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RESEARCH

Evaluating child care in the Family Health Strategy

Avaliação da assistência à criança na Estratégia de Saúde da Família
Evaluación de la asistencia al niño en la Estrategia de Salud de la Familia

Simone Albino da Silva[I], Lislaine Aparecida Fracolli[I]

[I] *Universidade de São Paulo, School of Nursing, Postgraduate Program in Nursing. São Paulo, Brazil.*

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ABSTRACT
Objective: to evaluate the healthcare provided to children under two years old by the Family Health Strategy. **Method:** evaluative, quantitative, cross-sectional study that used the *Primary Care Assessment Tool* - Child Version for measuring the access, longitudinality, coordination, integrality, family orientation and community orientation. **Results:** a total of 586 adults responsible for children under two years old and linked to 33 health units in eleven municipalities of the state of Minas Gerais, Brazil, were interviewed. The evaluation was positive for the attributes longitudinality and coordination, and negative for access, integrality, Family orientation and community orientation. **Conclusion:** there are discrepancies between health needs of children and what is offered by the service; organizational barriers to access; absence of counter-reference; predominance of curative and long-standing and individual preventive practices; verticalization in organization of actions; and lack of good communication between professionals and users.
Key words: Nursing; Family Health Strategy; Children's Health; Primary Health Care; Health Evaluation.

RESUMO
Objetivo: avaliar a assistência à criança menor de dois anos de idade prestada na Estratégia de Saúde da Família. **Método:** estudo avaliativo, quantitativo e transversal no qual se utilizou o *Primary Care Assessment Tool* – Versão Criança para a aferição dos atributos de acesso, longitudinalidade, coordenação, integralidade, orientação familiar e orientação comunitária. **Resultados:** foram entrevistados 586 adultos, responsáveis por crianças de até dois anos de idade e vinculados a 33 unidades de saúde, em onze municípios do estado de Minas Gerais, Brasil. A avaliação foi positiva para os atributos longitudinalidade e coordenação, e negativa para o acesso, a integralidade, a orientação familiar e orientação comunitária. **Conclusão:** há desencontros entre as necessidades de saúde das crianças e o que é ofertado pelo serviço; barreiras organizacionais ao acesso; ausência de contrarreferência; predominância de práticas curativas e preventivas consagradas e individuais; verticalização na organização das ações; e falta de comunicação adequada entre profissionais e usuários.
Descritores: Enfermagem; Estratégia de Saúde da Família; Saúde da Criança; Atenção Primária à Saúde; Avaliação em Saúde.

RESUMEN
Objetivo: evaluar la asistencia al niño menor de dos años de edad prestada en la Estrategia de Salud de la Familia. **Método:** estudio evaluativo, cuantitativo y transversal en el cual se utilizó el *Primary Care Assessment Tool* – Versión Niño para el arqueo de los atributos de acceso, longitudinalidad, coordinación, integralidad, orientación familiar y orientación comunitaria. **Resultados:** fueron entrevistados 586 adultos, responsables por niños de hasta dos años de edad y vinculados a 33 unidades de salud, en once municipios del estado de Minas Gerais, Brasil. La evaluación fue positiva para los atributos longitudinalidad y coordinación, y negativa para el acceso, la integralidad, la orientación familiar y orientación comunitaria. **Conclusión:** hay desencuentros entre las necesidades de salud de los niños y lo que es ofertado por el servicio; barreras organizacionales al acceso; ausencia de contra referencia; predominancia de prácticas curativas y preventivas consagradas e individuales; verticalización en la organización de las acciones; y falta de comunicación adecuada entre profesionales y usuarios.
Palabras clave: Enfermería; Estrategia de Salud de la Familia; Salud del Niño; Atención Primaria a la Salud; Evaluación en Salud.

CORRESPONDING AUTHOR **Simone Albino da Silva** E-mail: simonealbino76@hotmail.com

INTRODUCTION

The Family Health Strategy (FHS) was established in the 1990s as a way to operationalize the Primary Health Care (PHC) and the doctrinal and organizational principles of the Unified Health System (*Sistema* Único *de Saúde* - SUS). Among the main objectives of the FHS are increased accessibility to health services, overcoming the healing model and hospital-centered model of assistance, reorientation of the attention model toward health monitoring, development of actions aiming at health promotion, implementation of new practices of assistance and multidisciplinary, interdisciplinary and intersectoral action.

According to Harzheim et al.[1], the FHS can be aptly characterized as a strategy for implementation of PHC teams, but the definition of the legal landmark of a public health policy does not necessarily guarantee its actual application.

In Minas Gerais, the restructuring of PHC started in 1994 with encouragement from the federal government for the implementation of the Family Health Strategy in the North regions and Jequitinhonha. It was a gradual implementation, with a prospect of stimulating equality of access to health services. Currently, FHS covers 72.05% of the population of Minas Gerais, with 4,552 teams in 846 of the 853 municipalities. The progressive increase in population coverage by this service has been accompanied by improvements in physical structure of services and the training of professionals and managers of that level of care[2].

Considering the magnitude and heterogeneity that characterizes the implementation of the FHS in the municipalities of Minas Gerais, the evaluation of the degree of orientation toward PHC of each health service or team allows the production of knowledge about its effectiveness[3]. Thus, the aim of the present study was to evaluate whether the essential and derivatives attributes of PHC are incorporated into care practices directed to children under two years of age in municipalities of the health region of Alfenas, Minas Gerais, Brazil.

The conception of this study consists in the evaluation on the practical outcome of user assistance in primary level of care, covering the dimensions of achievement of right to full health assistance, PHC as the focal point of the organization of a health model and PHC as a technology of assistance. The assessment proposed here is based on the technological dimension, proposed by Starfield[4] who listed the inherent qualities of PHC, the so-called essential attributes of access to first contact, integrality, coordination of care and longitudinality as well as derivative attributes including family and community orientation and cultural competence.

In the list of essential attributes of PHC is the individual's access to first contact with the healthcare system: accessibility and use of the health service as a source of care for each new problem or new episode of the same health problem, excepting real emergencies and medical urgencies. Longitudinality corresponds to the existence of a continuous source of care as well as its use over time. The relationship between the population and their source of attention should be reflected in an intense interpersonal relationship that expresses mutual trust between users and health professionals.

The range of services available and provided by the primary care service represents the attribute known as integrality. It concerns the organizational arrangement of actions that the health service should provide so that users receive full attention from the perspective of biopsychosocial aspect of the health-disease process and the perspective of health promotion, prevention, healing and rehabilitation adequate to the PHC context, even though some actions may not be offered within the PHC units. It includes referrals to medical specialists and hospitals, among others.

The coordination of care assume some form of continuity, either by the service offered by the same professional, either through medical records, or both. Recognition of problems addressed in other services and integration of this care on overall patient care must also be focused on this attribute. The primary care provider must be able to integrate all care the patient receives through coordination between departments.

Three other characteristics, known as derivative attributes, also qualify the actions of primary care services. Family orientation is the attribute whereby family background and its potential care and also health threat is considered and includes the use of tools with family-approach while assessing individual needs for integral care.

The recognition by the health service of community's health needs through epidemiological data and direct contact with the community, the relationship between health service and community, as well as planning and joint evaluation of services are characteristics of community orientation. Finally, cultural competence proposes the adaptation of the provider (team and health professionals) to the special cultural characteristics of the population in order to facilitate the relationship and communication with it. From these definitions, a form of evaluation of the PHC was established, verifying the presence and scope thereof.

METHOD

This is an evaluative research with quantitative approach and cross-sectional design[5]. The site of study corresponded to eleven municipalities of Alfenas microregion in Minas Gerais, Brazil. Quota sampling was used to select participants with estimate of mean and with standard deviation of 1.2, 0.1 error and 95% confidence interval. The total number of participants was divided proportionally between cities and the size of the population covered by the FHS.

Participants were people over 18 years of age, responsible for the care of children aged between 0 and 2 years, resident and registered for over one year in the area covered by FHS units of urban area that were operating continuously for at least five years in municipalities, with FHS population coverage higher than 50% in the health region of Alfenas, Minas Gerais, Brazil. Before starting the interview, the objectives were presented to selected users of the FHS and they signed a Informed Consent form confirming they agreed to participate, in accordance with current legislation. This project was approved by the Research Ethics Committee of the School of Nursing of the University of São Paulo.

Data collection took place during June and July 2012 through interviews at users' domicilie that lasted twenty-five minutes in average. The *Primary Care Assessment Tool* - Child Version (PCATool) was used as interview script, which is a health evaluation instrument based on the assumptions of structure, process and outcome of Donabedian[6]. This instrument was developed in the US by the group headed by Starfield and has been translated and validated to different countries, including Brazil[3].

The PCATool in the version of child care has 56 questions. The first three questions are intended to identify which health unit the user has as a reference of assistance and the degree of affiliation through a punctuated algorithm from 1 to 4. In the sequence, there are 53 questions distributed among the essential attributes of PHC: Access to first contact - Use; Access to first contact - Accessibility; Longitudinality; Coordination - Integration of Care; Coordination - Information System; Integrality - Available Services; Integrality – Provided Services; and among derivative attributes, Family Orientation and Community Orientation. The possible answers for each item are "definitely yes" (value = 4); "probably yes" (value = 3); "probably not" (value = 2); "certainly not" (value = 1) and "I do not know/ I do not remember" (value = 9). The scores for each attribute or its components are calculated by simple arithmetic mean of the responses of the items that compose them.

The evaluation by PCATool results in two measures: the Essential Score which is the average of the scores of the components that belong to the essential attributes and General Score, that is the average of the scores of the components of the essential attributes summed up by scores of derivative attributes. These results characterize the degree of orientation of the service or the health system to the attributes of primary health care.

The responses were organized into a database created in *Microsoft Excel for Windows software* and statistical analysis was performed using the Statistical Package for Social Sciences software - SPSS 14.0 adopting 95% confidence interval. For the measurement of each attribute, a score was made, using the arithmetic mean of the responses that is compared to the reference value 6.66, the boundary between high and low scores. In order to compare the mean scores of the PHC attributes by groups, we used ANOVA with post hoc Tukey method. Each attribute was also analyzed taking as a reference the percentage of 66.6% as adopted in the PCATool. This analysis had internal consistency and reliability assessed by Cronbach's alpha method.

RESULTS

Interviews took place in areas covered by 33 FHS units located in 11 of the 17 municipalities that make up the health region of Alfenas. Participants of the study consisted in 586 responsible adults/caregivers of children aged between 0 and 2 years that, despite the inclusion criteria described above, did not unanimously indicate the FHS as a regular source of health care for the child. This service was indicated as regular source of health care by 330 users (56.31%), followed by specialized clinics (25.26%), traditional basic unit (9.39%) and Emergency Room (9.04%).

In order to meet the proposed objectives, we decided to analyze the data collected from the 330 participants who responded on FHS teams. These were were mainly female (98.46%); white (53.44%); mothers (86.50%); in the age group of 20-39 years (59.73%); married/living a common-law marriage (75.65%) and rasing between 1 and 2 children (65.22%).

For this group, the degree of affiliation was 3.55, based on a scale of 1 to 4. The mean scores of the attributes of PHC conferred by participants are shown in Table 1.

Tables 2-5 present attributes that received the lowest mean scores, as follows: access to first contact - accessibility, integrality - available services, family orientation and community orientation. This aims to understand which are the greatest barriers of achieving high-quality childcare at the level of primary health care. Attributes will be analyzed by observing the mean values of each of its components, which also had the internal consistency and reliability assessed by Cronbach's alpha method.

Table 1 - Mean values and standard deviations of the attributes of primary health care, essential score and general score, conferred by those responsible for children under two years old in the evaluation of the Family Health Strategy, health region of Alfenas, Minas Gerais, Brazil, 2012

Attribute of PHC	n	Minimum	Maximum	Mean	SD
Access to first contact - Use	329	0.00	10.00	7.99	2.45
Access to first contact - Accessibility	329	0.00	10.00	4.87	2.45
Longitudinality	329	0.71	10.00	6.66	1.97
Coordination - Integration of Care	47	0.00	10.00	6.88	3.24
Coordination - Information System	317	0.00	10.00	6.98	1.95
Integrality - Available Services	288	0.00	10.00	5.18	1.88
Integrality – Provided Services	322	0.00	10.00	6.50	3.42
Family Orientation	324	0.00	10.00	5.10	2.97
Community Orientation	295	0.00	10.00	5.69	2.24
Essential score	330	2.75	8.67	6.44	1.18
General score	330	2.65	8.96	6.21	1.20

Table 2 - Percentage distribution of answers of people responsible for children under two years old assisted by the Family Health Strategy to the items that make up the attribute Access to first contact - accessibility, health region of Alfenas, Minas Gerais, Brazil, 2012 (Cronbach's alpha = 0.696, N = 329)

Evaluation	C1	C2	C3	C4	C5	C6
	%	%	%	%	%	%
Definitely yes	32.62	33.74	42.38	10.06	31.31	29.79
Probably yes	22.56	20.25	20.12	13.41	23.40	10.94
Probably not/I do not know, don't remember	19.21	19.02	15.55	20.12	14.29	28.27
Certainly not	25.61	26.99	21.95	56.40	31.00	31.00
Total	100	100	100	100	100	100

Notes: C1 - When the "name of the health service/ name or doctor/nurse" is open and your child gets sick, does someone of this health service receive you at the same day? C2 – Do you have to wait too long or talk to many people to make an appointment at the "name of the health service / or doctor/nurse name"? C3 – Is it easy to make an appointment for a follow-up child consultation ("routine visit") in the "name of the health service / or doctor/nurse name"? C4 - When you arrive at the "name of the health service / name or doctor/nurse", do you have to wait more than 30 minutes for your child to see the doctor/nurse (not counting screening or host)? C5 – Is it hard for you to receive medical care for your child in the "name of the health service / name or doctor/nurse" when you think it is necessary? C6 - When the "name of the health service / name or doctor/nurse" is open, do you get quick advice over the phone if you need?

Table 3 - Percentage distribution of answers of people responsible for children under two years of old assisted by the Family Health Strategy to items that make up the attribute Integrality - Available Services, health region of Alfenas, Minas Gerais, Brazil, 2012 (Cronbach's alpha = 0.650, N = 288)

Evaluation	G1	G2	G3	G4	G5	G6	G7	G8	G9
	%	%	%	%	%	%	%	%	%
Definitely yes	60.90	37.50	65.97	32.64	23.61	24.39	6.97	40.07	12.15
Probably yes	6.23	21.18	13.89	17.71	15.28	17.77	5.92	19.51	17.01
Probably not/I do not know, don't remember	8.65	22.92	11.11	22.57	37.50	39.37	23.00	20.21	31.94
Certainly not	24.22	18.40	9.03	27.08	23.61	18.47	64.11	20.21	38.89
Total	100	100	100	100	100	100	100	100	100

Notes: We present bellow a list of services/guidelines that you and your family or the people who use this service may need at some point. Please indicate if the these services or guidelines are available in the "name of the health service / name or doctor/nurse": G1 - Vaccinations (immunizations). G2 - Check if your family can participate in any program of social assistance or social benefit. G3 - Family planning or birth control methods. G4 - Nutritional supplementation program (for example, milk and food). G5 - Counseling or treatment for the harmful use of drugs (legal or illegal, for example alcohol, cocaine, sleeping pills). G6 - Counseling for mental health problems. G7 - Suture a cut that needs points. G8 - Counseling and HIV testing request. G9 - Identification (any kind of evaluation) of visual problems (to see).

For people responsible/caregivers of children between 0 and 2 years old, this attribute had a lower mean score. The items that make up this component of integrality concern the entire experience of the interviewee with the health service and do not refer exclusively to the child in question. Not necessarily the child should have received these services but the respondent must know or not about their availability[3].

Table 4 - Percentage distribution of answers of people responsible for children under two years old assisted by the Family Health Strategy to items that make up the attribute Family Guidance, health region of Alfenas, Minas Gerais, Brazil, 2012 (Cronbach's alpha = 0.600, N = 324)

Evaluation	I1	I2	I3
	%	%	%
Definitely yes	23.46	51.54	25.31
Probably yes	11.11	13.58	25.93
Probably not/I do not know, don't remember	18.52	8.95	29.63
Certainly not	46.91	25.93	19.14
Total	100	100	100

Notes: I1 – Does your "doctor / nurse" ask about your ideas and opinions on the treatment and care of your child? I2 – Does your "doctor / nurse" ask you about diseases or problems that exist in the family of your child (cancer, alcoholism, depression)? I3 – Does your "doctor / nurse" would meet with other child's family members if you found it necessary?

Table 5 - Percentage distribution of the responses of people responsible for children under two years old assisted by the Family Health Strategy to items that make up the attribute Community Orientation, health region of Alfenas, Minas Gerais, Brazil, 2012 (Cronbach's alpha = 0.588, N = 295)

Evaluation	J1	J2	J3	J4
	%	%	%	%
Definitely yes	84.07	46.44	20.68	17.29
Probably yes	7.46	31.19	16.61	4.41
Probably not/I do not know, don't remember	4.41	16.61	24.75	11.86
Certainly not	4.07	5.76	37.97	66.44
Total	100	100	100	100

Notes: J1 – Does anyone from the "name of the health service / name of the doctor/nurse" make home visits? J2 – Does the "name of the health service / name of the doctor/nurse" know the important health problems in your neighborhood? Ways to evaluate the quality of health services are listed bellow. Does the "name of the health service / name of the doctor/nurse" perform some of these? J3 – Does it/he/she conduct research in the community to identify health problems that it/he/she should know? J4 – Does it/he/she invite family members to participate in the Local Health Council (Manager Council/Users Council)?

DISCUSSION

The high percentage of users of the FHS that mentioned other services of the healthcare network as a reference for assistance to children under two years old endorsed the observations made during data collection that some municipalities have implemented the FHS without rearranging the existing traditional primary care. An example of this situation is the maintenance of pediatric visits and vaccine rooms out of FHS. This made services sometimes complimentary but other times competitors. In other assessments using the same methodology, the percentage of people indicating the FHS as the main source of care for children under two years old is much higher. Ribeiro et al.[7], for example, reports 77.6% and Leão, Caldeira and Oliveira[8], 77.7%.

The high degree of affiliation and the average of positive evaluations for the attribute access to first contact - use showed that users of Alfenas health region confide the responsibility for child healthcare to the FHS. Other studies have also obtained positive results for the degree of affiliation[9-10].

In contrast to the result regarding degree of affiliation, the attribute access at first contact - accessibility received a low score in the evaluation. The main barriers according to the interpretation of the items that compose this attribute showed in Table 2 were difficulty to schedule a service for the same day or for when the person thinks to be needed and the difficulty of receiving a rapid advice by telephone from a professional. It is easier to schedule a routine consultation, and for that, it is not necessary to wait more than thirty minutes.

The difficulty with accessibility to PHC service is common, as evidente in other studies[8-10]. This indicates a fragility in early care process. For Leão, Caldeira and Oliveira (2011[8], difficulties of reaching this attribute are possibly linked to child's peculiarities and healing demands presented to health services in face of the high amount of acute occurrences typical of in this age group. Under this understanding, it seems that such increased demand makes this negative assessment even more legitimate. The summary of these results shows that this attribute of PHC did not achieve full development and offering only partial assistance to users that consider the FHS as the gateway to the health system.

Longitudinality is the process of follow-up over time with an implicit therapeutic relationship characterized by responsibility on the part of health professionals and trust on the part of the patient[11] and is considered the central attribute of PHC[4]. Its development results in more accurate diagnoses and treatments, reducing unnecessary referrals to experts and to perform more complex procedures[12]. This attribute achieved a high score in the evaluation of participants of Alfenas health region. A similar result was also found in other studies[8,10,13].

In order to evaluate the attribute coordination - integration of care, the responsible/caregiver was first questioned if the child had been referred to a specialist while under treatment in the FHS. Among all participants, 47 (14.24%) gave a positive answer and attributed a high score to the quality of PHC. This low percentage of referrals reported by respondents and the positive assessment of this attribute are related to the evaluation of

longitudinality, it can be inferred as a result of this and as a positive result of the regional organization of health services implemented in the *locus* of the study. The work of Oliveira[9] had similar results, and the study of Braz[10], divergent.

Participants of Alfenas health region attributed high scores to coordination - information system, showing that there are favorable conditions concerning the existence of registration and availability of information for development of coordination and longitudinality of care. The evaluation of childcare performed by Braz[10] also obtained positive results for coordination - information system. In other hand, this quality did not reach the threshold for classification in the evaluation of Oliveira[9]. In studies where this attribute is not divided, results showed low score[8,13].

The attribute Integrality is divided into two elements, integrality - available services and integrality – provided services. For the element integrality - services, there are issues that concern the whole experience with the health service and address services available to the entire family. The evaluation by users of Alfenas health region was low, just as in other works[8-10,13].

In the study of the items of this attribute, notably, items related to immunizations, family planning and contraception among all available services received positive evaluations above the threshold for a good result. However, most items received the highest percentage of negative evaluations, what led to a low final score of the attribute. Noteworthy are the lowest results to items as availability of suture; visual evaluation; treatment/counseling; on abuse of legal/illegal drugs and treatment/counseling on mental health. The outcome of the evaluation of this attribute in other studies is coincident in items about drugs, mental health[9-10,13], visual evaluation[9-10] and counseling and detection of HIV[9-10,13].

The need for FHS units to expand the scope of action of the FHS services[13] and better train professionals in the management of the most common conditions and causing of major impacts on the health of families and the community, such as alcoholism, drug use and mental health problems[8]. PHC units can not be oriented by vertical programs, but rather by the health needs of its population[13].

The score of integrality - provided services was classified as low, but very close to the threshold for classification. In other evaluations used as reference, available services were positive[8-10,13]. Items of this element make reference to services exclusively available to the child and the result shows that this falls short of needs. To Starfield[4], the second highest valued attribute for users is the integrality, behind longitudinality. Patients recognize the importance of integrality and express their dissatisfaction when this is absent. When services are very limited in range or depth, preventable diseases can not be avoided, diseases can progress for longer than justified, the quality of life can be compromised and people may die earlier than they should.

The evaluation of the attributes Family and Community Orientation received also low score, as happened in other studies[8-10,13].

Family Orientation is a derivative attribute that involves the family as the subject of attention[8] and, as shown in Table 4, all items received evaluations below the threshold for classification. This reinforces the results found for the attribute longitudinality, highlighting the work process in FHSs is perceived by caregivers of children bellow 2 years old as focused on the biological question of the health-disease, with little appreciation of the caregiver's opinion and the characteristics of the family group of the child.

Harzheim[13] arguments that the presence of a new member in the family organization opens important opportunities for health professionals work together with the other members involved. The aim is to learn the biopsychosocial context of the health-disease, to address health-related beliefs and behaviors of the family, to avoid problems of transition of the family cycle and to increase the use of family as a valuable and dependable resource for the health of children and of the other members. Missing this opportunity of care impede actions on individual basis - the child's consultation – to become a collective dimension, reducing the potential impact of the relationship professional - child - caregiver.

Costa et al.[14] state that health professionals, especially those with higher education, are still limited to individual guidance given at the doctor's office, even in the context of the FHS.

The attitude of professionals of trying to learn the problems of the community they assist as well as participation and social control in FHS actions and services in the health region of Alfenas – MG, according to the interpretation of data presented in the Table 5, received a high negative percentage. Braz[10], Oliveira[9] and Leon, boiler and Oliveira[8] found similar results in their assessments. In contrast, Harzheim[13] found high values for the items community orientation while evaluatind the FHS.

According to Starfield[4]

> all needs related to the health of patients occur in a social context; the recognition of these needs often requires knowledge of this context. The attribute community orientation results from a high degree of integrality of general attention.

Users recognize community orientation mainly due to the work of extramural monitoring, health monitoring and follow-up of families and community. This work is done mainly by community health agents and in varying degrees by other health professionals[8,13].

The Essential Score evaluation obtained a high score. This correspond to the average of the scores of the components that belong to the essential attributes (access to first contact - use; access to first contact - accessibility; longitudinality; coordination - integration of care; coordination - information system; integrality - available services; integrality – provided services) divided by the number of components. Other studies had similar[8] or divergent[10,13] results. The present high score, although slightly above the threshold for classification, is a positive testimony on how the FHS organizes actions and services toward child health, but indicates aspects to be strengthened and that will be discussed later on.

However, the General Score, which consists of the average of the scores from all attributes summed to Afilliation, was evaluated as low. This was influenced by the low scores of the attributes of Family and Community Orientation, likewise in other studies[8,10,13].

There was no statistical difference between average scores of attributes of the FHS when comparing groups of participants classified according to sex, age and parenting. Comparing the groups according to skin color, self-declared brown-skin participants attributed lower values than the other groups to longitudinality. Comparing groups according to marital status, widowers and single people gave higher values than the other groups for Coordination - Information Systems.

FINAL CONSIDERATIONS

The evaluation of the FHS in Alfenas region, Minas Gerais, reveals that child healthcare is not imbued with many components of the PHC attributes until the presente date. Although the health model established in the guidelines of the FHS focuses on integral care, with emphasis on promotion of health and prevention of diseases, it was clear that there are issues to be developed.

Organizational barriers to access; absence of counter-reference; predominance of curative and long-standing and individual preventive practices; incipient health-promoting activities; verticalization in organizing actions; lack of adequate communication between professionals and users; and little room for participation and inclusion of new health demands of the population. The arrangement of some municipalities that maintain a mixed PHC with traditional primary care units and FHS units, making them parallel, contributes to the fragmentation of care provided to the child and the family.

REFERENCES

1. Harzheim E, Starfield B, Rajmil L, Álvarez-Dardet C, Stein AT. [Internal consistency and reliability of Primary Care Assessment Tool (PCATool-Brasil) for child health services]. Cad Saúde Pública [Internet]. 2006 Aug[cited 2014 Dec 2];22(8):1649-59. Available from: http://www.scielo.br/pdf/csp/v22n8/13.pdf Portuguese.
2. Brasil. Ministério da Saúde. Departamento de Atenção Basica. Teto, credenciamento e implantação das estratégias de Agentes Comunitários de Saúde, Saúde da Família e Saúde Bucal Unidade Geográfica: Estado - Minas Gerais [Internet]. 2013[cited 2013 Nov 27]. Available from: http://dab.saude.gov.br/portaldab/historico_cobertura_sf.php
3. Brasil. Ministério da Saúde. Secretaria de Atenção em Saúde. Departamento de Atenção Básica. Manual do instrumento de avaliação da atenção primária à saúde: Primary Care Assessment Tool PCATool - Brasil. Brasilia: Ministério da Saúde; 2010.
4. Starfield B. Primary care: balancing health needs, services, and technology. Brasília: Unesco; 2002.
5. Novaes HMD. [Evaluation of health programs, services and technologies]. Rev Saúde Pública [Internet]. 2000 Oct[cited 2014 Dec 2];34(5):547–9. Available from: http://www.scielo.br/pdf/rsp/v34n5/3227.pdf Portuguese.
6. Donabedian A. Evaluating the quality of medical care. 1966. Milbank Q [Internet]. 2005 Jan[cited 2014 Dec 2]; 83(4):691–729. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690293/pdf/milq0083-0397.pdf
7. Ribeiro LCC, Rocha RL, Ramos-Jorge ML. [Reception of children in primary health care: a study on attitudes by family health team members]. Cad Saúde Pública [Internet]. 2010[cited 2013 Sep 19];26(12):2316–22. Available from: http://www.scielo.br/pdf/csp/v26n12/10.pdf Portuguese.
8. Leão CDA, Caldeira AP, Oliveira MMC. [Aspects of primary care for children: an evaluation of care-givers]. Rev Bras Saúde Matern Infant [Internet]. 2011 Sep[cited 2014 Dec 2];11(3):323–34. Available from: http://www.scielo.br/pdf/rbsmi/v11n3/a13v11n3.pdf Portuguese.
9. Oliveira VBCA, Veríssimo MLOR. Children's health care assistance according to their families: a comparison between models of Primary Care. Rev Esc Enferm USP [Internet]. 2015[cited 2015 Apr 24];49(1):30–6. Available from: http://www.scielo.br/pdf/reeusp/v49n1/0080-6234-reeusp-49-01-0030.pdf
10. Braz JC. Avaliação da atenção às crianças menores de um ano na Estratégia de Saúde da Família em um município da Bahia, sob a ótica dos cuidadores [dissertação]. Ribeirão Preto: Escola de Enfermagem, Universidade de São Paulo; 2012.
11. Cunha EM, Giovanella L. Longitudinality/continuity of care: identifying dimensions and variables to the evaluation of Primary Health Care in the context of the Brazilian public health system. Cienc Saúde Coletiva [Internet]. 2011[cited 2014 Jan 23];16:1029–42. Available from: http://www.scielo.br/pdf/csc/v16s1/a36v16s1.pdf
12. Gérvas J, Pérez Fernández M. [The scientific basis for the gatekeeping role of general practicioners]. Rev Bras Epidemiol [Internet]. 2005 Jun[cited 2014 Apr 2];8(2):205–18. Available from: http://www.scielo.br/pdf/rbepid/v9n2/12.pdf Spanish
13. Harzheim E. Evaluación de la atención a la salud infantil del Programa Saúde da Familia en la región sur de Porto Alegre, Brasil [thesis]. Alicante: Departamento de Salud Publica: Universidad de Alicante; 2004.
14. Costa GD, Cotta RMM, Reis JR, Ferreira MLSM, Reis RS, Franceschini SCC. [Evaluating child healthcare in the context of Family Healthcare in the city of Teixeiras, Minas Gerais (MG, Brazil)]. Cienc Saúde Coletiva [Internet]. 2011 Jul[cited 2013 Sep 19];16(7):3229–40. Available from: http://www.scielo.br/pdf/csc/v16n7/22.pdf Portuguese.