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Attention to school complaints in the view of primary health care professionals in the city of Campinas

Atenção às queixas escolares na visão de profissionais da atenção primária à saúde no município de Campinas

Atención a las quejas escolares en la visión de profesionales de la atención primaria de salud en el municipio de Campinas

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Abstract

Introduction: School complaints also emerge in primary health care. Therefore, a multiprofessional team of the health department of a municipality in São Paulo developed a protocol that guide the referral of children and adolescents who need clinical care in this area. **Purpose:** To analyze from the point of view of primary health care professionals how school complaints have been received, including the application of the protocol organized specifically for these referrals. **Methods:** Qualitative study, for which five basic health units of the municipality were selected. Then, ten questionnaires were distributed in each unit for professionals to respond. These questionnaires sought to identify the professionals' perceptions regarding the school complaints received at the unit where they work, besides the application of the protocol in the work routine. **Results:** 27 questionnaires were answered. The protocol is completed in a multidisciplinary way, offering the opportunity for the child / adolescent to be evaluated in its different aspects and environments. However, most professionals consider possible changes in the process of

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APS: study design, methodology, data collection, writing of the article
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acquisition of reading and writing, as organic origin, which coincides with the protocol, which opens space for the proposition of an organic cause for the learning problem. **Conclusion:** There is a need for a better understanding of the health-education relationship that is established in primary care, and how the learning disorders are understood in the country, because in this study the low value of family and social relationships in the acquisition of reading and writing was verified.

Keywords: Speech, Language and Hearing Sciences; Primary Health Care; Child Health; Learning Disorders.

Resumo

Introdução: As queixas escolares também emergem na atenção primária à saúde. Por isso, uma equipe multiprofissional da secretaria de saúde de um município do interior paulista elaborou um protocolo que rege o encaminhamento de crianças e adolescentes que necessitam de atendimento clínico nessa área. **Objetivo:** Analisar sob a ótica dos profissionais da atenção primária à saúde como as queixas escolares têm sido acolhidas, incluindo a aplicação do protocolo organizado especificamente para esses encaminhamentos. **Método:** Estudo qualitativo, para o qual foram selecionadas cinco unidades básicas de saúde do município. Em seguida, distribuídos dez questionários em cada unidade para os profissionais responderem. Esses questionários buscaram identificar a percepção dos profissionais em relação às queixas escolares acolhidas na unidade onde trabalham, além da aplicação do protocolo na rotina de trabalho. **Resultados:** 27 questionários foram respondidos. O protocolo é preenchido de forma multidisciplinar, pela equipe de saúde e pela escola, oferecendo a oportunidade da criança/adolescente ser avaliada em seus diferentes aspectos e ambientes. Entretanto, a maioria dos profissionais encaram as possíveis alterações no processo de aquisição da leitura e escrita, como de origem orgânica, que coincide com o protocolo, que abre espaço para a proposição de uma causa orgânica para o problema de aprendizagem. **Conclusão:** É necessária maior compreensão da relação saúde-educação que tem sido estabelecida na atenção primária, e como as queixas escolares têm sido compreendidas, já que neste estudo constatou-se a pouca valorização das relações familiares e sociais para o processo de aquisição da leitura e da escrita.

Palavras-chave: Fonoaudiologia; Atenção Primária à Saúde; Saúde da Criança; Transtornos de Aprendizagem.

Resumen

Introducción: Para entender mejor las quejas escolares que llegan a la Atención Primaria un equipo multiprofesional de un municipio del interior paulista elaboró un protocolo que rige el encaminamiento de niños y adolescentes que necesitan atención clínica en esa área. **Objetivo:** Analizar las impressiones de los profesionales de la atención primaria de salud como las quejas escolares han sido acogidas, incluyendo la aplicación del protocolo organizado específicamente para esos encaminamientos. **Metodos:** Estudio cualitativo, para el cual se seleccionaron cinco unidades básicas de salud del municipio. Se han distribuido diez cuestionarios en cada unidad para que los profesionales respondan. Estos cuestionarios buscaron identificar su percepción en relación a las quejas escolares recibidas en la unidad en que actúan, y la aplicación del protocolo en la rutina de trabajo. **Resultados:** 27 cuestionarios respondidos. El protocolo se llena de forma multidisciplinaria, ofreciendo la oportunidad del niño / adolescente ser evaluada en sus diferentes aspectos y ambientes. La mayoría de los profesionales encaran las posibles alteraciones en el proceso de adquisición de la lectura y escritura, como de origen orgánico, que coincide con el protocolo, que abre espacio para la proposición de una causa orgánica para el problema de aprendizaje. **Conclusión:** Es necesaria una mayor comprensión de la relación salud-educación que se ha establecido en la atención primaria, y cómo las quejas escolares han sido comprendidas, ya que en este estudio se constató la poca valoración de las relaciones familiares y sociales en la adquisición de la lectura y de la escritura.

Palabras claves: Fonoaudiología; Atención Primaria de Salud; Salud del Niño; Trastornos del Aprendizaje.

Introduction

Many issues may arise to learners as complicating factors during the written language acquisition process, such as the lack of contact with written material, auditory, visual and speech problems[1], organic[2,3,4], cognitive[2,4], and psychosocial issues[1-5], family dynamics[1,3-7], pedagogical issues[2,5-9], relationship with teacher and peers[5,7], political[5], socioeconomic and cultural issues[6], and hospitalizations and institutionalization[4]. This leads many authors to understand learning difficulties as multifactorial issues[1-3,5-7,10].

These difficulties presented by many children during the learning process could also be justified by the importance of reading and writing habits in the environment where they live and how much the school understand their experiences related to these skills[1]. In addition, learning difficulties may also be related to the emergence of problematic behaviors within and outside the school environment[1,4,8] and to emotional problems[4,9].

As each child will establish a unique relationship with written language, it will be based on their school, family and social experiences, which are intrinsic to their constitution as a subject. It is possible to notice several factors that impact on children's reading and writing learning, such as: a) school influences: those related to school choice[11], pedagogical method[5-7,11], capacity building[5,7,10] and motivation[5] of teachers, as well as to the activities proposed, evaluation methods, access to learning materials[11], facilities[5], or changes related to teachers, classrooms and school[4;] b) family influences: those related to school life monitoring, participation in home activities[12], characteristics of parents, family functioning[4], organization of the home environment[4,12], verbal encouragement[12], parents' education and profession, written materials available, the value given to the written language[11], family-school relationship[12]; c) social influences: those related or not related to precarious financial conditions[4], participation of literate practices in different environments, and not only in the school and family environments[11].

The way the relationship of the child with the written language is structured shows the influence of the factors mentioned in the learning process[11]. Thus, the experience with written language early in school life may be closely linked to success in the learning process[1].

Historically, the school aims to homogenize the students, and to place children in the same level of learning with similar knowledge[13]**.** This goal of the school institution distances the diversity of educational practices, generating numerous complaints and referrals of children who have distinct teaching and learning processes. The multifaceted aspect of the teaching and learning processes is not considered and, consequently, the school has supported the complaints in organic and family aspects, which culminate in the referral of children to health services[14,15].

Thus, complaints related to learning difficulties have generated frequent referrals from schools to health services[2,5,10] that could also be justified by the fact that teachers don't understand these learning difficulties[2,10,14], which would lead to inadequate referrals of children who do not have any learning disorder, and the lack of appropriate interventions that could ensure the learning process[2]. Faced with the unknown situation, it is common to justify the difficulties presented with family and/or physical problems. As this difficulty does not concern the school, there is a referral to health professionals[10,15]. However, the problem may be directly related to the pedagogical practice adopted by the school, and to reflect this reinforces the need to investigate in the classroom if there is a problem, or if the learning process of children is permeated by teaching problems. And if there is a problem, the professional should try to understand it to better solve it[2,10].

In Primary Health Care, the professional who performs the first listening can identify their vulnerabilities, classify the risk to set the priorities of their care and refer them to the care according to their classification[16]. However, when the complaint is related to learning difficulties, there may be losses in the overall process including the referral, diagnosis, therapy and child and family care, due to the communication issue between health and education professionals. As it involves knowledge and practices in the understanding of learning disabilities, this cross-sector interaction may be impracticable[5], which leads to the emergence of a demand for primary care that will be heard, reflected and understood in the biomedical model, generating more timely and healing behaviors[17], disregarding its multifactorial aspects[18].

Screening tools that can be used by different health professionals may be needed for primary care, due to the belief that they may contribute to

the systematization of the evaluation, as long as their application is simple and efficient to detect any risk of change[19,20]. The use of protocols is critical in public health for communication between services, even if that occurs only for reference and counter-reference forms[21]. However, the professional should be aware to listen to the complaints from children and their families in order to qualify the service provided[19,20]. These instruments cannot be simply interposed between the health professional and the user, who have unique characteristics, putting at risk the care and potentially leading to inappropriate behaviors[21]. Tests imply in overestimating the object that is being evaluated, which is just one form of an infinitude of actions that may be expressed and may imply a devaluation of what is said by the person evaluated and his carers[13].

Campinas (SP) has a service specialized in children and adolescents care with school complaints, the Interdisciplinary Knowledge in Learning (*SABIÁ*), which in an attempt to better organize the referral flow to the service, has developed a protocol that allows a comprehensive look at the child and/or adolescent who presents complaints in the process of reading and writing acquisition. This referral protocol allows an interface between health and education, by promoting clinical research of school life, family relationship and sociocultural aspects of the school. Despite the great importance of action promoted by the *SABIÁ* initiative, by bringing the school as co-responsible for the investigation process of the school complaint, the operation of the protocol still needs to be widely reviewed in order to understand its effectiveness for its purposes.

In this sense, this study that was developed as term paper of the Multiprofessional Residency Program in Child and Adolescent Health aims to analyze the referral protocol of children with school complaints for the specialized service in the assessment and therapy related to educational issues, *SABIÁ*, from the point of view of primary health care professionals.

Method

This is a qualitative study approved by the Research Ethics Committee (REC) of the University of Campinas under the No. 73265717.2.0000.5404.

The study was conducted as qualitative research, because "when we deal with health and disease, these categories bring a historical, cultural, political and ideological burden that cannot be addressed using only a numerical formula or statistical data"[22]. In addition to the superficial aspects, the researcher must understand the complexities that make up the reality, since they summarize knowledge that materializes in different disciplines and also, that transcends the scientific knowledge[22].

The study, which was developed at the School of Medical Sciences of UNICAMP in a partnership with the Municipal Health Department of Campinas, enrolled five Health Units (UBSs) for data collection, one from each health district of the municipality (Northern, Southern, Northwestern, Southwestern And Eastern).

The UBSs were selected by telephone call. Only the UBSs that were successfully contacted were selected for the study. In this call, the UBS coordinators were informed about the research, its objective and that it would be conducted through questionnaires, which would be delivered personally. In addition, these coordinators received by e-mail the statement signed by the Secretary of Health along with the REC's opinion.

In December 2017, all units were provided with 10 questionnaires along with the FIC in sealed packages to be distributed to all professionals involved in the care of children and adolescents with school complaints. The coordinators of the Primary Care Units were responsible for the distribution of the questionnaires and were asked to have it answered individually and sealed immediately after completion. After a month, the responsible researcher collected the questionnaires from each of the five UBS.

The questionnaire aimed to investigate the perception of several primary health care professionals on school complaints received at the UBS where they work, as well as general knowledge about the *SABIÁ* and more specifically on the use of the protocol (completion of referral forms) arranged by the *SABIÁ* in the routine of each unit

The participants of the research were professionals from Primary Health Care Units of Campinas (nurses, physicians, mental health staff - psychologist and occupational therapist, among others), who are in some way linked to the care (individual and/or group) of children and adolescents. Given the purpose of the study, the research excluded all professionals who do not provide care (individual and/or group) of children and adoles-

cents with school complaints in the primary care unit where they work.

The qualitative analysis was based on Content Analysis, which is "a set of communications analysis techniques in order to obtain, through systematic and objective procedures of description of message content, indicators (quantitative or not) that allow the inference of knowledge related to the production/reception conditions (inferred variables) of these messages"[23].

Results

The instrument provided by *SABIÁ* consists of three referral forms that together include, respectively: the clinical, school and social history of the child/adolescent. For a city with more than one million people with a single service specialized in dealing with learning complaints in the public health network, the instrument can provide greater assertiveness of referrals, by filtering the (supposedly) school demand of the UBS.

According to the *Guidance for Referral to SABIÁ*, the inclusion criteria adopted for the service are: the child must be between 7 and 14 years and 6 months old and also must be enrolled from the 2nd to the 9th grade; there should be a case discussion in a meeting in the Health Districts (Mixed Network/ Children and Adolescents Network/Matrix-Based Strategies) with the participation of the *SABIÁ* team and completion of the forms that will be mentioned and explained below. The Guidance emphasizes team discussion, since "learning difficulties" can be mistaken with "school complaints" and also advocates the use of referral forms that aim to help in the construction of care networks and in the construction of the PTS (Unique Therapeutic Project).

The referral forms, which make up the protocol, are classified as: a) Clinical Health Assessment; b) Complementary Observations of the Health Team; and c) School Observation Protocol. The first form is the shortest one, which consists of two pages and investigates the clinical history of the child/adolescent since pregnancy, neuropsychomotor development, sensory disabilities, dysmorphic signs, hereditary diseases, drug treatments or therapies, nutritional status and environmental risk. In addition to the clinical aspects, this form requires information on the school material.

The second form, Complementary Observations of the Health Team, consists of four pages, two of which are an evaluation journey. The first page focuses on the cultural and organizational aspects of the family, and to investigate the structure of the house, family dynamics and its involvement in the education of the child/adolescent, in addition to the social risks. The remaining pages contain a suggested evaluation for the reading, writing, mathematics and drawing production of the child/ adolescent. In addition, it asks for the description of the child/adolescent by the professional.

Finally, School Observation Protocol, which is the third and longer form and should be completed by the teacher. It consists of four pages, covering the education history, motor, perceptive and affective-emotional aspects, oral communication, reading, writing and mathematics, as well as classroom behavior and the family relationship with the education of the child. The form is completed with the conducts of the school.

In this way, the *SABIÁ* protocol is completed in a multidisciplinary way, that is, the physician and other members of the health team and school are responsible for it, what provide the opportunity for the child/adolescent to be seen and evaluated in its different aspects and environments.

According to the flow established by the service, after its completion, the material follows to the matrix-based strategies with participation of the *SABIÁ* team in order to decide if the case must be accepted. If there is a decision that the child/adolescent should not remain in the *SABIÁ*, other behaviors will be discussed according to the matrix-based strategies.

As previously mentioned, 50 questionnaires were distributed in five UBS at Campinas. Each unit received 10 questionnaires. And 27 completed questionnaires were collected. Table 1 shows that Pediatricians, Nursing Team (Nurses, Nursing Technician and Nursing Assistant), Occupational Therapists, Psychologists and a Dentist are among the participating professionals.

Table 1. Distribution of professionals among health districts

Professionals \ Districts		Northern	Southern	Eastern	South-western	North-western	Number of professionals by category	
							n	%
Physician		2		2	2	3	9	33,5
Nursing staff		4		3	2		9	33,5
Psychologist		2				1	3	11
Occupational Therapist					1	1	2	7,5
Dentist					1		1	3,5
No answer			3				3	11
Number of professionals by Health District	n	8	3	5	6	5	**27**	
	%	29,5	11	18,5	22	18,5	**100**	

Table 2 shows the knowledge about the changes that may occur in the learning process, which was obtained from the answers of professionals. Among all professionals, only one reported that he never heard about changes in the learning process, even though he was working for almost ten years in the same UBS. Only a few professionals reported their working time at the UBS. Regarding the existence of cases related to learning disorders, four (15%) professionals reported that these cases are not common in the unit where they work.

Table 2. Knowledge of professionals concerning changes in the learning process

- They recognize that they are multifactorial, influenced by language, motor, psychic, auditory, visual, psychiatric and neurological difficulties;
- They emphasize the importance of physical, family and cultural aspects to be evaluated;
- They affect the learning of new knowledge/skills;
- They result in a discrepancy in the time required to the learning process causing the child to distance himself from the group in which he is inserted in school;
- They fail to achieve expected goals in the school process, such as reading, writing, and math;
- When investigated, they may be due to dyslexia, dyscalculia, ADHD, among other disorders.

The professionals report that the family is welcomed at UBS to better understand the complaint and to understand its dynamics. Parents are instructed and an appointment is scheduled with the pediatrician or mental health team. A home visit is conducted, if required. The child is inserted in a non-specialized care, either individually or in groups at the Health Center, while they are referred to the *SABIÁ*. A school report is requested and the form related to the school data (School Observation Protocol) is submitted to the teacher for completion. If required, the child/adolescent is referred for specific evaluations with speech-language pathologist and neurologist and for a visual examination. Alongside this, the referral forms (Clinical Health Assessment and Complementary Observations of the Health Team) are completed. Consequently, the case is discussed in the matrix-based strategies conducted by the *SABIÁ* or at a meeting of the Child Network, where they will decide which cases will be included in the service. It is possible to notice that only serious cases are required to complete the *SABIÁ* forms in some UBSs. Among these professionals, only three (11%) never received learning cases, namely, two nurses and the dentist. Regarding the application of the forms, 13 (48%) professionals never applied them in their routine in the UBS. Pediatricians, psychologists and an

occupational therapist are among those who applied the forms.

Among all professionals, only three (11%) nurses did not know the *SABIÁ*, which is the reference service in learning difficulties care in the city. When asked if they know the referral forms, seven (26%) nurses reported that they did not know this instrument. 24 (89%) professionals reported that there have been patients referred to care in their units, while one professional (3.5%) reported that any patient was referred by it to his unit, and two (7.5%) did not know.

Most (66.5%) of the professionals reported the need for training to apply the referral forms. On the other hand, only eight (29.5%) professionals (six pediatricians and two who did not report their profession) disagreed and one (3.5%) professional did not respond. As for the characterization of the forms proposed by the service, 40.5% reported that they believe that the forms are objective, while 15% reported that the forms are understandable, and 15% reported that it is difficult to implement. Finally, 18.5% reported that the forms are restrictive (professionals were allowed to provide multiple answers).

According to the reading and interpretation of other answers obtained by the questionnaires on the knowledge about the changes in the learning process, the *SABIÁ* and its referral forms, the following categories were obtained: Efficaciousness of referrals to the *SABIÁ*, Care continuity in cases not included in *SABIÁ*, Benefits and disadvantages of referral forms and Opinion with respect to the care of changes in the learning process. These results are shown in Table 3.

Table 3. Distribution of answers obtained in the questionnaires according to categories of significance

Efficaciousness of referrals to *SABIÁ*	Care continuity in cases not included in *SABIÁ*	Benefits and disadvantages of referral forms	Opinion with respect to the care of changes in the learning process
Few cases have managed to progress at *SABIÁ* and some professionals indicated difficulties in finding a place due to delay in hearing, school and other evaluations, in addition to factors that are not only physical (social and family) impacting the learning process, and the priority for children with greater difficulties. Some were not included in the service as they were not referred according to requirements. Some professionals also indicated the lack of human resources of the service and the demand greater than the supply as obstacles to the resolution of the referrals. In addition, some patients did not join the service, or relatives did not return to the service.	Children who have not been able to receive medical care remain on the waiting list or they return to the Health Center for individual or group care with Mental Health professionals, or in social facilities and NGOs. In some cases, children/adolescents only receive guidance and attend school with more support. In other cases, parents seek care in private service.	The referral forms help to broaden the knowledge of cases, to direct the investigation of important items for history detailing, and to stimulate team discussion. The referral forms also provide an instrument for better evaluation of the case and help in checking the need for referral to *SABIÁ*. These forms are extensive and require time to be completed and, as there are three forms, more time is required in order to gather them. Therefore, it causes a delay in identifying the causes related to the difficulty presented by the child. It is difficult to include the evaluations in the routine of the professional, since they require more time than the other consultations and, sometimes, they require the patient to return, which may prevent the conclusion of the process. This generates inefficient forms that are complex and confusing.	The service receives a very specific demand for changes in the learning process, which does not include social and/or family issues, referred to as "pure". Learning difficulties should be considered in the range of possibilities of their causes. In addition, it does not seem correct to exclude adolescents above 14 years of age from the possibility of care, as well as children who are literate, but who still present some difficulty. There is a need for a service that includes children/adolescents who are not included in *SABIÁ*, since Health Centers should not meet a specialized demand.

Discussion

The multifactorial aspect of the changes in the learning process was disseminated among the professionals participating in this study, as shown in Table 2. However, many professionals (55.5%) associate these changes to several physical causes and at no time they associate it to external causes, such as school, family and social aspects, which are also very important in reading and writing acquisition process[4,11,12]. Of these, a small group (11%) reported non-physical influences as potential barriers to learning, but they did not rule out the possibility of physical causes. Eight professionals (29.5%) did not report physical aspects as causes of complaints related to learning. The recurrence of a view focused on the physical factors as main cause for changes in the learning process can be a reflection of the biomedical model, which still prevails in health care practices[17]. This model structures its practices based in the centrality of the subject, which opposes the purpose of the Family Health Strategy, in conceiving a subject that is based on his history, governed by social, cultural and family experiences. That is, an individual who is part of a community and cannot be understood alone, but in an integral way [18] .

This view can be reinforced by the intense physical emphasis present in the *SABIÁ* referral forms. Since there is a specific form to investigate the clinical history of the child/adolescent (Clinical Health Assessment), and almost two pages in the form are related to the school (School Observation Protocol). On the other hand, family and social issues are restricted to a page in the Complementary Observations of the Health Team, as well as with some items repeated in the Clinical Health Assessment form and some questions in the School Observation Protocol. The instrument itself opens space for proposing a physical cause for the learning problem of the child/adolescent.

The participants have a clear idea about a possible homogeneity of the classroom, by stigmatizing the child/adolescent who does not learn or who is not in the same pace of learning compared to the class. The answers shown in Table 2 allow us to reflect on the expectation that all schoolchildren acquire knowledge at the same pace and that there can be no disparities between them. Time is an important variable in the teaching-learning process; however, the different paces of learning in the classroom should be noted[24]. However, when there is a disparity, study participants associated it to physical factors, what assigns the responsibility of the teaching-learning process only to the child/adolescent, and ignores that school failure also results from educational policies from the school institution itself[2,10,13,14]. This assignment embodies a label of "non-learners" in the child/adolescent, which affects not only their school life, but all aspects of their life. As so, the child/adolescent "ceases to be incapable in school to become just an incapable person." And if the cause is physical, it is assumed that it will be referred to a health professional for an evaluation. Finally, this process will result in a diagnosis that is not always the solution to the so-called "problem", but it will be enough to reassure the conflict that a disparate child/adolescent causes at school[13].

The frequent referrals generated by the school[2,5,10] indicates that school institutions have not been held responsible for the education of children/adolescents who have different learning processes and who do not fulfill educational expectations.[25]. The school starts to perform an early identification of possible learning problems, which can be attributed, in part, to the media availability of descriptive material on mental disorders that allow the classification of schoolchildren, making diagnoses and becoming a technique for referral to health care services[25]. As indicated by the professionals in Table 3, referrals for complaints of learning difficulties have generated a demand that exceeds the capacity of *SABIÁ*. This situation limits the access of many students to specialized care, thus generating a repressed demand and a long queue at the UBS, since this is the gateway of the user to health care. However, the number of referrals is not the only complication to maintain the child/adolescent in the *SABIÁ*, but also the waiting for exams and school evaluations that meet the requirements of the service.

What draws attention in the answers of the professionals is that they reported that one of the difficulties to get a place in *SABIÁ* is to have social and familiar factors that interfere in the learning process in their history (which is provided to the matrix-based strategies). A contradiction can be observed in this respect. According to the analysis of the answers, there is a dissemination of the idea that the service only accepts children who present physical factors that change the reading and writing

acquisition process. Professionals also reported that the cases discussed in the matrix-based strategies and chosen to be evaluated by them have been quickly scheduled, although they have not specified the time required exactly. Another issue that disturbs professionals is the age limit of 14 years for insertion of children/adolescents in the service, since learning problems can be long lasting, causing damages in activities involving reading and writing, reflecting also in social and professional life[26].

In order to understand the referrals generated by schools to UBS, then, through the data set comes the idea that the relevance of physical factors for health professionals from UBS, as well as for *SABIÁ* staff reflects directly on the way the schools has seen children/adolescents who differ from the group of students in the learning process. This situation when combined with the exposure of medical knowledge by the media, as mentioned, generates anxiety for a diagnosis as a pedagogical solution to solve the situation of those who have not reached the goals that are assigned to them[25]. The referrals generated by the schools create a first demand to the UBS that is directed to the *SABIÁ*. On the other hand, the inclusion criteria of this service generate an excluded demand that has returned to the UBSs, generating a queue, or a care provided by professionals who are not specialists in aspects of reading and writing, or by the mental health team, private services, social equipment and Non-Governmental Organizations (NGOs). However, it is important that these referrals to other services are not limited to a simple referral, but that there is co-responsibility and active participation of the referent, from the arrival of the patient to the new destination and in the follow-up of the case, as sometimes the UBS only transfer the referral to a specialist[27].

The *SABIÁ* referral forms are important for some participants, as they promote the investigation of the child/adolescent's history, and since they cause an intersectoral mobilization to understand the subject that arrives at the UBS in an integral way. However, 48% of the participants have never used them in their routine. Pediatricians, psychologists and an occupational therapist are among the 52% who applied the forms. A study carried out in São Paulo, which aimed to verify the efficacy of guiding pre-school teachers through monthly journals, selected schools that participated in the "*FONO Program at School*" and received monthly journals with speech-language pathology topics addressed to teachers in order to "provide [...] the basic principles of speech-language pathology that can contribute to their classroom practice". With this initiative, the authors realized that the information provided to teachers contributes to the qualification of the referrals that are carried out by them. The authors also reported that it is up to the speech-language pathologist not only to provide tools to detect the changes, but also to contribute with means so that teachers in their routine can also help in the process of language development[28]. In another study also conducted in São Paulo[5], a service focused on learning issues created a referral guide that, according to the authors, "sought to optimize and provide tools to the teacher to identify, discriminate and size the learning difficulties of a student that the teacher intended to refer to health services." Based on this experience, they reported that there was a greater understanding of the child's situation by the health team, which coincides with this research. In addition, the provision of tools that was mentioned as objective of the study is one of the benefits present in the answers of professionals with respect to the use of the forms from *SABIÁ*. While the provision of tools to teachers for identification, discrimination, and measurement of learning complaints is regarded as positive,[5] another study indicates that referrals are a factor that promotes referrals, and it decreases the responsibility of teachers for solving conflicts in the learning process of their students[25].

Some authors[29] report that:

> "The energy expended in the evaluation and referral procedures should be redirected to the training and monitoring of educators, with a view to child development. Therefore, part of the existing problems (lack of professional availability in order to maximize primary prevention, high demand in the evaluation service with respect to the professional availability, queue) would be effectively reduced due to the formation of multiplier agents in the school. [...] A simple diagnosis does not mean a solution to the problem, but a problem generated for the family, the child, and the school."

On the other hand, a group of professionals composed of pediatricians, nurses, psychologists and an occupational therapist understand that the forms are extensive, and require a lot of time to be completed in a consultation and to be gathered.

They also say that the forms are complex, confusing, inefficient, and absolutely contrary to what is expected for instruments to be used in the UBS[19,20]. While 40.5% believe that the forms are objective, 66.5% of professionals understand that a training is required to its application. As for the 18.5% that understand that the forms are restrictive, it should be emphasized that it should not be an impediment in the care provided to the child/adolescent and their family, since the primary care professional should qualify the care provided, valuing the individuality of each subject that is referred to his/her evaluation[19,20,21], not limiting the investigation only to what is proposed in the instrument. As for its size and the amount of time required to complete it, it is suggested to combine the *Clinical Health Assessment* and the *Complementary Observations of the Health Team* forms in just one form: which could be called as *Health Team Observation Protocol*. Thus, by removing the items that are repeated on the two forms and combining other items (such as the items that investigate the existence of diseases) there would be a single form composed of about two and a half pages instead of four. Another suggestion would be to avoid the attachments, which pre-determine activities to be conducted and to perform an informal screening that does not establish a direct relationship with school activities, which could value the spontaneity of the moment of evaluation, and also could investigate what the child/adolescent can do; therefore, directing the research from what has already been obtained[13]. On the other hand, the school should make an overall assessment of its performance. In addition to the analysis of school material, the school could be responsible for attaching photocopies of the school material that justify the complaint, to further contribute to the child/adolescent evaluation process.

Conclusion

Case discussion from protocol data in matrix-based strategies enables the learning of knowledge on this demand, which arises in professionals from other fields, such as the speech-language pathologists, in schools of the municipality. Through the collected data, the complaint reported by the patient, the caregiver and the school, is qualified, thus allowing the root cause analysis of the issue reported, and allowing to "choose" the most appropriate course of action. In addition, it promotes the relationship of specialized care with primary health care, reducing the gap between the services in the municipal health network.

However, the protocol, which, for the most part, consists of items that investigate clinical aspects in the child/adolescent's history, indicates the premise of changes in the reading and writing acquisition process due to physical factors. The organicist view that prevails among professional participants, when combined with the idea resulting from the protocol, is faced with a subject that produces a demand and becomes, first of all, a subject with a "learning problem", in any environment (at school, at home, or at the UBS). So this subject is recognized only by the physical problem that needs to be evaluated and diagnosed, even if it does not exist. Then, the search for a diagnosis arises and is encouraged by the school in order to solve a problem that the school environment should try to understand and solve.

Therefore, there is a need to held more conversations with schools, which are the sources of referrals, so that they become aware of the demand they have produced, since it is possible that this is not even a real demand, but only a situation with children who are in their normal learning process, which differs from others. And they must understand that they can differ from others, since reading and writing learning process is an individual construction that reflects the daily family, social or school experiences that are provided to the child/adolescent.

However, it cannot be overlooked that primary care professionals also need spaces with matrix-based strategies where they can discuss learning issues, which are not limited to educational knowledge, since it is a recurring health demand. Believing that a diagnosis and referral to *SABIÁ* is a solution to the demand of the UBS, is also lack of understanding that the care with non-specialist professionals is equivalent to not taking care of this population, as required.

Proposals as hiring more professionals or increasing the service capacity so that more children can be assisted, or even the review of the inclusion criteria to *SABIÁ*, may not be the main conclusion of this work. Since structural change without reflecting on how school complaints have been addressed by health and education professionals would not provide a meaningful transformation. More than ever, children/adolescents need profes-

sionals who do not attribute to them something that is beyond their own responsibilities. More studies are needed for a better understanding of the health-education relationship that has been established in primary care, and how school complaints have been addressed in the country.

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