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Veröffentlichungsversion / Published Version
Zeitschriftenartikel / journal article

Empfohlene Zitierung / Suggested Citation:
Morais, J. M. O., Nogueira, C. M. C. d. S., & Morais, F. R. R. (2017). First contact access in primary health care for children from 0 to 9 years old. *Revista de Pesquisa: Cuidado é Fundamental Online*, *9*(3), 848-856. https://doi.org/10.9789/2175-5361.2017.v9i3.848-856

REVISTA ONLINE DE PESQUISA

CUIDADO É FUNDAMENTAL

Universidade Federal do Estado do Rio de Janeiro • Escola de Enfermagem Alfredo Pinto

RESEARCH

DOI: 10.9789/2175-5361.2017.v9i3.848-856

Acesso de primeiro contato na atenção primária à saúde para crianças de 0 a 9 anos

First contact access in primary health care for children from 0 to 9 years old

Primer acceso contacto en la atención primaria para niños de 0 hasta 9 años

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Evaluation of child health care in the context of primary health care in the municipality of Mossoró/RN, 2014. Dissertation (Master in Health and Society). University of the State of Rio Grande do Norte (UERN).

How to quote this article:
Morais JMO; Nogueira CMCS; Morais FRR. First contact access in primary health care for children from 0 to 9 years old. Rev Fund Care Online. 2017 jul/sep; 9(3):848-856. DOI: http://dx.doi.org/10.9789/2175-5361.2017.v9i3.848-856

ABSTRACT

Objective: To identify the follow-up of the principle of primary care access first contact in basic family health units in health care for children from zero to nine. **Methods:** descriptive study with cross-sectional design and quantitative analysis of data held in eight Family Health Basic Units (BFHU) Mossoro/RN. For data collection was used questionnaire validated in Brazil called the Primary Care Assessment Tool in the children's version (child PCATool). The instrument was applied to the mothers of children enrolled in the coverage areas of health teams selected for the research. **Results:** It is considered fundamental rethink aspects that have proven insufficient to ensure the presence and extent of the first contact Access attribute in BFHU's surveyed. **Conclusion:** Improvements require changes in both structural and process elements to deliver primary health care quality that is proposed since its inception.

Descriptors: Attention to children's health, Primary Health Care, Login first contact.

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RESUMO

Objetivo: Identificar o seguimento do princípio da atenção primária acesso de primeiro contato, em unidades básicas de saúde da família, no cuidado de saúde para crianças de zero a nove anos. **Métodos**: Pesquisa descritiva, com delineamento transversal e abordagem quantitativa dos dados, realizada em oito Unidades Básicas de Saúde da Família (UBSF) de Mossoró/RN. Para coleta de dados utilizou-se questionário validado no Brasil denominado de Instrumento de Avaliação da Atenção Primária na versão infantil (PCATool infantil). O instrumento foi aplicado com as mães das crianças cadastradas nas áreas de abrangência das equipes de saúde selecionadas para a pesquisa. **Resultados**: Considera-se fundamental repensar os aspectos que se mostraram insuficientes para garantir a presença e extensão do atributo Acesso de Primeiro Contato nas UBSFs pesquisadas. **Conclusão**: As melhorias requerem mudanças tanto em elementos estruturais e processuais para oferecerem Atenção Primária à Saúde na qualidade que se propõe desde a sua criação.

Descritores: Atenção à saúde da criança, Atenção Primária à Saúde, Acesso de primeiro contato.

RESUMEN

Objetivo: Identificar el seguimiento del principio de acceso a la atención primaria de primer contacto en unidades básicas de salud de la familia en el cuidado de la salud para los niños de cero a nueve. **Métodos**: Estudio descriptivo, con diseño transversal y análisis cuantitativo de los datos contenidos en ocho Unidades Básicas de Salud Familiar (BFHU) Mossoró/RN. Para la recolección de datos se utilizó un cuestionario validado en Brasil llama la Herramienta de Evaluación de la Atención Primaria en la versión infantil (niño PCATool). El instrumento se aplicó a las madres de los niños inscritos en las áreas de cobertura de los equipos de salud seleccionados para la investigación. **Resultados**: Se consideran aspectos replanteamiento fundamental que han demostrado ser insuficientes para garantizar la presencia y extensión del primer atributo de Acceso de contacto en BFHU de encuestados. **Conclusión**: Las mejoras requieren cambios tanto en los elementos estructurales y de procesos para ofrecer una calidad de atención primaria de salud que se propuso desde sus inicios.

Descriptores: Cuidado de la salud del niño, Atención primaria de salud, El primer contacto de acceso.

INTRODUCTION

For a few decades, much has been reflected in the search for changes in the health sector. A priori, the Universal Declaration of Human Rights of 1948, which has come to regard health as a fundamental human right.[1]

The First International Conference on Primary Health Care, held in 1978 in the city of Alma-Ata in Kazakhstan, also brought important achievements to this area. Since then, countries such as England, Canada, Spain and Cuba have reorganized their health systems, prioritizing easy-to-access, comprehensive and continued assistance to be developed within the community.[2]

This reorganization started to point to practices that outlined the assistance based on Primary Health Care (PHC), setting as a priority the attendance of the health needs of the different groups. In fact, health care began to be thought of in the perspective of a primary practice, articulated with the different needs of individuals, to the detriment of a clinical practice, curative and excluding.[2-3]

In Brazil, after the implementation of the SUS, in 1991, the Ministry of Health (MS) launched the Community Health Agent Program (PACS), the initial framework for the integration of PHC into the health system. In these changes, Brazilian health services organized to meet the diverse demands of social groups.[4]

It should be noted that Primary Health Care is defined as the first level of care within the health system. It is characterized by the presence of four essential attributes (access in the first contact with the health system, longitudinality, integrality of care and coordination of care within the system) and three attributes derived (family orientation, community orientation and cultural competence), Principles that make up the total dimension of Primary Care.[5]

For primary care, a health service must be composed of functional and structural elements in the organization of its actions, in order to guarantee coverage, universal access and integral and integrated care over time.[6] In particular, this study focuses on the first essential attribute, the first contact with the health system, whose definition implies the accessibility and use of the health service to each new problem, or new episode of a problem, in which people seek health care.[5]

In addition, it focuses on the child's health, understanding the vulnerability of this group and the fact that PHC is characterized as fundamental for improving the quality of health care. In this dimension, the health sector should have as its constituent steps for Integral Health Care of the Child, the following basic actions: monitoring of growth and development, health care of the newborn, promotion, protection and support to breastfeeding and violence prevention and the culture of peace promotion.[4]

However, despite all these aspects, a strong influence of the hegemonic model is observed in daily health services, based on punctual and curative practices. This form of action ends up hampering the development of health promotion and prevention practices.[3]

It is also evident that the quality of care provided to the children's public ends up not meeting the needs of this group, due to the difficulty in accessibility to Primary Care services. In turn, it tends to be configured as one more in-built instrument, which fails to respond to the yearnings of the population and the professionals that are part of this dynamic.

Thus, the present study aimed to identify the follow-up of the primary care principle first-access access, in Basic Units of Family Health, in health care for children from zero to nine years old.

DOI: 10.9789/2175-5361.2017.v9i3.848-856

METHODS

Descriptive study, with a cross-sectional and quantitative approach, carried out in eight Basic Family Health Units of the Mossoró/RN, located in the north, south, east and west of the municipality. The UBSFs were selected by lottery, and for each zone, two health units were selected, composed of teams from the Family Health Strategy (ESF). As a tool for data collection, a Primary Care Assessment Tool (PCATool-Brazil) was used as a Primary Care Assessment Questionnaire in the children's version, validated in Brazil.[7-8]

This questionnaire was proposed by the Ministry of Health, consisting of blocks of questions that correspond to the attributes of Primary Health Care (Access, Longitudinality, Integrality, Coordination, Family Orientation, Community Orientation) and three initial questions that measure the degree of affiliation to the health Service.[7]

In order to guarantee the correct choice of the scores for the answers, all respondents were informed about the possible answers to each question (1 = certainly not, 2 = probably not, 3 = probably yes, 4 = certainly yes, 9 = no I know/do not remember) before applying the questionnaire.

The instrument was applied to the mothers/guardians of the children residing and registered in the areas covered by the family health teams selected for the research. For the calculation of the quantitative sample, the total number of mothers/guardians of children from 0 to 9 years of age enrolled in the BFHUs selected in this study was taken into account. It was assumed that the population corresponded to 6,535 mothers/guardians and that, for the calculation of the sample, the 95% confidence interval and the Tolerable Sample Error of 5% were used. At the end, the sample consisted of 363 mothers/guardians, an average of 91 per zone.

A non-probabilistic sampling of the intentional type was used with the mothers/guardians, and the mothers/guardians were selected for children from zero to nine years old who were using the services of the health units at the time of data collection.

The inclusion criteria for mothers/guardians of children from zero to nine years old were: being 18 years or older; Reside in households registered with family health teams for at least one year, and agree to participate freely in the research. As exclusion criteria: those who identified as a reference health service a service outside the municipality of Mossoró; The mothers/guardians who presented some type of mental disorder and who did not show health conditions to understand questions and to give answers.

Data collection was carried out from January to March 2013, in the selected BFHUs, and it happened with mothers/guardians of children in the corresponding age group and who sought care in the services. The objective of the research was presented and the interviews happened in a specific space in the unit itself.

The analysis of the data followed the recommendations of the PCATool organizers. Tables were constructed in the SPSS program (Statistical Package for Social Sciences), Inc IBM®, version 20.0, with the result of the APS quality scores calculated from the average values of the items that make up the "First Contact Access" Of PCATool-Brazil child version. It is considered that the value 6.6 is the minimum for the health unit to have the presence of the attribute in its service according to the assessment of the mothers/guardians of the children served.[5]

The data collected from the PCATool-Brazil child version were also described from percentage in order to characterize and distribute the sample. The Mann-Whitney test (U) was used to compare two groups and the Kruskal-Wallis (x^2) test was used to determine the relationship between the variables of characterization of the subjects and the difference between the BFHUs with respect to primary health care For comparison of three or more groups. A significance level of 5% was adopted in order to minimize a Type I error.

The research followed the guidelines of Resolution No 196/96 of the National Commission of Ethics in Research (CONEP) and obtained approval from the Committee of Ethics in Research (CEP) of the State University of Rio Grande do Norte (UERN), and the CAAE No 07538912.0 .0000.5294.

RESULTS

In order to trace the profile of the mothers/guardians and the participating children, the characteristics of the study population were systematized in Table 1. The results of the evaluation of the performance of the studied attribute and the comparison between the BFHUs will be presented, after knowing the scores reached by each health unit participating in this research.

As previously mentioned, 363 women mothers or grandparents of children between 0 and 9 years of age participated in the survey. Most of the participants were mothers and had between 20-29 years, 153 (42.1%), and 30-39 years, 116 (31.9%), and 358 (98.6%) were literate, being Subdivided into eight reference UBSF.

Table 1 – Characterization of the sample of the mothers/guardians and the participating children, Mossoró, Brazil, 2013

Characteristics	N (%)
Age of person in charge	
Mother < 20	45 (12,4%)
Mother between 20-29	153 (42,1%)
Mother between 30-39	116 (31,9%)
Mother between 40-49	30 (8,2%)
Grandmother between 40-49	11 (3,0%)
Grandmother between 50-59	7 (1,9%)
Grandmother between 60-69	1 (0,3%)

(To be continued)

DOI: 10.9789/2175-5361.2017.v9i3.848-856
First contact access in...

(Continuation)

Characteristics	N (%)
Education of the person in charge	
Literate	358 (98,6%)
Iliterate	5 (1,4%)
UBSF of reference	
Abolição IV	45 (12,4%)
Santa Delmira	45 (12,4%)
Belo Horizonte	50 (13,8%)
Santo Antônio	62 (17,1%)
Barrocas	55 (15,2%)
Lagoa do Mato	56 (15,4%)
Vingt Rosado	43 (11,8%)
Walfredo Gurgel	7 (1,9%)
Gender of the child	
Male	166 (45,7%)
Female	197 (54,1%)
Children's age	
0-11 months	115 (31,7%)
1 a 2 years old	80 (22,0%)
3 a 4 years old	52 (14,3%)
5 a 6 years old	43 (11,8%)
7 a 8 years old	40 (11,0%)
9 years old	33 (9,1%)

Source: Fieldwork conducted in the areas covered by the Family Health Strategy of the municipality of Mossoró/RN in the year 2013.

From the data it is possible to infer the similarities between the profiles of the main responsible for the children that composed the sample in all the Basic Units of Family Health studied. It was observed that the mothers are mainly responsible for the children and that these were between 20-39 years old (74%). In no interview the father was referred to as the primary responsible for the child.

In the sample characterization, the age and sex of the children were systematized, with the female predominance (197 children or 54.3%) being observed in all the BFUs evaluated, with a higher concentration in the age group of 0-2 years (53,7%).

Table 2 – Mean values, respective standard deviations, value of the statistical significance and the comparison between the BFHUs regarding the Degree of Affiliation in the service, Mossoró, Brazil, 2013

Variables	Average (sd)								
	UBSF 1	UBSF 2	UBSF 3	UBSF 4	UBSF 5	UBSF 6	UBSF 7	UBSF 8	p-value
Does the health professional know the child and the family?	7,11	6,37	6,13	6,12	6,12	5,83	5,96	6,6	0,08

Source: Fieldwork conducted in the areas covered by the Family Health Strategy of the municipality of Mossoró/RN in the year 2013.

Table 2 shows the items referring to the Degree of Affiliation, which refers to the responsibility that the health service has over the user. Then, in the definition of the scores, those responsible for the children were asked about what service they took the child to when they were sick and/or when they needed advice about their health. Also as to the relationship with the health professional of the service and which he knew and/or was most responsible for the child. These questions make up the PCATool child version.

Table 3 – Mean values, respective standard deviations, value of statistical significance and comparison between the BFHUs for First Contact Access - Use, Mossoró, Brazil, 2013

Variables	Average (sd)								
	UBSF 1	UBSF 2	UBSF 3	UBSF 4	UBSF 5	UBSF 6	UBSF 7	UBSF 8	*p-value*
Goes to their health service before going to another for a routine appointment.	8,66	7,70	7,73	7,36	6,42	4,58	8,37	8,57	<0,001
Goes to their health service before going to another for a new problem.	9,25	9,55	9,13	9,35	9,39	8,75	6,12	6,66	<0,001
Health service will refer them to a specialist when necessary.	5,18	7,40	8,53	6,61	4,30	6,42	7,82	7,61	<0,001
TOTAL SCORE	7,70	8,22	8,46	7,77	6,80	6,58	7,44	7,61	<0,001

Source: Fieldwork conducted in the areas covered by the Family Health Strategy of the municipality of Mossoró/RN in the year 2013.

As noted in Table 3, the "Usage" attribute shows the family's initiative in going to the APS service for a routine consultation of the child, if there are other health services to which the responsible person takes the child and if there has been a need for Referral to specialists. 87.5% of those in charge evaluated this attribute with a high overall score in the studied BFHUs (x^2 = 26,0; p < 0,001), being the highest score in the UBSF 3 (8.46) and lower in the UBSF 6 (6.58).

Table 4 – Mean values, respective standard deviations, value of statistical significance and comparison between the BFHUs for First Contact Access – Accessibility, Mossoró, Brazil, 2013

Variables	Average (sd)								
	UBSF 1	UBSF 2	UBSF 3	UBSF 4	UBSF 5	UBSF 6	UBSF 7	UBSF 8	p-valor
The health service answers them the same day.	6,44	5,62	5,13	5,16	5,15	4,64	7,59	8,09	0,21
Waits a long time to make an appointment at the health service.	6,44	5,77	7,60	7,41	5,87	4,34	4,49	4,28	<0,001
It is easy to make a routine appointment for the child.	6,0	5,7	3,93	3,65	6,00	5,95	5,42	3,80	0,01
Has to wait more than 30 minutes for consultations	8,88	8,44	9,26	8,87	8,66	8,45	7,75	8,09	0,06
Difficulty in getting medical care for the child.	4,22	4,29	6,13	6,02	4,36	3,57	4,26	5,23	0,01
Gets quick advice on the phone from the service.	3,62	3,03	4,46	8,11	4,54	9,46	2,17	3,33	<0,001
TOTAL SCORE	5,93	5,48	6,10	6,54	5,77	6,07	5,28	5,47	<0,001

Source: Fieldwork conducted in the areas covered by the Family Health Strategy of the municipality of Mossor/RN in the year 2013.

As can be seen in Table 4, unlike "Utilization", the attribute "First Contact Access - Accessibility" registered low overall scores in all evaluated health units. These results indicate that, even though those responsible for the children seek to use Primary Care services or look for them as a "gateway" to the system, they do not have their health problems solved. Thus, these findings point to difficulties in access and accessibility to Primary Care services in Mossoró regarding health care for the child.

It is worth mentioning in Table 4 the lower means in all the BFHUs studied in the questions "It is easy to make routine appointments for the child" and "Difficulty in getting medical care for the child".

DISCUSSION

The presence and extension of APS's Essential First Contact Access attribute will be discussed as per the guidelines of Barbara Starfield.[5] The author affirms that the average scores equal or above 6.6 are considered high, being in accordance with the precepts of the APS.

When tracing the profile of the main responsible for the children who composed the sample, the findings in this study are corroborated when another study,[9] points out that it is the mother who, in most cases, takes the child to the health services, being also considered the person most qualified to report the health care of the child.

Regarding the level of schooling, 98.6% of those responsible are considered literate. To define this condition, we used Justo and Rubrio[10] who consider "literate" those who can read and write and "illiterate" those who can not read and/or write.

UBSF 1 and UBSF 8 reached a high score for PHC, reaching an average of 6.6 or higher, indicating that those responsible for the children attended at these units had a higher index of affiliation with their referral health service. However, considering that the degree of affiliation to the health/professional service refers to the frequency in which the user recognizes that service or a professional as a reference for health care, it is noticed that the other UBSF studied, obtained A relatively low score. This, in turn, demonstrates that, even with the identification of the service as a regular source of care for the child, those interviewed reported that the search for this space is associated with other variables such as vaccinations and Sporadic visits to the doctor. In this highlight, the main focus was not related to the link with the health professional and/or, even less, to the quality of care.

Similar data were found in a study developed in the city of Teixeiras/MG. When assessing the child's health care in the context of family health, it was found that those responsible for the children did not recognize the services of the family health units as a reference in the care of the child. Criticism and non-binding were related to the non-resoluteness of the same, especially the delay between the appointment and the consultation, or waiting in line and still often not getting the necessary care.[11]

Several researches in the field of Primary Health Care present the reasons that lead the population to choose a service for health monitoring, highlighting the geographical proximity to the health unit and the quality of care as the most referred.[12-13-14]

Studies highlight that the lack of demand for APS services may be related to the offer of shares, lack of attendance and/or insufficient quantity.[14] The number of professionals, mainly physicians, is cited for their attendance, as well as their turnover, which leads to a fear of seeking new information from the population. Other impediments such as difficulties in geographical access, financial issues and hours of operation were also cited as limiting the demand for health services.[14]

A survey on PHC and the degree of affiliation of mothers to services from the perspective of professionals carried out in the city of Cascavel/PR showed the preference of the families for the services of Pronto Continent Care. The characteristics of health units functioning, with scheduling of appointments and only with the presence of the pediatrician at certain times, tends to contribute to the search for other types of services, by the mothers, through the health needs presented by the children. Even the professionals interviewed reported that mothers considered emergency care services more resolvable due to diagnostic support tests such as X-rays and blood and urine tests.[15]

Starfield[5] defends the idea that there is an entry point for the user in the health system every time a new care for a health problem arises. This entry point needs to be easily accessible and essential to any health service organization, be it primary, secondary or tertiary care.

The gateway to the APS, based on data from the PCATool child, still presents limitations in regard to meeting the needs of the population in focus. At the management level, there is disbelief as to the capacity of the services to deal with perceived problems and, at the level of care, there is a search for emergency and emergency care, foreseeing that these are more resolutive.[15] There is also a shortage of personnel, especially physicians, in addition to their turnover in health services. In turn, issues of this dimension further diminish the link between the user and the service, favoring the search for solutions understood as immediate.[14-15]

Para Starfield,[5] the terms "access" and "accessibility" are used interchangeably and often misleadingly. For the author, it is important to understand that accessibility makes it possible for users to reach health services. It is characterized as an aspect of the structure of a health system or unit that is necessary for effective attention to the first contact. Access, however, is the way users experience this feature of their health service. However, accessibility is not an aspect of primary care alone, since other levels of care (secondary and tertiary) should also be accessible. However, in Primary

Care, the specific requirements for accessibility differ, since it constitutes the point of entry into the health system.

Research developed in the municipality of Colombo/PR[16] evaluated the APS for the child using PCATool with responsible for children from 17 to 22 months registered and assiduous to the activities of the health unit. In the "Utilization" attribute, higher general scores for Primary Care in the units with Family Health Strategy were identified, data similar to this study.

However, the results of the UBSF 5 and 6 registered averages below the recommended one for PHC in the item in which those responsible answered that they go to their health service before going to another for a routine consultation of the child. This suggests that they seek prior care. It is possible that these results are related to the great demand for services in the services, the reduced number of consultations offered in the units and/or the difficulty in marking them. This, in turn, may favor the search by the responsible for other UBSF with lower demand and greater availability of care, or even of private services for the proper monitoring. It may also be related to the relationship with the workers of the services and the resolution of the assistance.[16]

In the attribute "Accessibility", those responsible were questioned about the service's usefulness and the possibility of attending the same day the child is sick, the waiting time for the service and the facility to obtain consultations or advice by telephone. Starfield[5] affirms that the absence of an easily accessible entry point prevents the development of quality health care, since it is expected that, based on Primary Care guidelines, problems presented by users may receive the best source of attention.

Accessibility is a necessary structural element for PHC. Their lack of effectiveness may hamper the resolution of the health problems of the assisted population and hamper the performance of the service itself. Affordable service is that of easy approach, attentive in the first contact and available to users, without barriers, be it geographical, administrative, financial, cultural and/or language.[5]

The attribute "Accessibility" is far from the ideal level for the APS, also in other spaces, reinforcing the barriers of access to health units.[16] The low scores on this attribute may be due to the units' restricted hours, which run from Monday to Friday, from 7:00 AM to 5:00 PM. They may also relate to the waiting time to mark something in the service or also to the time greater than 30 minutes in the waiting of the consultations.[16]

A study in the municipality of Cascavel/PR[15] on first contact access in basic health units, showed that the organization of services based on the scheduling of consultations or by spontaneous demand, has not solved the health problems of that population. Either you can not attend all users who are looking for the services or there is no resolution in this service. In addition, scheduled care is not performed as a practice of these health services. In this case, the (un)humanization of care in this system is evidenced, since the users to get the care they need need to be at the door of the health units at dawn, for spontaneous demand care.[17]

An alternative to overcome these limits and positively impact this access would be the convenience of the hours of operation of the primary care services. In addition, it is necessary to reflect the formatting and organization of these spaces with regard to the waiting time for the queries; Professionals and specialties available; The development of reception practices and the humanization policy, and the technical quality of care.[18]

The hours of operation of services in the Family Health Strategy need to be reviewed in order to allow users access at alternative times, either weekends or after 6:00 PM.[19] With the objective of reorienting health care in the SUS, the ESF needs to have its units functioning according to the users' needs, in partnership with the communities, in order to reduce access barriers and enable the use of PHC services as a first contact with the health system.[18]

In order to guarantee accessibility to health services, reception is characterized as an indispensable strategy for health promotion and prevention practices. To do this, changes are required in the work process in health units, identifying the users' needs, and ensuring humanized access when the population seeks care.[20]

The practice of the host requires the responsibility of the worker/team for the user, from the arrival to the exit of the unit. It is more than a qualified screening. It is necessary to listen to their complaints, evaluating anxieties, worries and anxieties, which implies qualified listening, identification of the demand, lifting of the problems and decisive interventions for their confrontation.[20]

In this dimension, it is possible to guarantee integral care, with more resoluteness and continuity of care when necessary, seeking to articulate the internal networks of services, which allows the horizontality of care, and external networks, with other types of health services.[20-21] In this sense, the host is also seen as a posture committed to the construction of the understanding of the health-disease process by the user, with the objective that he participates as a subject of his healing process.[22]

CONCLUSION

In this research, in the attribute "First Contact Access – Use" of the services by the children from 0 to 9 years, it was evidenced, in general, satisfactory results in the Units investigated. On the other hand, the attribute "Access First Contact – Accessibility", registered general scores below the ideal for APS in all the studied UBSFs. This represents problems for comprehensive attention to the health of the child, since the findings of this study show weaknesses in the aspects: "Does the health service attend the same day?" "Do you wait a long time to make an appointment at the health service?" "Ease To get medical care for the child on the same day or make a routine appointment?"

The results show that both access and accessibility to the services of Primary Care of Mossoró in relation to the health care of children from 0 to 9 years are insufficient. The research participants do not recognize Primary Care services as a reference in the care of children. Dissatisfaction and noncompliance with these spaces is noticeable, related to non-resoluteness, especially not being able to obtain the service sought by the child and/or the delay between the appointment and the consultation or waiting in line.

It is possible to infer that changes in the organization of services, with new formatting for the attention of the general public and, in particular, the child, will tend to contribute to higher scores regarding accessibility. In addition, trying to stimulate greater accountability and linkage, by health professionals, is another positive aspect for improvements in the care of the population that enters the public health services.

In fact, it is possible to infer that, although PHC is considered the "gateway" to the Unified Health System, many obstacles need to be overcome if this level of attention is to be taken as a reference in the health care of the groups, and in particular child. Therefore, it is considered fundamental to rethink the aspects that proved to be insufficient to guarantee the presence and extension of the attribute First Contact Access with the health system in the studied MSUs of Mossoró/RN. And these improvements require changes both in structural and procedural elements to provide Primary Health Care in the quality that has been proposed since its inception.

It is considered that much still has to be produced in order to evaluate the Primary Health Care services in Brazil, including to allow the regional comparison between the performance of the attributes of PHC, with the aim of improving access and accessibility in these services Throughout the national territory.

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Received on: 29/05/2016
Reviews required: No
Approved on: 10/10/2016
Published on: 10/07/2017

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