

Ways of comprehensiveness: adolescents and young adults in Primary Healthcare¹

José Ricardo de Carvalho Mesquita Ayres^I, Yara Maria de Carvalho^{II}, Mariana Arantes Nasser^{III}, Rodrigo Marcinkevicius Saltão^{IV}, Valéria Monteiro Mendes^V

^IDepartamento de Medicina Preventiva, Faculdade de Medicina da Universidade de São Paulo (Department of Preventive Medicine, University of Medicine from the University of São Paulo). Av. Dr. Arnaldo, 455, 2º andar, São Paulo, SP, Brasil. 01.246-903. <jrcayres@usp.br>.

^{II}Departamento de Pedagogia do Movimento do Corpo Humano. Escola de Educação Física e Esporte da Universidade de São Paulo (Department of Human Body Movement Pedagogy. School of Physical Education and Sports from the University of São Paulo).

^{III}Centro de Saúde Escola Samuel B. Pessoa, Departamento de Medicina Preventiva, Faculdade de Medicina da Universidade de São Paulo. (Escola Samuel B. Pessoa Health Center, Department of Preventive Medicine, University of Medicine from the University of São Paulo).

^{IV}Physiotherapist.

^VPost graduation program in Human Body Movement Pedagogy, School of Physical Education and Sports, University of São Paulo).

ABSTRACT

Adolescents and young adults constitute an important challenge to the construction of integrality in primary healthcare. This is due to the complexity to hold and respond to their health needs, resultant from the process of growth and development - which is part of the proper life stage - but mainly from socio-cultural aspects related to that phase. The present study attempted to recognize achievements and constraints in how the principle of integrality has been implemented at a Basic Healthcare Unit. Although it was possible to identify an effective perception of the specificity required to take care of this group, important constraints related to the construction of healthcare projects that could integrate the several purposes of the daily work at the Unit were observed. Insufficiency of professional and sector interactions, and weaknesses in communication among the professionals themselves and the professionals and the healthcare unit users stand out.

Keywords: Adolescence; Young Adults; Comprehensive Healthcare (Integrality); Primary Healthcare.

Introduction

Adolescents and young adults healthcare constitutes an important challenge to health practices, due

¹ Unpublished article, based on the research “Caminhos da Integralidade: Levantamento e Análise de Tecnologias de Cuidado Integral à Saúde em Serviços de Atenção Primária em Região Metropolitana – área temática Saúde do Jovem e do Adolescente” (Paths of Integrality: Survey and Analysis of Comprehensive Healthcare in Primary Healthcare Services in a Metropolitan Region – themes: Young adults and Adolescents’ Health).

to either specific characteristic of this population or ways healthcare services are organized (Ayres, França Júnior, 1996; Queiroz, 2011).

Specificities of this group result, on the one hand, from the growth and development processes, which implies in monitoring and supporting needs on morphofunctional aspects, but mainly on socio-cultural aspects related to this process. Therefore, adolescence and young adults definitions which are generally used in health take into consideration pubertal as well as growth and development milestones, life experiences, adolescent contexts, and the chronological limits associated with the socially established civil and legal norms as well (Saito, Silva, Leal, 2008; Coates, Beznos, Françoso, 2003).

In Brazil, the main delimiting criteria in health practices are the ones from the World Health Organization (WHO) and from the Statute on Children and Adolescents (Estatuto da Criança e do Adolescente – ECA), (Brasil, 2010). According to the WHO, adolescence corresponds to the second decade of life, ages from 10 to 19, while the young adults range from 15 to 24 (WHO, 1975). For the ECA, the adolescence is the stage between 12 and 18 years old, with some exceptions when the statute refers to people who are up to 21 years old (Brasil, 1990).

Hebiatry, medical knowledge field that studies health and disease in adolescence, defines this phase as the moment of transition from childhood to adulthood. Hebiatry indicates puberty, the biological and body dimension of this maturation process, as a physical mark of this stage which is not restricted to it. Puberty is most clearly manifested by the first signs of sexual maturation, that is, the emergence of the first secondary sexual characters: in girls, the appearance of the breast bud; in boys, the increase of testicular size (Setian, Colli, Marcondes, 1979).

The social-cultural processes that characterize adolescence and young adults are mainly related to the experience and perception of the aforementioned biological changes and, mostly, of the new discoveries, experienced in concrete contexts where the adolescents live (Muuss, 1976; Oliveira, 1999).

This stage of life is marked by contradictions between wishes and duties related to children and adult worlds, the desire for new discoveries and the fear of the unknown translated by society into some notions and values related to: protection/custody *versus* emancipation; legal liability; self-questioning the capacity for the labor market; immaturity and impulsiveness; valuing beauty; prejudice due to lack of experience; movements of protest, introduction of the new and challenge of change (Ozella, 2003).

Other explanatory categories of society, among which social class, gender and race stand out, have influenced both individuals' experiences and meanings and judgments assigned to this group, particularly regarding health practices that may even cause differences in classification among children, adolescents, young adults, adults; consequently, they have influenced the ways to manage the healthcare for this population. In that sense, adolescents and young adults form a specific but not homogeneous group: they differ in age, life and health conditions, race, origin, social class, level of education, gender, sexual orientation, presence or absence of disabilities, marital status, number (or absence) of children, among other conditions - even if they have common features that allow them to be considered and cared as a collective group (Abramo, Branco, 2005).

All these aspects make very complex holding and responding to the set of adolescents and young adults health needs. Nevertheless, the active consideration of these aspects is essential for an appropriate healthcare of this group, which could effectively embrace them as whole individuals, with their specific needs and demands, favoring the work that integrates promotion, prevention and recovering/rehabilitation (Ayres, 1994).

Hence, adolescence and young adults are population identities that challenge the organization of the health work to make effective one of the guiding principles of the Brazilian Unified Health System (SUS): the doctrinal principle of integrality, defined as an articulated and ongoing set of individual and collective preventive and healing services and actions required by each case in all levels of system complexity (Vasconcelos, Pasche, 2006).

Nevertheless, the operationalization of the principle of integrality is not a simple matter. Mattos (2001) has already pointed out the apparently paradoxical situation of integrality being the most polysemous principle of the Brazilian Unified Health System (SUS) and, at the same time, one of

the most fruitful “objective-images” to stimulate people to consolidate the Brazilian health reform. The author synthesizes this movement towards a double perspective: on the one hand, as a way to respond to the citizens’ health needs, and, on the other hand, as a way to organize healthcare as follows:

[...] what characterizes integrality is obviously the expanded comprehensiveness of needs, but mainly the ability to recognize the adequacy of our offers to the specific situational context in which the meeting of the individual with the health team takes place (Mattos, 2004, p.1414).

Ayres (2009) supports this position when he analyzes the place of integrality among the doctrinal principles of the Brazilian Unified Health System (SUS):

[...] universalization, equality and integrality are mutually related, each one demands the others. [...] The principle of universality compels us to build access to everyone; the principle of equality demands us to share with everyone what each one needs; however, the principle of integrality challenges us to know and to do “what” and “how” can be done towards health in order to universally meet the needs of each one (Ayres, 2009, p.13).

Aiming to understand this practical meaning of the principle of integrality without missing the richness expressed by its polysemy, we adopt here a definition of integrality that refers to four closely interrelated axes in the organization of healthcare:

A) axis of needs: it is related to the quality and nature of listening, embracing and responding to healthcare demands. The most relevant impulse here is the one developing sensibility and capacity to meet the needs which are not restricted to prevention, correction and recovering of morphological or functional disturbs of the organism, without neglecting them;

B) axis of purposes: it concerns the degrees and ways of integration among actions of health promotion, prevention of health worseness, treatment of diseases and suffering, and recovering of health/social reinsertion. The prevailing sense here is the one of not fractioning actions, but rather of creating synergetic mechanisms to optimize the actions development both from the means-ends rationalization perspective and from the comfort and convenience of individuals, families and communities;

C) axis of articulations: it refers to degrees and ways of composition of interdisciplinary knowledge, multi-professional teams and inter-sectorial actions in the development of target actions and strategies of healthcare. The purpose here is to create the best conditions to offer effective responses to health needs within a broaden perspective - as described in item A;

D) axis of interactions: it refers to the quality and nature of interindividual interactions in healthcare daily practices. The motivation of proposals identified in this axis is the construction of effectively dialogical conditions between the individuals participating in the meetings related to healthcare, being either from person to person or from the perspective of teams/communities without which the previous axes cannot be performed (Ayres et al., 2006 apud Ayres, 2009, p.14).

Although the principle of integrality, as the other principles, is applied to any level of the health

system, it is in Primary Healthcare (PHC) that it acquires its most strategic importance. This happens because, by definition, it is its core responsibility to identify, carry out and articulate health actions that transversely and longitudinally should be developed in order to meet the health needs of individuals, families and communities (Starfield, 2002; Schraiber, Mendes-Gonçalves, 1996).

Primary Healthcare (PHC) has also been defined according to different interests and perspectives privileged in the analysis: by the nature of needs and demands that are peculiar to it; as one of the system organization levels or as a technology, that is, as a way to operate the work process effectively performed in the Basic Healthcare Units (Mendes-Gonçalves, 1994).

Although the three dimensions are completely interrelated in the concrete plan, in the present study we will focus on the technological dimension as it is the one that seems to better grasp the dynamics that mutually determines the health needs and demands placed (and replaced) for services, for technical and organizational resources which are available to meet those needs and demands (continuously rebuilding them), and for the practical (political, ethical, moral) perspective of the individuals who interact as health actions performers and receivers.

Hence, Primary Healthcare (PHC) will be understood here as a technology composed by a set of non-material and material instruments focused, in an integrated way, on programs and actions to promote health, prevent health worseness, recover and rehabilitate the health of individuals, families and communities, using low complexity equipment, employing high complexity knowledge and organization, and being guided by integrality to direct their actions.

As the technology actually implemented at the Brazilian Unified Health System (SUS), Primary Healthcare (PHC) is characterized by preferably being the first alternative of user attendance, for being the entrance door to the system, for having a strategic character in structuring target healthcare actions, and for meeting the basic healthcare needs. Therefore, work complexity at the Primary Healthcare (PHC) refers less to the level of physiopathological commitment of its users – although it also deals with patients with very serious, generally chronic, cases – than to the role it plays and to the daily situations with which it has to cope with and that imply in the management of social, cultural and economic aspects directly related to needs that demand responses on this level (Schraiber, Mendes-Gonçalves, 1996).

Based on the conceptual framework built here, we shall then argue how far and in which way Primary Healthcare (PHC), as the technology used in the context of the Brazilian Unified Health System (SUS), has managed to provide comprehensive healthcare to this group. In that sense, the aim of the present study is to survey and to analyze Primary Healthcare (PHC) actions for adolescents and young adults by examining the case of a healthcare unit with specific activities for a group in the western zone of São Paulo city.

Methods

Resultant from a broader protocol of investigation on the practical operation forms of the principle of integrality in Basic Healthcare Units (BHUs) in the western zone of São Paulo city, in the State of São Paulo, Brazil, the present study is a qualitative research, conducted as a case study, based on a solid observation of the healthcare service and on semi-structured interviews with users and professionals.

The general research protocol involved 14 Basic Healthcare Units (BHUs) of the Municipal Department of Health in São Paulo/Health Technical Supervision Division in the district of Butantã. Three of them are organized according to the Family Health Strategy (FHS - Estratégia de Saúde da Família – ESF), while the others are organized in consonance with traditional or mixed models (Basic Healthcare Units - BHUs). It is composed by six sub-protocols, or thematic areas of investigation, on the integrality of healthcare: work process organization and health team; gender and health; race and health; aging and health; adolescent and young adult health; and mental health and primary healthcare. Although the research has also involved a unit of Family Health Strategy (FHS – ESF, in Brazil) in the sub-protocol related to adolescents and young adults, the results shown in this article refer only to the direct observation and interviews with users and professionals

from a Basic Healthcare Unit (BHU).

After a preliminary inventory phase on the characteristics of the 14 Units in the region (carried out from June 2008 to May 2009), the Basic Healthcare Unit (BHU) analyzed here was selected for study in this sub-protocol for being the only Unit in the region (except for a school-healthcare center with very peculiar characteristics as a teaching, research and education) that developed a program specifically focused on adolescents' healthcare. It seemed to be a privileged situation to investigate the work process with that group in primary healthcare attendance, what would certainly be more difficult to be done in Units where the adolescents and young adults are not separated in a demand group. Consequently, it was decided to sacrifice, to some extent, the extension of analysis carried out here for being a not very common situation in Basic Healthcare Units, in the modes of Basic Healthcare Unit (BHU) or of Family Health Strategy (FHS – EFS in Brazil), for the benefit of having a deeper and more perceptive investigation.

After the necessary clarifications and ethical consents, the field work reported here was carried out between May and September 2009. The field researchers (responsible for the interviews and observation) were two teachers (a medical doctor and a physical education professional) with experience in adolescents' health and three professionals trained and supervised by them (a medical doctor, a physiotherapist and a physical education professional).

During the aforementioned months, seventeen observations of service (approximately 60 hours) in different areas (reception, waiting room, doctor's office, group room) and activities (medical appointments, care received from other professionals, educational activities, team meetings) were carried out. These observations, recorded in field journals, covered what could be called a "typical week" regarding relevant activities developed in different periods.

Approximately 14 hours of interviews were made, involving five adolescents and twelve professionals, varying from administrators to graduated professionals and employees. This number resulted from a combination of the following criteria; 1) research operational capacity; 2) scope, diversity and expressivity of the interviewees in relation to the set of professionals and users of the researched unit; 3) accumulation of material necessary to meet the objectives of the study.

The selection of young people to be interviewed sought to include both genders and age ranges, as follows:

- young people under and over 15. Because of the characteristics of the service and demand, it was only possible to access and interview female young adults during the field work;
- truly dominant profile in the program's demand highly associated to the culture of pediatric healthcare service and also for being the most accessible to participation. The selection of professionals sought to include different levels of training and professional profiles, from the manager to the non-specialized employee, looking for different views of the work process in the Unit.

As the presentation and the discussion of the results, due to the theoretical framework adopted and the nature of the object studied, depends on the division of the users', professionals' and researchers' views, the expressive fragments of the field work will be presented in an articulated way. In order to facilitate the identification of the different participations, the adolescents' testimonies will be marked by a fictitious name, followed by age; the professionals' testimonies will be marked by a fictitious name, followed by the professional category; and the researchers' observations and impressions will be marked by the denomination "field notebook".

The interviews were recorded and transcribed. This material, together with the notes of observations in the field notebooks, constitutes the corpus on which the analyses were based. The guidelines for field observation and interviews, as well as their interpretations, were based on the framework of *integrality as a technology of Primary Healthcare (PHC)* and on its four analytical axes, described in the Introduction of this paper.

Results and discussion

The Basic Healthcare Unit (BHU) in focus in this study – according to the IBGE Censorship from 2000 and the population forecasts for 2007; data available when the field work was carried out –

serves a population of 24.281 inhabitants, with a slight predominance of women (51.8%), from which, 26.2% are aged 10 to 24 years old. The average family income of the population served by the Unit was 5 minimum wages or less in 40.68% of the houses. As far as schooling is concerned, 37.1% of the inhabitants had 4 or less years of education.

The Basic Healthcare Unit (BHU) had four doctor's offices (hebiatry, pediatrics, general practice, gynecology), 1 dental office, 6 offices for other professionals (physiotherapy, occupational therapy, phonoaudiology, nursing, social service and psychology), 1 room for group activities of the adolescents' program, 1 toy room, a bandage room, an immunization room, a sample collection room, and a nebulization room. Its team was composed by 48 professionals, 11 doctors (3 general practitioners, 4 pediatricians, 4 gynecologists), 4 dentists, 2 nurses, 15 nursing assistants, 2 psychologists, 2 occupational therapists, 1 physiotherapist, 1 phonoaudiologist, 1 social worker and 9 administrative professionals.

The region covered by the Basic Healthcare Unit (BHU) did not have other public health units and had little social equipment – in the initial inventory of the Units, some Municipal Elementary Schools - EMEI, a non-governmental organization that works with STD/AIDS, a community group for elderly people, a Unified Educational Center from the Municipal Department of Education (CEU) and a community cultural center were mentioned. However, some of them are far from the neighborhood where the Unit is located.

The individuals who participated directly in the research (interviewees) are listed with their fictitious names in table 1. Table 2 summarizes the activities of healthcare attendance observation, recorded in a field notebook.

Table 1. Summary of the interviewees' profiles

Professionals			Users		
Name*	Sex	Profession	Name*	Sex	Age
Ana	Female	Physiotherapist	Nadja	Female	13
Paula	Female	Social Workers	Glória	Female	10
Beatriz	Female	Hebiatrician	Maria	Female	10
Letícia	Female	Manager	Ludmila	Female	10
Antônio	Male	Watchman	Fernanda	Female	15
Carlos	Male	Technical Adm. Assitant 1			
Rafael	Male	Technical Adm. Assitant 2			
Priscila	Female	Manager Assistant			
Catarina	Female	Occupational Therapist			
Joaquim	Male	Gynecologist			
Denilson	Male	Gynecologist			
Keyla	Female	Pharmacy Assistant			

*The names of users and professionals are fictitious to preserve confidentiality.

Table 2 – Synthesis of spaces and activities observed in the field work

General overview of the Basic Healthcare Unit (UBS) and of the space occupied by adolescents and young adults	Meetings	Program activities of adolescents	Healthcare attendance of adolescents and young adults in areas external to the program
- physical structure of the Basic	- Basic Healthcare Unit	- educational group for younger female	- healthcare attendance of

<p>Healthcare Unit (BHU)</p> <ul style="list-style-type: none"> - visual communication materials; - users' internal flow; - adolescents and young adults in the waiting room and in the activities queue; - boardroom. 	<p>(BHU) general meeting;</p> <ul style="list-style-type: none"> - meeting of the team from the adolescents' program. 	<p>adolescents;</p> <ul style="list-style-type: none"> - mixed educational group for older adolescents; - educational group for pregnant adolescents; - herbiatric medical appointment; - group physiotherapy healthcare attendance; - activity of the program waiting room; - play activity for children and younger adolescents; - special activity celebrating the Statute of Children and Adolescents. 	<p>adolescents and young adults at the reception counter of the drugstore;</p> <ul style="list-style-type: none"> - oral healthcare attendance (for schools in the region); - pediatric medical appointment; - pre natal medical appointment; -- gynecology appointment; - GP appointment.
--	--	---	---

Adolescents and young adults' health needs

The diversity in experience lived in adolescence and youth can be gathered in the interviews carried out with the healthcare unit users, who, even belonging to the same social economic context, perceive themselves differently in the relation to their adolescent identity:

[Do you feel you are a child or a teenager?] Teenager. [When did you feel that?] When I started "growing little hairs". [How old were you?] Nine years old. (Glória, 10 years old)

I feel I'm a child. It's cool to be a child; I can play with my friends. (Ludmila, 10 years old)

This diversity also expands to other aspects, as the degree and type of domestic responsibility, the relation with school, sociability networks, leisure activities, patterns of social inclusion and the exercise of citizenship.

The needs, as emerged from the meeting of the adolescents and young adults with the Basic Healthcare Unit(BHU) program, show a more homogeneous pattern, related, mainly, to sexual and reproduction aspects; clinical complaints related to this phase of life, with emphasis on searching hebiatric care; specific follow-ups of occupational therapy - phonoaudiologic, psychotherapeutic and physiotherapeutic treatments advised by the adolescents' program - ; and social economic and family difficulties.

In relation to the theme sexuality, the needs of the group are translated in the daily activities of the healthcare unit by the search for "condoms" and the "morning-after pill" and by the search for pregnancy tests and prenatal healthcare. However, the interviews with the adolescents show that there are prospect and different demands - even before they were translated into reproductive health issues - which are also still related to the universe of a child:

I just made out once with a boy who lives on the same street I do... [...] my cousin saw me and told my mother, that put me grounded. [...] It was good, because I kissed him and it was bad because my cousin saw it. [...] I play

mum and babies with my friends. We play at a large yard in front of my friend's house [...] We access the orkut. [...] There are a lot of boys who want to make out with me, but I have already excluded all of them, but a lot have joined (my orkut) again. (Glória, 10 years old)

The demands from sexuality are perceived by the professionals according to a model of healthcare in which a normative view, practically restricted to the reproductive sphere, is predominant. In the professionals' understanding, adolescents and young adults look for the Basic Healthcare Unit (BHU) with the intention to avoid "early pregnancy" and prevent STD/AIDS, without a deeper discussion about senses, values and meanings of experiencing sexuality and reproduction.

YOU

Girl or woman

What about getting pregnant at the right time?

Come to know all the contraceptive methods, and then you will be able to plan your pregnancy.

Make an appointment at the reception to take part of the group of FAMILY PLAN

(Field notebook: text from the bulletin board for divulgation of activities)

The needs related to clinical complaints refer to specific matters, related to prompt healthcare service, consumption of examinations or specialists' referrals, and, in some cases, report concerns of the person responsible for the adolescent about his/her growth. From this perspective, the complaints are identified as health needs, according to an approach that privileges the biological component of the clinical healthcare and favors medicalization, the consumption of examinations and internal and external referrals. The low incorporation of other components of young adults' lives to the hebiatric healthcare stands out, such as the relation with school and also their interests and desires. It is worth noting that in the periods that no hebiatric healthcare service is available, the prompt healthcare for this clientele is provided by pediatricians and general practitioners, when the "complaint-behavior" model tends to increase.

In cases in which adolescents and young adults' needs are restricted to their difficulties to get adapted to school, phonation and literacy, social appropriateness, psychological distress, postural disorders, and complaints about respiratory problems; they were referred to internal professionals of the Program: occupational therapist, social worker, psychologist, besides other external professionals - phonoaudiologist and physiotherapist. It was noticed that there is little interaction among these activities as well as scarce mechanisms to actively look for new cases, what, according to the healthcare unit, happens due to the lack of professionals.

Socioeconomic and family needs, such as unemployment, poor education, drug addiction, not to mention daily situations of domestic violence, can be observed among the users.

[...] Violence, sexual abuse, marijuana, cowardice, beating, torture. If it were me, I wouldn't commit these crimes. A friend had already been raped. It is hard to stop that. (Fernanda, 15 years old)

But my friend's father was stabbed and died. The daughter saw it. The father died in the arms of his daughter. It was sad! (Glória, 10 years old)

Those needs are, however, shortly incorporated into the work process with the group, which is attributed, among other aspects, to weaknesses in the professionals' education.

[...] lack of professional training, lack of a real vision of what this young adult is, how he is interacting with the present world, and in the present society [...] we become very focused on issues related to physical and mental health. [...] A little more openness, a mapping of these young people

in their territory would be necessary [...] there are very different young people in the city of São Paulo, with different experiences, and perspectives... If you don't map that, understand that, your efforts will fall on your face. (Priscila, manager assistant)

The observations and interviews show that there is a specific look for each group, particularly for adolescents – the oldest tend to be cared in a more decentralized way in activities for women and clinical health. But the interpretation of these specific needs, either due to biomedical emphasis or pre-established positions of normative character, sometimes imbued with moral judgments, end up creating obstacles to possibilities of an effective dialog with these individuals.

Marcela, 13 years old, female, olive skinned. She comes to a return appointment accompanied by her mother. She complains that her menstrual period flux is too heavy. Dr. Beatriz makes questions about her flux, period duration, frequency, etc. and explains that it is normal. The girl does not even feel pain or discomfort. Dr. Beatriz says that both the mother and the observer may be in the room during the examination, she says it is common. Dr. Beatriz orientates the girl to accept menstruation and explains its importance, as a sign of good health. She asks for examinations for harmonies related to menstruation. The girl leaves the doctor's room looking dissatisfied with the explanation.

(Field notebook: observation of a hebiatric appointment)

Purpose of the health work with adolescents and young adults

Despite the existence of a specific program for adolescents and young adults, there is little discussion within the unit about healthcare projects that integrate several professional knowledge and actions, and the interfaces among health promotion, prevention, treatment and rehabilitation are limited.

There are a few other interactions, for example, there will be an education and... education and health action, it seems to me that... it will be next week [...] Catarina (OT) is the one who can say more about these details because she has participated in these events. Because... as I have some time constraint, you see? I cover my work load, 20 hs/week. So, I come here early in the morning and I am busy all the other periods. Then, I don't participate very much. (Beatriz, hebiatrician)

Interactions among the professionals are based on the logic of internal referrals. It is noticed that an important objective of the healthcare service is to meet the demands that come up on a daily basis – what is observed both in the doctor appointments set by the “complaint-behavior” logic as in the focus of meetings on solving particular cases, restricted to planning the next activity without further discussions on projects of unique care or a project for the overall Program.

There is not a technology to organize the access to the Unit. The meeting between young people and the healthcare service is based on the “word of mouth” and on spontaneous demand. Generally, the service makes little use of protocols to guide its actions as well as to offer each kind of activity to users, and the condition for a specific appointment to be made is the interest of the user and availability in the schedule, regardless of a discussion on the impact of actions to the needs in focus, whether individual or collective. Besides that, the model of healthcare in the Unit takes the users registered there, and not the territory, as the universe of health actions, what provides little possibility of active search for users.

A 13-year-old boy asks to make an appointment with the hebiatrician for his younger brother, aged 11, who is with him. The receptionist says that the only vacancy in the timetable is for November, 25th and asks whether it is possible for the boy to come on that date. They agree. Then, she schedules it

on the computer and writes it on the card. [...] When asked by the observer whether she follows any orientation, she answers that, in general, she just does what the person asks, and checks whether there is a date available.

(Field notebook: observation of the reception)

Articulation of knowledge and actions in adolescents' and young adults' healthcare

Most of the professionals know about the Program for adolescents and young adults and link it mainly to professionals of Occupational Therapy and Hebiatry, but, in general, they do not know what is done in the program, and some healthcare workers do not even know it exists.

The work is centered on some people, particularly on the Occupational Therapist, the professional most sought by the adolescents already registered in the Program, and who centralizes the organization of the work; as the observations of her daily activities and the way she conducts weekly meetings of the group show, although an effort of integration can be perceived. Another example of centralization is the control of cases of adolescents that receive hebiatric care in a folder in parallel with the file records of the Basic Healthcare Unit (Basic Healthcare Unit(BHU)), which is not accessed by other professionals.

Still considering hebiatric care; it is based on spontaneous demand, and its divulgation is made by the adolescents, mainly female, by the “word of mouth”. The act of sending adolescents to group activities is related to the perception of social risks and learning difficulties, mainly by the hebiatrician, and, in a lower proportion, by other professionals in the clinic and pediatric; gynecologic and obstetric teams – who are responsible, respectively, for emergency care and pre natal examinations of adolescents and young adults. The observation found that integration takes place mainly by internal referral of the users themselves and not by formal mechanisms and by the development of joint projects. However, some of the professionals who were interviewed consider that the relation between the Program for adolescents and the workers responsible for the pre natal examinations is satisfactory.

[...] We have the Doctor, [...] a gynecologist that does not take part of the Project; He does not participate in the discussions, but he is open to embrace our adolescents. That is so much so that Paula (social worker) had meetings with a group on the same day he cared the adolescents, and there was an open channel to send some situations to him. (Beatriz, hebiatrician)

Another articulation basis within the Basic Healthcare Unit (BHU) is among the physiotherapist and the professionals who integrate the Program, mainly with the Occupational Therapist, who she tries to help with activities that go beyond rehabilitation. Besides referrals of users for motor and respiratory physiotherapy, adolescents are also referred to a work of body awareness through physical activity, which aims at working with situations related to self-esteem disturbs.

Catarina, for example, Occupational Therapist, believes that the body is not well, and if it gets better, it will help the work. She sends them to me, even if this person I am going to take care of does not have any respiratory neither orthopedic problem; we will be doing some body work that will lead to improvement. (Ana, physiotherapist)

It is pointed out, here, the example of a rich possibility of interdisciplinary interaction in healthcare, although, as it has already been pointed out, it is operated informally and depends on clinical demand.

There is also a great number of adolescents and young adults in the dental healthcare service offered by the Basic Healthcare Unit (BHU) that works with schools in the neighborhood, although an interaction between them and the professional from the Program cannot be observed. By the way, the dental healthcare area has little interaction with the other sectors in the Basic Healthcare Unit (BHU) and with the ascribed territory. Schools outside the area covered by the Basic Healthcare Unit (BHU) are served, and its reception and scheduling of appointments work independently from

the Basic Healthcare Unit (BHU).

In sum, a character of juxtaposition of knowledge instead of shared construction predominates in the team, besides that it is marked by a tendency to monopolize and centralize competences. There is a lack of effective spaces for communication among the professionals. It is possible that it is related to the lack of technology to concretely operate it, and, mainly, to management mechanisms that encourage the integration of professionals and service activities.

As far as inter-sectorial articulations are concerned, there were no reports, either in the interviews or in the observations, of systematic activities with external groups or institutions, except for the initiative to use leisure appliances from the area ascribed to the Basic Healthcare Unit (BHU), as sports courts in public squares and parks, in partnership with professionals from cultural work in the region.

Throughout the research, it was noticed that the axis of articulations is a delicate aspect in the unit, because, although there are some initiatives, they are isolated and there is low institutionalization in the Basic Healthcare Unit (BHU), what means that they depend on individual attitudes of some professionals. This fact is related to the model of team organization, the juxtaposition of knowledge and the centralization of roles, besides a management model that does not encourage the sharing of work instruments or therapeutic and institutional projects (Peduzzi, 2001; Brasil, 2007; Campos, 2010). An aspect that seemed to be positive is that the Basic Healthcare Unit (BHU) has large knowledge of the inter-sectorial network in the region, but the same knowledge cannot be seen in relation to community organizations that could also become partners.

Interaction among individuals in daily work

The interaction among adolescents and young adults and the health professionals seems to be cordial, but tends to be asymmetric and vertical, mainly, in healthcare spaces, when aspects related to the “demanding” and “little disciplined” character of the group are considered. Some activities that could be expanded, both in terms of physical space and distribution in the periods of healthcare service, sometimes, were not encouraged based on the relatively common criticism among the workers who do not integrate the specific Program that adolescents and young adults are inconvenient.

The toy room has created an adolescent, childish situation in which they come to the Unit and play in the parking lot, they are around the Unit... this creates more... the most hilarious situations possible. Employees get together to say that it is impossible to work with all the noise in the toy room. [...] The noise of children crying because of vaccine shots that echoes up here does not disturb us, but, when they are playing... this really bothers us. (Priscila, manager assistant)

As far as the professionals are concerned, we should point out the reduced institutional possibility for interaction based on formal spaces for discussions of themes, technologies, conceptions and projects for comprehensive care, or even, to exchange experiences on adolescent and young adults' healthcare, once the team meetings are focused on managing issues or isolated techniques and the participation is conditioned to individual availability.

I haven't attended the team's meeting for personal reasons... for about two years... because I am already too old to listen to some things, you know? And too old to talk about others. Then, for personal reasons, I haven't attended some meetings anymore... all the meetings, to be really frank, right? (Ana, physiotherapist)

In this sense, it is suitable to discuss the sense of personhood in the “choice” to attend or not the meetings – that are not, therefore, a requirement of the work management, - besides the necessity to point out a pattern of intersubjectivity in which there are difficulties regarding the mutual recognition of identities and otherness and dealing with diversity.

It is possible to draw a parallel between this pattern of professional inter-relationship and the way interaction takes place in the Basic Healthcare Unit (BHU) and its technical supervision, marked by a strong unidirectional character. It is mentioned, in this context, that some attempts to facilitate the appropriation of the physical space of the Unit by the users, through visual communication, for example, have been questioned by the regional technical supervision. That brought some embarrassment to the professionals that had proposed them and constraints to receive the users.

The analysis of the interactions between professionals and adolescents show low recognition by the former of the importance to value the intersubjective dimension in the healthcare work process. The nature of disciplinary actions and actions to rule the permanence of adolescents in the environment of the Basic Healthcare Unit (BHU), which disregard the characteristics of this phase of life, is particularly significant. Work in health claims primarily for meetings between users and workers and those moments may be configured in different ways: that is, from extreme situations that emphasize impersonality of health practices to the search for mutual recognition, what characterizes it as a real dialog (Ayres, 2004).

A summary of the results related to the four analytic axes of integrality can be seen in table 3

Table 3. Findings related to comprehensive healthcare for adolescents and young adults in the Primary Healthcare (PHC) unit.

Axes	Results (achievements and challenges)
Needs	Adolescents bring up sexuality, reproduction, socioeconomic and family issues. Professionals tend to work with actively expressed demands, based on an approach centered on complaints and biomedical interpretation.
Purposes	Diversified actions, but with little discussion on comprehensive healthcare projects and limited interfaces among health promotion, prevention, healing and rehabilitation.
Articulations	Healthcare attendance based on individual actions, limited integration of the multiprofessional team; relevant inter-sectorial actions in the region, but there is no institutional and inter-sectorial articulation policy with effective results.
Interactions	Cordial relationships, but with a tendency to verticality and asymmetry among young people, professionals and management. Low effectiveness of use of technological spaces for intersubjective construction of institutional healthcare projects. Weakness of the processes of recognition and mutual listening.

Conclusion: points of arrival and horizons in the path to integrality

The investigation shows us that, although there is effective perception of the specificity of healthcare to adolescents and young adults, as well as positive proposals to meet their needs in the healthcare service unit studied here, they are still insufficiently exploited and excessively dependent on individual initiatives, and developed upon the demands brought up by this public to the Basic Healthcare Unit (BHU). Thus, not only part of the needs of the group is not held, but also they are approached in a timid way in face of the potentialities identified in the unit for the construction of projects of comprehensive healthcare. We should highlight here the insufficiency of professional and sectorial interactions and the fragility of the communicational dimension in the meetings between professionals and users.

The construction of an effectively embracing space and efficient programmatic activities for this public still requires studies, attention and interest of workers and managers, as well as investments in different paths to the practice of integrality. It requires team co-responsibility, beginning with

management processes that enhance multiprofessional work and meetings, giving priority to the team work focused on changes in the routine of the healthcare service and improvement of quality of care provided.

The Primary Healthcare (PHC) requires attention to comprehensive health in opposition to the fragmentation of the work based on specializations; the recognition of social health needs of individuals and groups; and the commitment with comprehensive health production and care. This implies in instigating comprehensive practices, of different orders and distributed in different plans. In addition to that, the Primary Healthcare (PHC) has appropriate conditions to propose and implement these changes, since it is the main gateway to the Brazilian Unified Health System (SUS). This is true because it is based on the provision of attendance to specific territories and not to severe illnesses, as happens to secondary and tertiary healthcare; it brings innumerable elements to multiprofessional, transdisciplinary and inter-sectorial work; and it can be a perennial space for meetings and dialogs pervaded by intersubjective exchanges capable of producing healthier relationships and promoting communication and the construction of networks.

We cannot forget that the nature and quality of this kind of production, which is not material (a tangible product, as a drug, for example), but immaterial (attendance, meeting), is a way to build and rebuild the ways of thinking and acting in health.

The findings of this study indicate, in sum, that the design of actions in Primary Healthcare (PHC), especially aimed at adolescents and young adults, works positively as a differential capable of providing, simultaneously, the particularization of healthcare projects – according to a specific identity of the way of being (physical, mental, cultural, etc.) – of specific individuals, and the identification of needs and purposes that go beyond what is spontaneously demanded and clinically defined in the healthcare attendance services, enlarging it to aspects related to sociability, school, work, leisure, sexuality, reproduction, among others. However, this potential to move into the direction sought by the principle of integrality does not still have instruments to integrate and enhance the healthcare in the routine of team work and of the unit according to this broader and more complex perspective.

In this sense, it is reinforced that the major challenge in the construction of integrality is, in fact, in the intimacy of the work process with adolescents and young adults, as perhaps it may also happen with other identities that require integrality in the organization of healthcare. Even when the needs and purposes are in full process of expansion and requalification, as in the case studied here, it will be difficult to respond to them in an effective way while barriers that stand especially in the level of articulations (among knowledge, professionals, activities and activity sectors) and interactions (between professionals and users) are not overcome.

Therefore, they are emphasized here as paths to build/strengthen comprehensive healthcare technologies for taking care of adolescents and young adults at Primary Healthcare (PHC) (and possibly also for other identity groups that need to be cared through the comprehensive healthcare approach); an approach that considers: the improvement of spaces and careful listening mechanisms free from prejudice and moral condemnation of the health needs of individuals and populations; the active exercise of inter and transdisciplinarity, as well as of the democratic and participatory management of team work routines – including discussions of healthcare projects, for example; the establishment of solid relationships between the users and the professionals, by ensuring professional confidentiality and offering embracing environments; group work with problem-solving methodologies that provide opportunities to analyze situations and build possible responses to health needs based on the individuals' own experiences; systematic recording of activities and its shared access/use by all the professionals in different activities in the healthcare unit; activities of permanent education for all the professionals and in different activities; permanent education activities for users and professionals about the Brazilian Unified Health System (SUS), its aims and principles; network, formal and informal work, together with other healthcare units and social and community facilities.

Collaborators

José Ricardo Carvalho de Mesquita Ayres coordinated the elaboration and implementation of the research project, the general protocol and the adolescents and young adults components; he participated in the final analysis and writing of this article. Yara Maria de Carvalho participated in the elaboration and implementation of the research project, the general protocol and the adolescent and young adult components; she also participated in the field work and in various stages of analysis and writing of this article. Mariana Arantes Nasser, Rodrigo Marcinkevicius Saltão and Valéria Monteiro Mendes participated in the field work and in various stages of the analysis and writing of this article.

References

ABRAMO, H.W.; BRANCO, P.P.M. (orgs.). **Retratos da juventude brasileira: análises de uma pesquisa nacional**. São Paulo, Fundação Perseu Abramo; Porto Alegre, Instituto Cidadania, 2005.

AYRES, J.R.C.M. Ação programática e renovação das práticas médico-sanitárias: saúde e emancipação na adolescência. **Saúde em Debate**, v. 18, n. 42, 1994, p. 54-58.

_____. O cuidado, os modos de ser (do) humano e as práticas de saúde. **Saúde e Sociedade**, v.13, n.3, 2004, p.16-29.

_____. Organização das Ações de Atenção à Saúde: modelos e práticas. **Saúde e Sociedade**, v.18, n.2, 2009, p.11-23.

AYRES, J.R.C.M.; FRANÇA JÚNIOR, I. Saúde do Adolescente. In: SCHRAIBER, L.B.; NEMES, M.I.B.; MENDES-GONÇALVES, R.B. (orgs.). **Saúde do adulto: programas e ações na unidade básica**. São Paulo: Hucitec, 1996, p. 66-85.

BRASIL. Palácio do Governo. Casa Civil. **Lei n. 8069**, de 13 de julho de 1990. Dispõe sobre o Estatuto da Criança e do Adolescente e dá outras providências. Disponível em: <www.planalto.gov.br/ccivil_03/Leis/L8069.htm>. Acesso em: 17 jul. 2011.

_____. Ministério da Saúde. Secretaria de Atenção em Saúde. Departamento de Ações Programáticas Estratégicas. **Diretrizes nacionais para a atenção integral à saúde de adolescentes e jovens na promoção, proteção e recuperação da saúde**. (Série A. Normas e Manuais Técnicos). Brasília, DF, 2010.

_____. Ministério da Saúde. Programa Nacional de Humanização. **Cartilha HumanizaSUS: Gestão participativa / Co-gestão**. Brasília, 2007. Disponível em: <http://bvsms.saude.gov.br/bvs/publicacoes/gestao_participativa_co_gestao.pdf>. Acesso em: 17 dez. 2011.

CAMPOS, G.W.S. Cogestão e neoartesanato: elementos conceituais para repensar o trabalho em saúde combinando responsabilidade e autonomia. **Ciência & Saúde Coletiva**, v.15, n.5, 2010, p. 2337-2344.

COATES, V.; BEZNOS, V.W.; FRANÇOSO, L.A. (orgs.). **Medicina do Adolescente**. São Paulo: Sarvier, 2003.

MATTOS, R.A. Os sentidos da integralidade: algumas reflexões acerca dos valores que merecem ser definidos. In: PINHEIRO, R; MATTOS, R.A. (orgs.). **Os sentidos da integralidade na atenção e no cuidado à saúde**. Rio de Janeiro, UERJ/IMS, 2001, p. 39-64.

_____. A integralidade na prática (ou sobre a prática da integralidade). **Cadernos de Saúde Pública**, v.20, n.5, 2004, p.1411-6.

MENDES-GONÇALVES, R.B. **Tecnologia e organização social das práticas de saúde**: características do processo de trabalho na rede estadual de centros de saúde de São Paulo. São Paulo: Hucitec-ABRASCO, 1994.

MUUSS, R. **Teorias da adolescência**. Belo Horizonte: Interlivros, 5ª edição, 1976.

OLIVEIRA, M.C. (org.). **Cultura, adolescência, saúde: Argentina, Brasil, México**. Campinas, **Consórcio de Programas em Saúde Reprodutiva e Sexualidade na América Latina** (CEDES/COLMEX/NEPO-UNICAMP), 1999.

OMS. **El embarazo y el aborto en la adolescencia**. Genebra, 1975.

OZELLA, S. (org.). **Adolescências construídas**: a visão da psicologia sócio-histórica. São Paulo: Cortez, 2003.

PEDUZZI, M. 2001. Equipe multiprofissional de saúde: conceito e tipologia. **Revista de Saúde Pública**, v. 35, n.1, 2001, p.103-9.

QUEIROZ, L.B. **A medicina de adolescentes no Estado de São Paulo de 1970 a 1990**: uma dimensão histórica. São Paulo, 2011 (Dissertação de Mestrado – Faculdade de Medicina da USP).

SAITO, M.I.; SILVA, L.E.V.; LEAL, M.M. (orgs.). **Adolescência, prevenção e risco**. 2. Ed. São Paulo: Atheneu, 2008.

SCHRAIBER, L.B.; MENDES-GONÇALVES, R.B. Necessidades de saúde e atenção primária. In: SCHRAIBER, L.B.; NEMES, M.I.B.; MENDES-Gonçalves, R.B. **Saúde do adulto**: programas e ações na unidade básica. São Paulo: Hucitec, 1996, p. 29-47.

SETIAN, N.; COLLI, A.; MARCONDES, E. (orgs.). **Adolescência**. São Paulo: Sarvier, 1979.

STARFIELD, B. **Atenção primária**: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília: UNESCO, Ministério da Saúde, 2002.

VASCONCELOS, C.M.; PASCHE, D.F. O Sistema Único de Saúde. In: CAMPOS, G.W.S. et al. (Orgs.). **Tratado de saúde coletiva**. São Paulo: Hucitec; Rio de Janeiro: Fiocruz, 2006, p. 531-62.

ⁱ Address: Departamento de Medicina Preventiva, Faculdade de Medicina da Universidade de São Paulo (Department of Preventive Medicine, University of Medicine from the University of São Paulo). Av. Dr. Arnaldo, 455, 2º andar, São Paulo, SP, Brasil. 01.246-903.

Translated by Maria Aparecida Gazotti Vallim.

Translation from **Interface - Comunicação, Saúde, Educação**, Botucatu, v.16, n. 41, p. 67 - 81, 2012.