http://www.periodicos.uem.br/ojs/index.php/CiencCuidSaude
ISSN on-line1984-7513
10.4025/ciencuidsaude.v22i0.66107

ORIGINAL ARTICLE

CHALLENGES AND POTENTIALITIES IN THE CARE OF ADOLESCENTS AND THEIR FAMILIES: PERCEPTION OF THE HEALTH TEAM

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ABSTRACT

Objective: To describe the factors that influence the practice of care for adolescents in vulnerable situations and their families in the context of primary care. **Methodology:** a qualitative study with eighty-three primary health care professionals from a municipality in the State of Mato Grosso do Sul. Researchers collected the data in the second half of 2018 through nine focus groups and analyzed by the content analysis technique. **Results:** The social determinants, the delay of users in seeking health services, the lack of physical structure, insufficient human resources and not trained to serve the population in the face of the vulnerabilities experienced, and the lack of articulation between the different services of the care network are factors that influence the practice of care. The study highlighted elements that enhance assistance to this public, such as group activities, the articulation of the health system with the school, the link between professional-patient, government programs, and benefits. **Final considerations:** state investments in material and infrastructure resources are necessary in terms of expansion and humanized spaces for professional approaches, as well as adequate and prepared human resources to meet the health needs of this population in its entirety.

Keywords: Vulnerability Situations. Practice of Care. Adolescence. Primary Health Care.

INTRODUCTION

Adolescence is the stage of life permeated by physical, cognitive, and psychosocial changes inherent to human growth and development and characterized by the interaction of the subject with his peers, his family and society, being influenced by the sociocultural context in which he is inserted[1-3]. Such a context reflects on the way of thinking, acting, and feeling of the adolescent and can impact the health and well-being of these individuals[3,4]. The socio-environmental context in which adolescents are inserted and exposure to determinants and health conditions influence the health and well-being of this population[5].

In the Brazilian scenario, some examples of vulnerable situations experienced by adolescents have been described, such as housing conditions, child labor, prostitution, alcohol consumption and other drugs, teenage pregnancy, crime, and Sexually Transmitted Infections(STIs), among others[5]. The experience of these situations can affect the health of adolescents, as well as that of their families, in addition to causing impacts on family dynamics[4]. Linked to these factors, the fragility, and challenges of health care for this population potentiate the grievances to health, which consolidate in adolescence and permeate adult life[6].

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In this sense, WHO member states have agreed to implement global strategies, such as Action Plans for Women's, Children's, and Adolescents' Health (2018-2030). PAHO has developed an integrated action plan for these populations based on regional plans with an integrated approach to the life course to overcome common challenges and barriers to health and well-being[3,4].

The actions linked to the proposals of the global strategies include the strengthening of policies aimed at reducing inequities; the promotion of universal, effective, and equitable health and well-being; the expansion of access to comprehensive, qualified health services centered on the individual, family, schools, and communities; in addition to the strengthening of strategic information for these populations[3,4].

Thus, reflection on the concept of vulnerability can promote the renewal of care practices, culminating in the promotion of integrality and equity[7]. There should be health promotion and disease prevention actions at the primary level. Primary Health Care (PHC) plays a key role in promoting care, incorporating macro and micropolitical factors, which extend from social organization to daily dynamics and peculiar ways of life. This approach strengthens the individuals' protagonism, mobilizing the resources and potentialities present in their territories. In addition to the competence to establish the link between the adolescent, the family, and the health team, which enables effective monitoring of this population[6-8].

Given the above, the question is: what factors interfere with the care of adolescents in vulnerable situations and their families? The identification of these factors may contribute to the detection of barriers related to the practice of care, in addition to guiding the formulation of sectoral and intersectoral strategies aimed at meeting the needs of these populations. The aim of this study is to describe the factors that influence the practice of care for adolescents in vulnerable situations and their families in the context of primary care.

METHOD

This is a descriptive, qualitative study based on the theoretical framework of vulnerability, which defines it as the exposure of individuals to situations arising from different factors, covering individual, social, and programmatic aspects that influence the health-disease process[7]. The study used the Consolidated Criteria for Reporting Qualitative Research (COREQ)[9] to guide the description of the research report.

For the definition of the study sites, researchers visited all the thirteen Family Health Units (FHU) that comprised a health district of the municipality (defined for convenience, given that this territory concentrated most of the teaching-research activities-extension of the institution to which the researchers are linked) and the Center for Child and Youth Psychosocial Care (CAPSi); this as the only one in a large municipality in the State of Mato Grosso do Sul, occasion when professionals were invited to participate in the research. The inclusion of CAPSiwas motivated by the fact that it is one of the devices of PHC, which also aids adolescents in vulnerable situations and their families in the municipality of the study.

The study sample was for convenience, and all administrative professionals, health units' managers and health professionals, crowded in the eight FHU and CAPSi who met the inclusion criteria, were invited to participate. Individuals of both sexes, over 18 years of age, with minimum of one month of work at the study site, were included. Professionals who were away or on vacation at the time of data collection did not participate in the study.

Researchers collected the data by conducting a focus group in each participating health unit[10]. The focus groups took place in the second half of 2018, between August and November, in the health service itself, in a private environment, being recorded in digital audio format through a digital recorder, with an average duration of sixty minutes.

Due to the logistics of data collection and the occurrence of focus groups at simultaneous dates and times, the conduct of these groups was carried out by three trained researchers, according to their availability. The three researchers were nurses, two masters, and one doctor, all with experience in conducting focus groups.

Each focus group also had the presence of two auxiliary researchers, one with the objective

of reporting the focus group and the other to observe and note the dynamics of the group. All researchers involved in data collection underwent prior training, each playing their specific role to reduce biases.

In the development of the group, the study adopted the following guiding question: "What are the factors that facilitate and/or hinder the realization of care for the families of adolescents in vulnerable situations?" Research used some auxiliary questions to clarify and substantiate the experience, as well as explore and deepen relevant aspects that emerged from the group's explanation, such as: what situations of vulnerability experienced by adolescents and their families do you identify in your territory? How do they affect the mental and physical health of these individuals? How do you experience the care of this population in your work routine?

After completing the data collection with the focus groups, the data were transcribed and analyzed to define the main factors influencing the practice of care. Researchers organized the generated material, and all the information that could identify the participants, the people they indicated, or the health services were removed and replaced by codes. From this, the material was submitted to content analysis using the thematic modality[11]. Two researchers independently conducted this process: an undergraduate student with training in qualitative analysis and a PhD in nursing, coordinator of the project. The study identified the nuclei of meaning that synthesized the facilities and difficulties in the practice of caring for the families of adolescents in situations of vulnerability.

This study is part of a Matrix Research entitled "Nursing Family Intervention: the transfer of knowledge from scientific evidence to practice," which was submitted to the (CAAE: 76593417.1.0000.0021) and approved by the Ethics Committee in research with Human Beings No. 21 under Opinion No. 2,352,593, following Resolution No. 466/12. The Code U (Unit) and the number were inserted at the end of them to identify the speeches in the text, according to the sequence in which the focus groups were held (e.g., U1, U2, etc.).

RESULTS

A total of 83 health workers participated in the study, of which 79 were allocated in the eight FHUs and 4 in the CAPSi. The participants' ages ranged from 23 to 63 years old. The duration of work in the health services ranged from one month to 18 years.

Most of the professionals had higher education, followed by high school degree, technical, and primary education, comprising administrative managers (5), doctors (6), nurses (8), social workers (4), nursing technicians (6), dentists (6), oral health assistants (8), community health agents (28), endemic agents (2), administrative technicians (7), public health agent (1), speech therapist (1) and occupational therapist (1).

Challenges that weaken the practice of care for adolescents and their families

Regarding the factors that weaken care, the low schooling associated with vulnerable socioeconomic and cultural contexts of the families were pointed out as limitations to care actions. It is because the population has difficulty understanding the health guidelines offered by professionals and recognizing unhealthy behaviors.

> It lacks education, culture. It difficult for them to understand. That's the impression. If you ask them what is their background: did you study until what grade? 4th grade, 3rd grade, most did not finish elementary school (U7).

> Those who have some guidance about sexuality, or some health issues is because they learnt from health campaigns in schools. But some already carry this family cultural barrier, indoors, early pregnancy, psychiatric patient, drug user in families (U5).

For the participants, health risk behaviors seem to be perpetuated from generation to generation by family members, interfering with the understanding of health by the adolescent and by the family group itself. The study also indicated the divergent understanding of the factors that interfere in the health-disease process by these different actors.

> And we see a vicious cycle happening; they repeat

> the patterns of the parents. They get pregnant, start taking drugs very early because they do not have support because of the familiar structure (...) And the health unit often don't have the resources to intervene in these families. Many families present resistance to intervention professionals (U3).

> We observed that the other family members are exposed to situations of vulnerability before constituting their own family - where the teenager is inserted. It makes the service more difficult, and the cases end up being the most complex of vulnerability that we have (U2).

In some situations, in the face of the health-disease process, resistance to receiving the care offered implies non-attendance at scheduled appointments in the health service. Thus, the health team finds it difficult to provide educational guidance and effective interventions, which hinders access/care to adolescents and their families, as well as the assistance of their demands and needs.

> Mental disorders in general, drug users, suicide attempts, depression, all this greatly interferes. When the team conduct the visits domiciliary, some teens don't get out from the house, they do not open windows, and we need to go to the residence. It messes with the whole family structure and interferes with the care of the whole family, not only with the adolescent's (U2).

> The team shows up in a determined schedule and they set another time. Sometimes, the family does not receive the team at the residence or ask to schedule at the unit and does not attend to the service (U8).

Another difficulty indicated is that many adolescents and their families do not seek the service in advance to intervene in situations of vulnerability and health early and preventively. Access to health services occurs only when the adolescent is sick or when the problems are already established, which also hinders effective intervention.

> In my area, there was a case that the mother was prosecuted because her underage children were out of school. And her daughter was pregnant and needed to request exams. The team scheduled and she didn't attend. They made an appointment, but she didn't come (U3).

The context experienced by adolescents and their families, including situations of domestic violence, is perceived as a risk factor for the performance of health professionals. Adolescents express fear of some circumstances that they consider risky and prefer to omit information that they identify at home or with which they have already come into contact, or even choose not to intervene.

> Because they do not report to the team some situations like, for example, if a woman is beaten by her husband. The unit gradually investigates, but not directly, as the family keeps the secrecy, and our job is to visit residents. If they imagine that we report this, we already lose the resident, and it is dangerous to suffer violence in the area. We don't know about that problem and, when it arrives, because it came from another unit, it came from the Emergency Unit .(U1).

The study indicated the lack of human resources and adequate physical structure in the services to meet the population's demand as a difficulty faced, which implies an overload for the team. The team conducts the actions according to priorities and, as a result, some groups are less assisted, not guaranteeing comprehensive and universal care, which, consequently, becomes a hindering factor for offering a more centered approach in this population and in the family.

> The service of the basic family health unit, especially in a region like ours, due to the number of people that we must assist, the team listens, but it is suffocated by priorities. We have many children, pregnant women, hypertensive, diabetic, and older people, and these stifles working with adolescents (U5).

> Our difficulties are that we have no physical structure. The management room divides the space with the social service. And to approach a family, a case is complicated because it has no structure to keep secrecy. Sometimes you want to bring up a topic and you must wait for a room to vacate to have a confidential conversation, and the person leaves. I believe that a physical structure is our negative point, the second point is the FHSC (Family Health Support Center). The patient comes once a week, but it has a lot of demand, and there are no psychologists. Sometimes, the team loses the follow-up due to the delay (U4).

In addition, the lack of training or continuing education for professionals to care for adolescents and their families was mentioned as a factor that weakens the practice of care and the

provision of effective actions.

> The great difficulty today is that we don't have a training to prepare us to face situations like this (U4).

> I find it difficult to get to the point and talk. I have a teenager, I know he is a drug user, and I find it difficult to approach this subject. (U9).

The fragility in the articulation between the different points of the Health Care Network hinders appropriate assistance to adolescents and their families. In addition, the lack of care for individuals and their families, in all its biopsychosocial aspects, has led to feelings of frustration in the team playing in the promotion of health.

> Another problem is health. For focusing on health, it needed to provide the service, assist, and welcome this person. If we try to do just that, we can't. And it doesn't just depend on health services. (...) Education is failing, and it leads to a failure in the person's life. They join the Children's Education Center at the age of four or three, babies. But education begins to fail from there, and when it reaches adolescence or adulthood, it is difficult to change this individual. Everything that is inside there and that was not built, shown, or that had no option (...) the problem is not only health, but also education (U3).

Thus, the team faces several challenges in its care routine that tend to make it fragile, fragmented and sometimes absent. However, there are potentialities in this context that favor the promotion of care, as will be described in the following category.

Potentialities that promote the practice of care for adolescents and their families

Among the potentialities identified, professionals reported the articulation with the school as a strategy to facilitate access to adolescents and their families, which enabled better interaction and more effective actions with this population.

> It's just like the ones that come here. And those who are in school and/or social projects of the area, we work on the issues. We have a solidarity network that works with adolescents, but they are those who are in school (U5).

The activities promoted and developed in groups in the school context are perceived as an effective strategy to promote care for adolescents. The professionals describe that, when they identify a situation that requires individualized actions during these activities, they refer the adolescent to be assisted in the health unit. However, these group activities are carried out sporadically during the school term.

> They created quadrilhas groups, scavenger hunts. It increased their self-esteem, they united, a student who pursued an acting career. I saw this time as very positive for these young people, including oral health. From my area of oral health, they were interested, we lectured and, in the middle of these meetings that they had to do their rehearsal; we also offered dental guidance, and they liked to participate. The team elected one of them to pass the information on to others, and they felt responsible for it. This phase was very good; it seems that they had adolescents with other values; they began to value culture, health, everything (U7).

> They are served mainly in that school health program. There are many professionals who go there and assist. And most of the time teenagers are like that, girls who are pregnant, or with some sexually transmitted infection, something related to reproductive and sexual issues. (U6).

Professionals consider that the bond between them, adolescents, and families, is important for the success and resoluteness of the care offered to this population.

> I think a facilitator of the unit is when parents come for the care, we offer(...) When they feel safe in the care, in the treatment and, sometimes, see an evolution in the child, we gain that family, and then they adhere more easily to the treatment (U2).

> The health worker is our link, the most important person, who captures all this vulnerability for us (...) Our training is already that, observing, capturing what he said, what he did not say, then we do it, we do not judge. But we must format an opinion and a social opinion. It is in this area that I often listen; then, I make another visit, I collect information little by little, until I discover something like this, then we must act, independently (U9).

In turn, the State's policies, and social programs, which enhance adolescents' and their families' access to health services more

frequently, provide stronger links with the health team and expand care.

> It's twice a year only. The BolsaFamília program, you must be with the portfolio up to date, you also have to up-to-date vaccinations, but it is only twice a year (U3).

> The policies brought more adolescents in access to services and this family as a whole.(U3).

Thus, the intersectoral work with the school, the bond, and the existence of solid public policies contribute to the care of adolescents and their families in the context of primary health care.

DISCUSSION

The results of this study indicated factors that weaken the care of adolescents and their families, such as the level of education, the family organization in the face of health care, and the socioeconomic and cultural contexts in which they are inserted. From the perspective of the professionals participating in this study, these factors influence behaviors and health management.

Individual vulnerability, which includes factors such as low level of education and family organization, as well as social vulnerability, related to the cultural context, socioeconomic condition, and territory where these families and adolescents are inserted, interfere with the understanding of information about the health-disease process, the incorporation of knowledge and the production of meaning related to healthy practices and behaviors. This fact implies in the process of health management by families and, consequently, adolescents, in addition to affecting their access to health promotion actions, risk prevention, assistance to damage, and rehabilitation offered by health services[12-14].

Thus, the study reveals that the health services and their teams face difficulties in providing adequate and comprehensive care, with effective interventions based mainly on health promotion and prevention. By addressing the vulnerabilities identified at its three levels, there is an opportunity to strengthen the bond between users and health services. This strengthening of the bond can lead to greater adherence of the population to the health activities offered. In addition, it contributes to effective communication between teams and users, allowing the shared implementation of care actions, aiming at qualified management[15,16]. The authors described above point out that these actions reinforce the importance of PHC strategy within the framework of SUS and that the low adherence of users to these services directly affects health indicators.

The social and family context of adolescents identified as being at risk is perceived as a limitation for the assistance offered by health professionals. It is because, when faced with specific situations of vulnerability in the territories, such as cases of violence, many professionals do not feel prepared or have adequate support for manage the issue. In addition, the proximity of the teams to the family system generates a feeling of insecurity and fear in professionals and expose them to situations of physical and/or psychological violence[17,18].

On the other hand, the existing public and social policies associated with programmatic vulnerability was indicated as a factor that enhances this population's access to health services and, therefore, to actions promoted by the teams. However, the scarcity of necessary human and material resources and the failure to implement some policies related to the health of adolescents and their families may contribute to the fragility of access to care offered[13].

Studies conducted in different cities of Brazil also observe the scarcity of human resources and the lack of adequate physical structure as implicating aspects of comprehensive and universal care for the population. In addition, this fact has repercussions on work overload and the effectiveness of the care offered to users, and it has the potential to generate feelings of dissatisfaction in health workers[19, 20].

Thus, the provision of assistance focused on the specific needs of adolescents and their families was indicated as another factor by the participants. With this, the training or continuing education to care for adolescents and families is necessary in this caring process. In this way, the implementation of continuing education strategies is fundamental, as well as the expansion of support mechanisms for health

teams to instrumentalize them to act effectively in these demands[21,22].

The organization and fragility of the articulation between different spheres of the care network interferes with adequate care for adolescents and their families[23] since the provision of comprehensive health care is not restricted to access to the formal network of services, being necessary to follow the user's path to integrate him into the various relevant networks[14].

The articulation between the different points of the Health Care Network with other networks can be understood as a multidetermined complex, which demands the articulation of health services and systems based on integral and intersectorial actions. For this, articulation and development are necessary, in addition to monitoring intersectoriality in health and other instances involved, which cover different dimensions. In addition, there is a need for health planning, considering the demands of the health-disease process, the health context, local and regional demands, actors, and devices present in territories and management segments[23,24].

The school is a privileged space for health promotion through intersectoral policies, such as the School Health Program (SHP). Thus, integrated, and articulated actions between schools and health teams should be encouraged among these networks[25,26].

The bond between health service professionals with adolescents and their families was also mentioned as essential for the success and resoluteness of the care offered to this population. Associated with welcoming, the professional bond directly affects the resolution of care, improves user adherence to proposed interventions, adapts the service to users' needs, and provides continuity of care[20]. Therefore, actions such as health education, home visits, and humanized care should be implemented with users.

The existing policies and social programs enhance the access of adolescents and their families to health services and expand care. Among the characteristics of the government programs are the federal design, with decentralization and intersectoral guidelines; focus on the family as a unit of attention and care; extensive and very expressive national coverage in the most vulnerable and low-income population. In addition to the actions encompassed by the health conditionalities offered (immunization, nutritional monitoring, and prenatal care), which should already be guaranteed to the entire population[27].

In this sense, PHC was considered paramount in the management of the health conditionalities of the program in all spheres, observing a better monitoring of families by units that have the entire territory covered by family health teams[27]. This finding suggests a positive articulation between the Family Health Strategy and the BolsaFamília program.

Therefore, vulnerability is a complex and dynamic concept that involves different factors, conditions, and subjectivity of the actors involved, which help to understand and guide knowledge and practices in health. It becomes an important concept to understand, mediate, and act in adverse contexts and territories, as well as subsidize the development and implementation of public policies[28].

As a limitation, the study indicates the perception of health professionals only. For a better understanding of the phenomenon, it is crucial that new studies to show the perspective of adolescents and their families since this would contribute to the identification of barriers to the implementation of person-and family-centered care and, with this, knowledge transfer actions for more effective implementation of care .

CONCLUSION

In the present study, the challenges and potentialities in the care practicewere linked to the different vulnerabilities in health (individual, social, and programmatic). The results obtained in the current study may support the development of strategies for the practice of care for adolescents and their families, promoting tools for healthcare professionals for better performance in the activities performed by them, in addition to the offer of permanent education that helps in the work process.

DESAFIOS E POTENCIALIDADES NO CUIDADO AOS ADOLESCENTES E SUAS FAMÍLIAS: PERCEPÇÃO DA EQUIPE DE SAÚDE

RESUMO

Objetivo: descrever os fatores que influenciam na prática do cuidado aos adolescentes em situações de vulnerabilidade e suas famílias no contexto da atenção primária. Metodologia: estudo qualitativo com 83 profissionais da Atenção Primária à Saúde de um município do estado de Mato Grosso do Sul. Os dados foram coletados no segundo semestre de 2018, por meio de nove grupos focais e analisados pela técnica de análise de conteúdo. Resultados: os determinantes sociais, a demora dos usuários pela busca dos serviços de saúde, a falta de estrutura física, os recursos humanos insuficientes e não capacitados para atender a população frente às vulnerabilidades vivenciadas e a falta de articulação entre os diferentes serviços da rede de cuidado são fatores que influenciam na prática de cuidado. Destacaram-se elementos que potencializam a assistência a esse público, como as atividades em grupo, a articulação do sistema de saúde com a escola, o vínculo entre profissional-paciente, os programas e os benefícios do governo. Considerações finais: são necessários investimentos do Estado em recursos materiais e de infraestrutura no que tange a ampliação e os espaços humanizados para abordagens dos profissionais, além de recursos humanos adequados e preparados para atender às necessidades de saúde dessa população em sua totalidade.

Palavras-chave: Situações de vulnerabilidade. Prática do cuidado. Adolescência. Atenção Primária à Saúde.

DESAFÍOS Y POTENCIALIDADES EN EL CUIDADO DE LOS ADOLESCENTES Y SUS FAMILIAS: PERCEPCIÓN DEL EQUIPO DE SALUD

RESUMEN

Objetivo: describir los factores que influyen en la práctica del cuidado de los adolescentes en situaciones de vulnerabilidad y sus familias en el contexto de la atención primaria. **Metodología**: estudio cualitativo con 83 profesionales de la Atención Primaria de Salud de un municipio del estado de Mato Grosso do Sul-Brasil. Los datos fueron recolectados en el segundo semestre de 2018, por medio de nueve grupos focales y analizados por la técnica de análisis de contenido. **Resultados**: los determinantes sociales, la demora de los usuarios por la búsqueda de los servicios de salud, la falta de estructura física, los recursos humanos insuficientes y no capacitados para atender a la población frente a las vulnerabilidades vividas y la falta de articulación entre los diferentes servicios de la red de cuidado son factores que influyen en la práctica de cuidado. Se destacaron elementos que potencian la asistencia a ese público, como las actividades en grupo, la articulación del sistema de salud con la escuela, el vínculo entre profesional-paciente, los programas y los beneficios del gobierno. **Consideraciones finales**: son necesarias inversiones del Estado en recursos materiales y de infraestructura en lo que respecta a la ampliación y los espacios humanizados para elacercamiento de los profesionales, además de recursos humanos adecuados y preparados para satisfacer las necesidades de salud de esa población en su conjunto.

Palabras clave: Situaciones de vulnerabilidad. Práctica del cuidado. Adolescencia. Atención Primaria de Salud.

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Submitted: 30/11/2022
Accepted: 05/10/2023

Financial support

This study was funded by the Foundation for Supporting the Development of Education, Science and Technology of the State of Mato Grosso do Sul (Fundect), in partnership with the State Department of Health (SES), the Department of Science and Technology (Decit) of the Ministry of Health (MS) and the National Council for Scientific and Technological Development (CNPq) through notice FUNDECT/DECIT-MS/CNPq/SES N° 03/2016 – PPSUS-MS.Carried out with support from the Federal University of Mato Grosso do Sul Foundation -UFMS/MEC – Brazil, and with support from the Coordination for the Improvement of Higher Education Personnel – Brazil(CAPES)- Financing Code 001.