Preventable infant mortality and barriers to access to primary care in Recife, Northeastern Brazil

ABSTRACT

OBJECTIVE: Analyze the factors influencing avoidable infant mortality from the perspective of the protagonists involved.

METHODS: Qualitative study with a critical-constructivist approach, examining children’s access to health care and avoiding preventable infant mortality through health care campaigns and services in Health District I of Recife, Northeastern Brazil, between February 2007 and February 2008. The theoretical sample was designed in two stages: I) institutions providing health services to children; II) interviewees: managers (11); professionals [from the Family Health Strategy and Programme of Community Health Workers (48); and from outpatient clinics (12)]; mothers (20), with sample size defined by “saturation of the speeches”. Data was collected using individual semi-structured interviews and case studies of avoidable infant death. Thematic content analysis was used, generating mixed categories (emerging and scripted).

RESULTS: There were perceived to be conflicting positions between different stakeholder groups reflecting their role in the care network. All institutional participants related infant deaths to the absence/poor dissemination of child health policies and inter-sectoral actions; professionals and mothers highlighted difficulties in accessing health care due to insufficient global resources, especially the lack of doctors in Family Health Strategy, shifting health care to nurses. Lack of doctors, acutediseases rejection, and dehumanized and/or poortechnical quality care were the mainfactors which the mothers related to deaths. Family Health Strategy participants from the Programme of Community Health Workers and mothers identified thecondition of social exclusion and maternal neglectwith deaths, but the case study of deathrevealed the association withlowerquality of care offered.

CONCLUSIONS: Numerous barriers to access indicate insufficient Brazilian Unified Health System implementation and lack of resolution of the main access route, the Family Health Strategy. The results indicate the need for improvement of structural and organizational factors of supply, with emphasis on mechanisms to stimulate the recruitment of doctors for the Family Health Strategy professional training of all staff consistent with the model of care to comply with health care policies for children and avoiding preventable infant mortality.

INTRODUCTION

Over the last three decades, the Brazilian government has shown great interest in reducing infant mortality through the introduction of programs, plans and projects. These activities, together with a significant decrease in fecundity over the same period, have contributed to a decline in figures for infant mortality. However, the number of preventable infant deaths in the country remains considerable.

There is a strong link between preventable infant death and timely access to health care services, as preventable deaths, according to Rutstein et al. (1976), are defined as “deaths which could be partially or totally avoided by the presence of effective health care services”. The emphasis is even greater when the scene of these deaths is a regional hub city, constitutionally bound to provide universal access and comprehensive health care according to the precepts of the SUS (Brazilian Unified Health System).

Child health care policies, in accordance with these principles, aim to provide health care which is resolutory, welcoming, humane and accountable, provided by teams working together and with intersectoral cooperation, preferably offered by the Family Health Strategy (ESF) and the Program of Community Health Workers (PACS). The objective is to promote health and reduce infant mortality. It is the duty of the health care team to monitor the child throughout their first year, to identify at birth risk factors for illness and death (low birth weight, premature birth, hypoxia, teenage mothers and mothers with low levels of schooling and family history of death before age five) and decide upon the appropriate medical care. Also taken into consideration as risk factors are previous hospital admissions, delays in vaccination, living in risk areas, having no income and drug addiction.

In line with the national pattern, the infant mortality coefficient (IMC) for Recife, Northeastern Brazil, show a progressive reduction (IMC = 13 deaths/1,000 live births in 2007), similar to that seen in other, more developed, Brazilian cities such as Rio de Janeiro, São Paulo and Belo Horizonte, all located in Southeastern Brazil. However, 86% of these deaths could have been prevented by actions on the part of the health sector or partner organizations in other social sectors. This suggests the existence of barriers to access to health care services and campaigns.

The extensive literature which relates to infant deaths which could have been prevented through access to health care services, makes use of epidemiological or evaluative methods as the principal investigative tool. While these methods demonstrate the magnitude of the problem, they do not deepen the perspective of the social protagonists (users, health care professionals) or contextual factors (political and characteristics of supply) which influence access.

The majority of qualitative studies concentrate on barriers relating to the performance of health care professionals in welcoming and connecting, or on the maternal perspective of infant death, and few analyze the influence of barriers to access on the ongoing occurrence of avoidable deaths, or else do not include the points of view of all the participants involved.

Access to health care refers to the possibility of obtaining health care, conveniently and easily, when they need it. As access is something that can only be observed when health care services are actually used by those who need them, Aday & Andersen’s (1974) theoretical framework analyzes factors which influence use of health care services, defining the two most important dimensions of access: potential and realized. Potential access is concerned with the characteristics of supply (availability and organization of health care services) and of the users: predisposing factors (sociodemographic characteristics, beliefs and attitudes, level of information); enabling factors (personal and community) and health care needs. Realized access refers to actual use of health care services. The aim of this study was to analyze factors which influence preventable infant mortality, from the perspective of all participants involved in the phenomenon.

METHODS

This was a qualitative, descriptive-interpretive study using a critical-constructivist approach, aiming to uncover the relationship between children’s access to health care and infant death which could be prevented by actions and health care services, using Aday & Andersen’s (1974) theoretical framework to analyze access. The field work, the largest part of the sample, was conducted in the city of Recife, Pernambuco state, Brazil, and mainly involved the families of infants born in the city during the study period.
A two-stage theoretical sample was designed. The following institutions were selected: Health District 1 Administrative Headquarters; Primary Health Care Services (nine ESF units and one Traditional Primary Care Unit [UBT], which provide health care according to the traditional model, with basic children’s health care provided by pediatricians and without being ascribed to areas); and services of medium complexity (two outpatient clinics and an Allergology Service, which offered primary health care within the traditional model, as well as specialized health care). Ninety-one interviewees were selected, aiming for the greatest possible variety of discourse in order to guarantee sample sufficiency and saturation.

A two-part collection strategy was used to collect data: a) individual, semi-structured interviews (scripted according to the theoretical framework) with participants associated with the institutions and mother of children aged between 28 and 365 days. Ninety-one interviewees took part: 11 managers – nine district managers (M) and two unit managers (Geradm); 48 health care professionals from PACS and ESF: ten doctors (MED); 12 nurses (N); 26 Community Health Workers (ACS), 20 from ESF (PSF) and six from PACS; four outpatient clinic general managers (UB), one UBT director and seven pediatricians from outpatient clinics (PED); 20 mothers; b) a case study of a preventable, post-natal infant death. The areas of Health District 1 with the highest occurrence for post-natal infant death classified as preventable were identified; 18 events which occurred during the period in question were analyzed in order to select those which best exemplified problems with health care access culminating in a death which could have been avoided. In order to build the case, the following methods were used: examining ante-natal care cards completed by doctors and nurses in ESF units; examining medical records for mother and child appointments in maternity and pediatric hospitals; looking at notes from ACS home visits to mother and child; examining child’s growth and development and vaccination records; examining records from child’s appointments and referrals by the ESF; examining child’s death certificate from the Institute of Legal Medicine; individual, semi-structured interviews which health care professionals involved in child’s care and the death (ACS, doctors and nurses from ESF); and non-structured interviews with mother. Two interviews were necessary in order to establish a satisfactory relationship conducive to dialogue. The interviews took into account the mother’s wishes as to the details revealed about the events leading to her daughter’s death and took place at a time and place convenient to her.

The interviews lasted between 30 and 60 minutes, and were recorded and transcribed and accompanied by the field diary.

Thematic content analysis was carried out, with a topic deemed to be a unit of meaning, taken from the text according to criteria from the theoretic-conceptual framework. Mixed categories were produced (scripted and emerging). The quality of the data was guaranteed by triangulation between groups of interviewees, techniques and strategies of data collection and an external analysis.

The categories and sub-categories for analyzing access where those which the social protagonists associated with infant mortality: a) Factors related to SUS policies: implementation; dissemination, infant health programs; inter-sectoral actions; b) Factors concerned with the structure of supply: availability of human and material resources; c) Factors concerned with the organization of supply and professional performance: preventive and curative care (location; professional providing care); aspects of care (welcoming/humane/technical quality); d) Factors concerned with social context: social conditions of the families and the environment; social support networks.

The research was approved by the Instituto de Medicina Integral Prof. Fernando Figueira (IMIP), Committee of Ethical Research in Humans, process n° 892, 2006. All of the participants signed consent forms.

RESULTS

The majority of the participants were women; of the ten men interviewed, two were managers, three were health care unit directors, three were ACS and two were doctors. The interviewees from the institutions had been carrying out their work for between five and ten years, with the extremes represented by ACS from PACS and health care professionals from the outpatient clinics and the UBT (traditional model), who had been working there for more than 15 years, and for a doctor and ACS from ESF, where some members of the team had been there for a year. The 21 mothers interviewed were aged between 17 and 38; nine of them lived with their child’s father; 13 had not completed primary education, one had finished high school and two had steady employment; nine were employed informally and ten reported they were not working; monthly household income was of one minimum wage, with this being supplemented by benefits.

---

* Moraes Vanderlei LC. Mortalidad infantil evitable y acceso a la atención de la salud en Recife, Brasil en la perspectiva de los principales actores sociales [tese de doutorado]. Bellaterra: Universidad Autónoma de Barcelona; 2010.
For the majority of the interviewees, clear barriers to access emerged throughout the continuous care. The basic level stands out, with important differences in the level of intensity of the discourse, depending on the group from which it came. Four groups of barriers feedback into themselves, with repercussions on the avoidance of preventable infant mortality.

**Infant death and SUS policies**

The majority of participants from institutions related the persistence of deaths to barriers due to the SUS care model, including policies dealing with children’s health, not being properly established. However, there was disagreement among the different groups. The majority of participants from the traditional model (professionals from the UBT and the outpatient clinics) were unaware of policies aimed at infant health, emphasizing the effective absence of children’s health programs in the municipality; managers and professionals from the ESF/PACS highlighted the fragility of inter-sectoral cooperation. The mothers perceived the low problem solving capabilities of the ESF to be contributing factors. However, there were narratives about the decline in deaths being utilized by ESF/PACS, especially between members of these teams (Table 1).

**Infant deaths and structural and organizational factors of supply**

Almost all of the interviewees perceived the overall scarcity of resources to be prejudicial to access to preventive and curative health care. The groups had different perspectives regarding the outcome of infant death. For PACS/ESF health care professionals, infant mortality was linked to the large number of families the ESF teams were responsible for, meaning the health care professionals were overstretched. This would lead to programmed activities, such as those aimed at child health, not being carried out. All of the participants emphasized the lack of doctors in the ESF, displacing curative care onto nurses, adversely

### Table 1. Opportunities and barriers to access related to SUS policies. Recife, Northeastern Brazil, 2007.

<table>
<thead>
<tr>
<th>Category/participant group</th>
<th>Quotes</th>
</tr>
</thead>
</table>
| SUS policies incompletely established (participants from institutions)                        | - [...] once there are guidelines for children, the program for at-risk children, they must actually make it happen [...] things are not happening as they were planned to, visits monitoring this very child [...] (M8).  
- [...] this clinic (referring to the outpatient clinic) should be for support [...] and here the demand has been more direct to the staff rather than referred by the doctors (referring to ESF doctors) and ACS [...] there has to be integration [...] I believe it would significantly cut down on child illness and mortality. (PED4). |
| Lack of awareness of child health care policies on the part of health care professionals (health care professionals in outpatient clinics/UBT) | - With regards to pediatrics, when there is not a specific program [...] I believe that this still needs to be improved [...] in order for there to be better health care, be more attentive in these cases of infant mortality [...] or if this exists, I’m not aware of it, but this is not only my fault as I was not informed [...]. (UB1). |
| Fragility of inter-sectoral activities (managers/ESF/PACS health care professionals)          | - [...] when discussing avoidable deaths, the first aspect to be considered is the lack of effective inter-sectoral work [...] The health care sector managed to establish partnerships with other sectors, guarantee women’s education, housing, income, generate employment. All of this is happening, but at a slow pace. (M1).  
- [...] the responsibility for infant mortality does not lie so much with health care [...] it is also a political question, of social exclusion [...] there are other factors involved here, structural, socio-economic, political, family, health care is limited to treating these problems. (N9). |
| Poor problem solving on the part of the ESF (mothers)                                           | - I don’t know why they open at all! (referring to the USF) [...] when the boy gets sick I don’t even bother going there, they don’t resolve anything! (Mother 15).  
- I don’t like going to appointments at the USF very much, because the doctor there often doesn’t know what’s wrong, and refers us to another clinic (referring to outpatient clinics) [...] I prefer to go straight there. (Mother 1). |
| Establishing ESF/PACS (ESF/PACS health care professionals)                                    | - [...] I don’t think we’re one hundred percent there yet, but we’re getting there [...] infant mortality is falling [...] due to monitoring, the specific treatment we provide these children with [...] in the case of vaccination, diarrhea, these have been controlled. (PACS3). |

SUS: Brazilian Unified Health System; ESF: Family Health Strategy; UBT: Traditional Primary Care Unit; PACS: Community Health Worker Program; USF: Family Health Center; N: nurse; M: district managers; UB: general managers; PED: outpatient clinics
affecting the ability to solve problems. For health care professionals from the PACS/ESF, the lack of doctors interferes with supervision of the ACSs on their house calls, fundamental to monitoring at risk children. There was conflict between the mothers’ discourse, which linked infant death to the constant lack of medicines, and those of participants from institutions, who viewed the availability of medication as one of the positive points of the SUS and did not perceive any connection with the deaths (Table 2).

The great intensity with which organizational barriers emerged, and the refusal to treat serious illness in ESF units, was unanimous among the mothers, who viewed this as one of the causes of infant mortality, obliging them to make use of emergency pediatric services (Table 2).

Table 2. Barriers to access related to structural and organizational factors or supply. Recife, Northeastern Brazil, 2007.

<table>
<thead>
<tr>
<th>Structural factors</th>
<th>Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall lack of resources (all participants)</td>
<td>- Maybe lack of conditions, lack of care [...] I think lack of everything, in terms of the doctors, of medication [...]. Sometimes on the part of the mother [...] there is nowhere else to turn, you’re unable to buy medicine [...] the child ends up dying. (Mother 2).&lt;br&gt;- [...] there are no scales, none of the children are weighed [...] There is no measuring tape, no charts of cephalic perimeter [...] There’s absolutely nothing (PED6).&lt;br&gt;- [...] Children are not the only group the PSF cares for [...] we try to give priority to children, to women, to patients with high blood pressure and diabetes [...], the bureaucracy, the work, the blame, staff shortages, it all ends up affecting care [...] (N9).</td>
</tr>
<tr>
<td>Shortage of doctors in the ESF (all participants)</td>
<td>- [...] We have to solve all the problems [...] sometimes just looking after children who arrive here poorly, those who need advice and prevention to not fall ill [...] it’s wishful thinking, because there’s no doctor; if there is a doctor, they are overworked [...] (N9).&lt;br&gt;- In the center (USF) near home, you have to make an appointment (for a consultation) you have to go there early in the morning [...] there are times I don’t manage to get an appointment, sometimes there is a draw to see which day you will get an appointment! (Mother 12).</td>
</tr>
<tr>
<td>Lack of supervision for the ACSs (ESF/ PACS health care professionals)</td>
<td>- [...] I think nurses should accompany ACSs on home visits more often. Sometimes the ACSs are left totally alone (ACS5).</td>
</tr>
<tr>
<td>Lack of medicines (mothers)</td>
<td>- Just yesterday I bought this medicine here [...] sometimes I have to use grocery money because [...] they give you medicines that are not available at the center, then you have to buy it(Mother 11)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organizational factors</th>
<th>Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barriers to the treatment of acute illness in the ESF (mothers)</td>
<td>- If I have to get an appointment for my daughter to be seen, because she’s sick, she should be seen then and there, without having to wait for an appointment, without making an appointment, if it wasn’t serious I would make an appointment for another day, not wait one or two months [...] Everything goes to the emergency room, when they could be seen at the center (referring to the USF) which is much closer (Mother 8).&lt;br&gt;- [...] if it’s an illness that I know the center (USF) won’t deal with, if it’s going to be a wasted journey, I’ll go to the emergency room (Mother 16).&lt;br&gt;- [...] at the center (USF) we have to wait for those who have an appointment to be seen [...] to be squeezed in [...] then the boy will die, right? (Mother1).</td>
</tr>
<tr>
<td>Doctors and/or pediatricians substituted by nurses in ESF health care (mothers and doctors)</td>
<td>- I don’t like the health care at the center (USF) where I live, because it’s not a doctor who sees you, it’s a nurse, and she’s not really as capable as a doctor is [...] and there is only a general clinic there [...] there should be pediatrics. (Mother 18).&lt;br&gt;- [...] this idea of children being treated at the clinic, I don’t think it works out [...] and the mothers don’t seem to like it. [...] here (referring to the outpatient clinic) it is always really busy because they (referring to the mothers) are not satisfied with the care provided by the general practitioner at the PSF. (PED3).&lt;br&gt;- I can’t understand nurses providing pediatric care [...] a 10-month-old child turns up with a heart murmur and I immediately refer them to cardiology [...] nurses don’t have the training to diagnose heart murmurs [...] (MED5).</td>
</tr>
</tbody>
</table>

ESF: Family Health Strategy; UBT: Traditional Primary Care Unity; PACS: Community Health Worker Program; USF: Family Health Center; ACS: Community Health Worker; PSF: Family Health Program; MED: doctor; PED: outpatient clinics; N: nurse
Infant mortality and barriers to access

Vanderlei LCM & Vázquez ML

Barriers to curative health care in the form of the ESF substituting pediatricians with general practitioners and/or nurses were reported by mothers and doctors in outpatient clinics and the ESF as contributing to deaths. In the doctors’ opinions, nurses do not have the proper professional training to provide curative health care, suggesting conflicts within the health care team (Table 2).

**Infant mortality and factors of professional performance**

Almost all participants linked inadequate performance by professionals with low technical quality to preventable infant deaths. Among the interviewees from institutions, this lack of professional commitment was attributed to ESF health care teams being overworked, to specialists being poorly trained and to the perception of not being professionally valued. The mothers attributed infant mortality not only to poor technical quality but to de-humanized, unwelcoming health care at all levels of care (Table 3).

**Infant death and the social context**

The main determinant of preventable infant mortality was the families’ social exclusion, high levels of poverty, unemployment, violence and drug use, according to almost the participants. The mothers talked of a lack of social support network. For the participants from the ESF/PACS, in concordance with the mothers, infant death was particularly associated with maternal characteristics, blaming the mothers for negligence towards their children (Table 4).

**The case of preventable infant death**

The case of preventable, post-natal infant death in an area assigned to the ESF permitted a deeper analysis...
of the actual obstacles to health care services and campaigns which had emerged from the interviews, and showed links between the main barriers to access to children’s health care throughout the course of their day to day access (or lack of it) to health care. Situations which emerged in the process of interaction between the various participants involved with the child from in-utero to its death were analyzed: a) barriers to access such as the mother not having ante-natal checks, social risk and ESF doctors and nurses not monitoring at risk children. This suggests that SUS child health care policies are not completely established and a lack of professional commitment on the part of the ESF; b) the sick child not receiving care the day before their death, which demonstrates the barrier to treatment of acute illness in USF; and c) the lack of references to timely medical assistance when the USF refused treatment. Poor technical and scientific quality and a lack of professional commitment on the part of the ESF were reported. The events contributed to preventable infant death which could have been avoided by actions and health care services (Table 5).

DISCUSSION

In spite of the Brazilian government’s directors’ commitment to comprehensive child health care and a significant decline in infant mortality, numerous barriers to access indicate the fragility with which the SUS has been established and of the main access point: basic health care. Ultimately, this has repercussions on the perpetuation of preventable infant deaths. There were significant differences in the perception and/or intensity of the statements, probably due to the participant’s position with regards to the phenomenon. Lack of awareness of policies aimed at children’s health and of the health care model on the part of health care professionals, together with professionals from both levels of health care’s views that care is supplied better in the traditional model and the mothers’ perceptions of poor problems solving capabilities in the ESF, are examples of the model’s poor consolidation. This is worrying, especially in relation to the main point of access, where the majority of activities to avoid
Table 5. The course of preventable infant mortality: the diverse barriers to access. Recife, Northeastern Brazil, 2007.

<table>
<thead>
<tr>
<th>Barriers in the ESF Primary Care</th>
<th>Example Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ante natal</td>
<td>[...] she did not carry out the ante natal checks during pregnancy, nor was the child’s well being monitored. She only came when the child was sick (Nurse).</td>
</tr>
<tr>
<td>- Lack of home visits to at-risk pregnant women by the whole ESF team to provide guidance</td>
<td></td>
</tr>
<tr>
<td>Post natal</td>
<td>[...] she (ACS) came to the house on the day we went there (the maternity hospital) [...] later I went to the center (USF) and I told her (ACS) “the girl doesn’t have a crib and she’s sleeping with me in the bed with me and the other four children, five altogether counting her [...]” (Mother).</td>
</tr>
<tr>
<td>- Lack of preventative actions</td>
<td>[...] I always turned up at the center without making an appointment, I arrived at the last minute with the girl [...]. (Mother).</td>
</tr>
<tr>
<td>- RN not included in monitoring activities for at-risk children according to social criteria: unemployed mother, drug use, multiple partners, single mother, areas of social risk.</td>
<td></td>
</tr>
<tr>
<td>- No home visit by nurse and/or doctor.</td>
<td>[...] so she (ACS) comes to the house to go through her routine; and I said “the girl is distressed and vomiting” and she said “take her to the center”. I took her to the center. The doctor saw us and sent us to the hospital, gave me a bus ticket. (Mother).</td>
</tr>
<tr>
<td>- Child only has USF appointments when ill; lack of guidance on promoting health and avoiding infant death</td>
<td></td>
</tr>
<tr>
<td>No responsibility taken for the child throughout the course of their health care</td>
<td></td>
</tr>
<tr>
<td>- Team does not continue to provide care after referral and return to specialist services.</td>
<td></td>
</tr>
</tbody>
</table>

Failures in access to health care during illness which contributed to the death

- Refusal by the USF to treat a child with acute respiratory disease the day before death occurred. No guidance given as to other services where treatment would be provided.

- Death due to aspirating milk triggered by respiratory disease (and/or aggravated by smoke in the household / compression by the body of another child).

- Blame placed on the mother and on overwork caused by the death of the child. Intra-team conflicts.

- [...] she did not carry out the ante natal checks during pregnancy, nor was the child’s well being monitored. She only came when the child was sick (Nurse).

- [...] she (ACS) came to the house on the day we went there (the maternity hospital) [...] later I went to the center (USF) and I told her (ACS) “the girl doesn’t have a crib and she’s sleeping with me in the bed with me and the other four children, five altogether counting her [...]” (Mother).

- [...] I always turned up at the center without making an appointment, I arrived at the last minute with the girl [...]. (Mother).

- [...] so she (ACS) comes to the house to go through her routine; and I said “the girl is distressed and vomiting” and she said “take her to the center”. I took her to the center. The doctor saw us and sent us to the hospital, gave me a bus ticket. (Mother).

- [...] then I had a problem, phlebitis, and I was off for ten days. (Doctor).

- [...] he suspected she had a stomach infection, and prescribed an antibiotic, but I didn’t want to give it to her because it was very strong [...] she was very young [...] I gave her saline, I asked for it at the center [...] (Mother).

- [...] then I had a problem, phlebitis, and I was off for ten days. (Doctor).

- [...] So I tried to get in touch with the ACS and they told me “she’s not here, she’s out”, so I asked “where is the doctor?” “The doctor has left.” I took her back home, gave her Dipirona, the fever passed, I fed her, winded her, put her to sleep, she was playing, she wasn’t poorly, she was alert, and so we went to sleep. (Mother).

- [...] then I had a problem, phlebitis, and I was off for ten days. (Doctor).

- [...] she didn’t use contraceptives, the doctor didn’t give her a prescription, and I don’t give medicine if the doctor hasn’t already prescribed it. (Nurse).

- [...] as she (the mother) is a drug user, she fell asleep on top of the child, suffocating her, or she did not pay attention when she was feeding her, the child regurgitated the milk and ended up aspirating it [...]. It was an unplanned pregnancy [...] she didn’t use contraceptives, the doctor didn’t give her a prescription, and I don’t give medicine if the doctor hasn’t already prescribed it. (Nurse).

- [...] I believe the following: that families who need more health care should be monitored [...] more closely. [...] the vehicle for the doctor, the nurse, are the ACSs, not we say: “look at him, or look at her, these people need to be looked after” [...] but we are here with a lot of other people to look after [...]. (Doctor).

ESF: Family Health Strategy; USF: Family Health Unit; ACS: Community Health Worker

preventable infant death through actions and health care services take place. Infant death in areas assigned to the ESF as a result of failures in the Government Program to Reduce Infant Mortality highlights barriers to implementing child health care policies. The conflicts between the current model and the traditional, well-structured network, in which primary health care was provided by pediatricians, demonstrate the need for fresh adjustments to enable the new model to be understood and legitimized.5,22

The main criticisms of the new model which emerged from the mothers’ statements were the lack of doctors
in the ESF, limited curative health care, doctors being substituted for nurses and the refusal to treat acute illness. They made it difficult to monitor at-risk children, the priority of the whole health care team. The lack of doctors interfered in work processes and in interpersonal relationships as nurses were overworked and their roles in the ESF not clearly defined. This increased conflicts in the teams’ work, permeating into values, attitudes and historically determined conceptions.

The infant death case study revealed the ESF’s failure to monitor at-risk children as one of the main determinants of infant death as well as indicating the link between other lapses in the health care provided, such as difficulties in working in teams. The fact that responsibility for the death was avoided and blame placed on the mother reflects serious problems in communication and professional conduct as well as probable corporate issues. On the one hand, there is resistance to hierarchical change among medical professionals in the former care model and, on the other, promotion of nurses to a level equal to that of the doctors, which generates intra-team conflicts.

Barriers related to poor performance indicate the lack of quality health care in the ESF and no responsibility being taken for the child throughout the course of their health care. Failing to comply with government child health care directives highlight failures in the way comprehensive child health care policies are established. These were aspects present in the statements of all participants and in the infant death case study.

The mothers’ unanimous vision of the health care process as dehumanized suggests that access to health care through the means of welcoming, sympathetic interpersonal relationships between patient and health care provider is not common practice, making this a SUS operational directive which has not become incorporated in the minds of health care professionals dealing with children’s health care.

Blaming the child’s death on the mother’s negligence was something which emerged mainly among the mothers and female ESF/PACS health care professionals. These health care professionals emphasized maternal factors, separating them from the context of social misery and played down inadequate access to health care. These statements implied prejudiced, probably ideological attitudes. Among the mothers, contradiction appeared in the statements, which had a note of involuntary maternal involvement, intertwined with conditions of extreme vulnerability. These data are consistent with those from the Schepker-Hughes study, developed in Northeastern Brazil, but not with those of the study carried out by Nations, in the same area at the same time, in which the mothers perceived failures in health care as one of the determinants of death. The results show an attitude more of resignation on the part of the mothers, towards the miserable conditions of the context which overcame the perception of obstacles to health care access. They also reflect a position of little solidarity, based on the impersonality of the guiding question, which referred to the deaths of the children of mothers they did not know, which contributed to the development of blame in their statements.

To conclude, the existence of numerous barriers to access to child health care reflects the way the SUS, and its main access point, the ESF, have not been firmly established. The participants fail to perceive the link between poor quality health care services and the continuing occurrence of preventable infant mortality which could be avoided by actions and health care services through child health care policies.

The structural (lack of medicines in the ESF), organizational (restrictions on care for acute illnesses/doctors substituted for nurses) and professional performance (poor technical quality, care that is not welcoming/dehumanized and problems with team work) barriers prove themselves to be the main obstacles to access to primary care which takes responsibility for the child throughout the whole course of their health care.

Despite the mothers’ conditions of social exclusion being linked to infant mortality, these factors can be minimized with efficient primary care, bearing in mind the important role played by fairer and effective social policies.

---

1 Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. Agenda de compromissos para a saúde integral da criança e a redução da mortalidade infantil. Brasília (DF); 2005. (Série A. Normas e Manuais Técnicos).
REFERENCES


The authors declare that there are no conflicts of interests.

HIGHLIGHTS

The article analyzes barriers to primary health care as one of the factors associated with preventable infant mortality in Recife, PE.

The authors estimate that 86% of infant deaths could be avoided through timely, effective actions on the part of the health care services.

Managers and directors of health care units and districts, health care professionals, community health workers and mothers were interviewed. The authors selected 18 sentinel events for the study of health care access barriers.

The barriers identified by the interviewees were: the health care model being inadequately established, the fragility of inter-sectoral links, poor ability, on the part of the Family Health Service teams, to solve problems, scarcity of material and human resources, lack of medication, pediatricians substituted by clinicians not trained to care for children and inadequate professional performance.

The study showed concrete difficulties related to the implementation of the child health program, limitations of the care model and scarce health resources.

Profa. Rita de Cássia Barradas Barata
Scientific Editor
