who was taking notes in

> a form and in the medical records, as well as weighting babies at the nurse's office as there were no pediatric scale at the pre-consultation office. The priority of the nurse at this moment was the pre-consultation, because without this procedure the physician cannot treat the patients; there was a necessity to prepare the patient for the medical consultation, while the rest of the tasks were placed on hold. I realized that many times it is not possible to plan the caring services according to the program set by the FHU, in which, on a daily basis, the team that responds to the spontaneous demand that arrives there everyday generates that each professional end up working isolated from the others (P. S. 10 FHU).

The divided and fragmented workload was also observed at the traditional BHU:

> The nurse technicians would take turns in the vaccination room, the pre-consultation office, and in the dressing room (P. S. 4 BHU).

> During child care, the nurse was diagnosing a child, and whenever she felt it was necessary, she would schedule an appointment with a pediatrician on the next day (P. S. 7 BHU).

> On this day of observations, the drug dispensing area was closed because the one responsible for it was on medical leave (P. S. 9 BHU).

The working process is done individually and fragmented, divided in areas, rooms, and roles, such as the drug dispensing area, closed and with services unavailable as the one responsible was away. Each professional performs child care according to procedures described in pre-established rules and routines, considered as hard technologies. The knowledge of workers and users are almost never discussed and taken into consideration in health care services, and the findings and issues that arise from the health activity are mostly kept in and not shared by the members of the health teams, which lead to more fragmentation of tasks and roles, and eventually, to the lack of final resolutions of child health issues[3].

At the Primary Health Support (PHS) unit, and especially at the Family Health Strategy (FHS) unit, the teamwork is guided by a holistic approach, based on the theoretical concept they are built upon. Interdisciplinarity is one of their essential characteristics. However, the integration of health practices among different areas is still a challenge. To make interdisciplinary work more effective, the links among health professionals require further understanding regarding the affective ties, coexistence, and dialogue. This is a progressive learning process that is being incorporated into work routines of the multi-professional health team, and it can promote changes in the theoretical-practical references that guide the roles of each professional[10].

To promote a working environment that enables better labor conditions, in which laborers and users are protagonists into this environment, filled with moments to share mutual understandings to transform those into healthy and resolutive relationships. To build such environments it is necessary to build long-term bonds among the management team, the workers, and the users, combined with priority investments in improvements and adaptations of the infra-structure of the units, besides hiring more workers and providing them with permanent educational improvements[2].

In accordance to the aspects mentioned above, there is a study that evaluated the perception of users regarding the quality of service provided in family health units in the municipality of Recife, showing that a satisfactory level reached above 90% when people were asked about the respect to their rights and to the confidentiality of personal information, the abilities of health professionals, and the clinic support provided to the final user[11].

Another aspect of team working was related to the number of professionals:

> Changes that occurred due to the closing of the BHU during the afternoon reduced the number pf professionals. The ones that are still in the unit do not know if they will stay or if they will be transferred (P. S. 4 BHU).

> With the lack of employees, the nurse and one community health assistant were performing the pre-consultation, while mothers and children were waiting for child care. The unit was overcrowded, too many people waiting to get drugs, immunization, appointments, inhalation, and there were very few other workers available to perform all those roles (P. S. 10 FHS).

> The Community Health Assistants came to help the reception, sending patients to the specialists (P.S. 11 BHU).

The use of health units with a reduced number of laborers, based on the lower level allowed by law, interferes directly into the performance of caring and in the resolution of the necessities of child care, once this care is aimed to support momentary complaints, not promoting the preventive roles against illnesses and the promotion of health in the biopsychossocial context of the child. One example is the nurse that, as being the only professional present in all units, was alone in his routine, with a six-hours shift – not enough to supply the demands of health assistance of the given population, as this professional is only available for one shift only.

Even with the existence of policies and incentives aimed to provide further education in the area of health human resources, with the support of the Work Management and Health Education Office (SGTES, in Portuguese) and of the Brazilian National Policy for Humanization (PNH, in Portuguese)[12], significant changes were not observed in the way PHS is organized and manages general health support to the population.

The FHS was itself created to reorganize the model of health care service and to restructure the processes in health, but in fact it was kept working as the traditional BHUs, presenting some more problematic issues in the working process when compared to the traditional health units, especially because the purpose of the FHS units is the teamwork. This process of work is the ideological core in the construction of a policy in family health, however not found in the studied family health unit as seen in this research.

The everyday working procedures generated reflexes in the reaction of the laborers:

> "The nurse mentioned she was counting the days to go on vacation (after one year working as a public server for the local municipality) to prepare herself to enter in another public service in an area completely away from the area of health" (P. S. 10 FHS).

> In another moment: "it is possible to hear frequent complaints regarding neglecting, willing to retire or to be transferred, to give up from working in the area of health" (P. S. 13 FHS).

At the FHS unit, the signs of demotivation, stress, and dissatisfaction of the workers were move evident, caused by issues found in the infrastructure of the unit, as well as lack of support, the format the teams were established, and a significant delimitation of the working territory. The demand is considerably higher than projected, as around eight thousand people are attended, while the proposed limit is up to four thousand appointments.

FOCUS ON THE PREDOMINANT LABOR IN IN PRIMARY HEALTH CARE

Live labor can be defined as the one being performed at the moment of observation; in the care of the area of health, it is denominated as work in the act. Dead labor is inserted in the previous stages as a certain work process that can be exemplified by roles, proceedings, and equipments[2]. The match between the one that cares and the one that is being cared is an example of live labor in the act, which can involve a relationship, with attentive, resolutive, and welcoming listening. The opposite is seen as centered in standardized procedures, such as anamnesis, physical exams, prescription of therapy with a directive guidance, without the creation of bonds or communicative relationship with the other[13].

There was a predominance of dead labor over the live one, especially at the FHS unit, as described below:

> The nurse support during child care in one of the FHS units started by checking weight, height, and perimeters. As the professional was checking those items, he was taking notes at the child's health booklet and at the child's medical records (P. S. 2 FHS).

> The medical consultation started with the complaints, and then, a physical exam focused on the cephalocaudal region, with an emphasis in the area of complaint, and in the end, the drug prescription for the symptoms reported (P. S. 6 FHS).

> The vaccines were applied quickly, mechanically, and repetitively, to not allow the line grow bigger than it was already (P. S. 5 FHS).

> The moment can be described by: question – answer – notetaking, without a moment to clear out doubts. The mother of the child seemed to not understand the reason for the consultation and any of that made no sense to her (P. S. 2 FHS).

Despite the fact there was a predominance of dead labor, it was possible to observe that in some consultations there were some approaching moments, with unique professional behavior from the regular observed practice. This second experience revealed tasks that apparently seemed to aim into a reconnection to differentiated working processes, thus evidencing the dynamics of microprocesses.

> During the consultation, one of the physicians of the FHS asked the mother to show him how she was breastfeeding her child, and at this moment, he guided her on this procedure (P. S. 7 FHS).

> In some of the children assisted, it was possible to seen that there was a bond between the mother, the child, and the pediatrician, as the physician would recognize the patient, calling him by his name, and the mother could describe the issues with confidence, demonstrating that she trusted the professional (P. S. 4 FHS).

> Many children assisted at the vaccination room, at the child care room, and at the physician's office were known by the team. Even children from other neighborhoods are assisted, referred to the appropriate destiny, and some come back if and when necessary (P. S. 6 FHS).

It was possible to observe the existence of a bond among workers-users, even when there was a geographical issue to the mothers when they were in search for health services in this unit, as some of them were not from the designated area of assistance. This element, however, did not impede the welcoming, the establishment of bonds, and support to children and their care takers, with practices classified as care support because they allow room for caring, dialogue, intervention, and relationship[14].

Furthermore, the dead labor overcomes the live labor as seen before, by the fulfillment of merely bureaucratic functions:

> The nurses cannot assist during proceedings because they were in their offices, full of forms to be filled, to generate reports that must be sent out in the end of every month, counting the number of attendances and proceedings performed by the team (P. S. 5 FHS).

> Each member of the team is found in their own office working on their roles and filling up their papers (P. S. 8 FHS).

The working process of the team was most of the times concentrated in filling up records and reports, above the humane and attentive child caring support. Hence, the value of the information generated by the team is not always incorporated in their working practice, on the other hand, it is placed to quantify the productivity of the service provided.

It was seen that health care performed by these workers was concentrated in procedures such as questions-answers, complaint-resolution, performance of procedures and of pre-established procedures, thus indicating a predominance of dead labor, which are supported by the use of hard or light-hard technologies in child health procedures at the PHS units[2].

In another study at an PHS unit the fragmentation of working processes was also evidenced. It was observed that the answers to the necessities of the users were limited to perform proceedings, and many tasks are considered part of object of those working procedures[15]. The tasks are fragmented and the child is divided in parts, a movement contrary to the proposals of holistic approach in infant care, which proposes that children need to be understood as subjects inserted in a holistic social and family environment, in constant interaction with the milieu[16].

The holistic approach is essential to child care assistance, as it involves health care practices that articulate the team, the family, and the community. On the other hand, a more resolutive application of this approach is still a challenge. A second study, with professionals of health care teams, family members, and people from the community has found that the practice of health care faces many limiting factors from political, managerial, institutional, and structural natures, exemplified by the lack of resources, inadequacy of the physical structure of the units, and the lack of meetings among the members of the health care team. The mothers go through hard situations when they seen their children exposed to low resolutive care services, which also do not seem to prioritize life, exposing children to a fragmented, disqualified and unjust health care system[17].

During the consultation, the child and the mother are present in the unit and deserve a warm welcoming that will foster a relationship among them and the team, helping to establish a

bond of trust and safety. It does not matter the nature of the visit: immunization, a consultation with the nurse or with the physician. The nature of health care service should not aim only to respond to the necessities of the users; health care practices that dissipate in the moment of the consultation do not achieve a continuity in health care, as felt both by the health worker and by the user at home[18].

The link established allows the user to return to the unit searching for the professional who supported the user first, thus becoming his referential. These continued meetings can help to edify a path to a more resolutive and effective health practice, which can foster the child's growth process in a healthier environment. The inversion of caring technologies, searching to insert in the therapeutic processes tasks that will empower the user through knowledge also elevate their self-esteem and incorporate the experience of the users in the therapeutic process; at the same time, this behavior permit that professionals work the state of health in a more relational than instrumental way, centered on the necessities of the users and on their own health care practices[19].

Even besides countless difficulties experienced in the everyday working conditions of health teams, there were some initiatives found that enable workers in a more humane and resolutive health care practice. A study on the humanization of working processes for family health teams showed that, despite all fragilities found in infrastructure and little investment to educate the teams, the professionals were compromised with the work they were performing, as well as a high sensibility towards the needs and the issues of the population assisted[20].

Although there are challenges regarding the availability of resources, the organization of a more suitable background to enable better relationships among service-user and worker-user, the aspects related to a more welcoming human relationships must be considered, once it is in the live labor in the act, in this intersection that good quality in health care support is placed[21].

While child care is seen divided and glued to proceedings, complaint-resolution, and drug prescription, the micro-spaces of work will be even more saturated and oppressed, with institutional, political, and structural issues to solve. The space for light technologies is the one in which health professionals are better placed towards the other in a therapeutical relationship. Hence, depending on the way this space is organized, there are more or less chances that, through a flow of practical knowledge of wide array of available understandings and techno-scientifical elements, the presence of the other is more effective and creative[13].

Quantitative aspects of health production are more prevalent over the quality and the respect that health care requires. It is needed that the record information, sent to management and archived become alive and take a dimension – based on them policies aimed to improve the structure and care to the population supported by the PHS[2].

A study about the working process of a nurse in a FHS unit has found that the time spent in managerial duties was 33% of the working period of the nurses, plus other 9,5% of the time to feed the computers, and other 1,5% to send reports; almost half of the time spent with hard technologies[22]. Furthermore, another study also found that the fulfillment of instruments of the Basic Care Information System (SIAB, in Portuguese) is much more intended to fulfill the commitment the units have against the municipal health coordination than to organize the team dynamics, readapting their tasks to better respond to the health necessities of the population attended[23].

FINAL CONSIDERATIONS

We learned aspects in health work process in at the PHS that were related to the resolution of issues in child care, such as the predominance of dead labor over live labor in the act, tasks centered in proceedings, and expressive dedication of the nurse to his bureaucratic role.

The observation in a traditional BHU and at a FHS demonstrated that working processes were not aligned with the goals required by the health necessities of the children assisted. In both cases, the working process of the teams studied was still centered in the illness, in a single professional, according to the procedures established. Some workers, however, demonstrated a wider view of the procedures, looking to the family and social context,

preoccupied to prevent and promote children and community health, integrated to their everyday life in a work that establishes relationships among the individuals, performing care aimed to achieve a satisfaction of the needs of child's health.

Problems related to health labor were highlighted, which tend to build up as challenges in child health care in PHS, especially at the FHS unit, such as the precarious situation of the human resources and the emphasis given to the fulfillment of established goals and bureaucratic roles, removing from the nurses part of their time in caring roles to administrative ones.

It was evident as working goals, the recuperation of the state of health through the observation of the disease, the action upon the biological dimension, according to the understanding of each professional, guided by isolated tasks, which are not shared among the members of the team. In the working process, even at the family health unit, it was seen some gaps that limit the holistic health care as a common working project of the multidisciplinary team.

O PROCESSO DE TRABALHO NA ATENÇÃO PRIMÁRIA À SAÚDE NO CUIDADO DA CRIANÇA

ABSTRACT

Na Atenção Primária à Saúde (APS), o cuidado realizado pela equipe de trabalhadores deve responder às necessidades de saúde dos diversos grupos sociais. Objetivou-se apreender o processo de trabalho de equipes da atenção primária vinculadas a unidades básicas de saúde tradicionais e da estratégia saúde da família. Estudo descritivo de abordagem qualitativa, cujos dados foram obtidos em duas unidades de APS por meio da técnica de observação não participante, no período de dois meses, um em cada unidade de saúde, com registro das observações em diário de campo. Os dados foram analisados de acordo com os preceitos da análise temática. Os resultados foram discutidos em duas unidades temáticas: o trabalho em equipe na APS e enfoque do trabalho predominante na APS, as quais indicam a existência de um trabalho fragmentado e centrado nos profissionais em ambos os modelos assistenciais. Os problemas na organização do processo de trabalho em saúde tendem a dificultar o cuidado à saúde da criança na APS, com impactos negativos na resolutividade.

Palavras-chave: Saúde da Criança. Recursos humanos. Criança. Atenção primária à saúde.

EL PROCESO DE TRABAJO EN LA ATENCIÓN PRIMARIA A LA SALUD EN EL CUIDADO AL NIÑO

RESUMEN

En la Atención Primaria a la Salud (APS), el cuidado realizado por el equipo de trabajadores debe responder a las necesidades de salud de los diversos grupos sociales. El objetivo fue el de comprender el proceso de trabajo de los equipos de la atención primaria vinculados a unidades básicas de salud tradicionales y de la estrategia salud de la familia. Estudio descriptivo de enfoque cualitativo, cuyos datos se obtuvieron en dos unidades de APS por medio de la técnica de observación no participativa, en el período de dos meses, uno en cada unidad de salud, con registro de las observaciones en un diario de campo. Los datos fueron analizados de acuerdo con los preceptos del análisis temático. Los resultados fueron discutidos en dos unidades temáticas -el trabajo en equipo en la APS y enfoque del trabajo predominante en la APS- que indican la existencia de un trabajo fragmentado y centralizado en los profesionales en ambos modelos asistenciales. Los problemas en la organización del proceso de trabajo en salud tienden a dificultar el cuidado a la salud del niño en la APS, con impactos negativos en la resolución.

Palabras clave: Salud del Niño. Recursos humanos. Niño. Atención primaria a la salud.

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