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# Evaluation of the Family Healthcare Strategy from the Perspective of Health Professionals

## *Avaliação da Estratégia Saúde da Família na Perspectiva dos Profissionais de Saúde*

## *Evaluación de la Estrategia de Salud de la Familia en la Perspectiva de Profesionales de Salud*

Eliane de Fátima Almeida Lima[1]
Ana Inês Sousa[2]
Franciele Marabotti Costa Leite[1]
Rita de Cassia Duarte Lima[1]
Maria Helena do Nascimento Souza[2]
Cândida Caniçali Primo[1]

1. Universidade Federal do Espírito Santo. Vitória, ES, Brazil.
2. Universidade Federal do Rio de Janeiro. Rio de Janeiro, RJ, Brazil.

## Abstract

**Objective:** To evaluate the quality of the Family Health Strategy (FHS) by the attributes of Primary Healthcare in the healthcare professional's perspective; and to VERIFY the association between These attributes and the socio-demographic and professional characteristics of the FHS staff. **Methods:** This is a cross-sectional study. For data collection, the questionnaire That Is validated in Brazil was used, called 'The Primary Care Assessment Tool' (PCATool). The instrument was applied to 205 professionals acting in Family Healthcare Teams. To VERIFY the associations, the Fisher Exact Test, the Pearson chi-square test's, and logistic regression Were used. **Results:** The dimensions more positively Were Evaluated: Family Instruction and Longitudinality. When Associating the essential attributes of Instruction Level and Previous Experience in the FHS was found to be significant. **Conclusion:** The professionals perceive the attention offered the successful, contributing positively to strengthening and humanizing basic healthcare.

**Keywords:** Primary Health Care; Family Healthcare; Nursing.

## Resumo

**Objetivo:** Avaliar a qualidade da Estratégia Saúde da Família (ESF) através dos atributos da Atenção Primária na perspectiva dos profissionais de saúde e verificar associação entre esses atributos e as características sociodemográficas e profissionais da equipe. **Métodos:** Estudo seccional, realizado nas unidades de saúde da família do município de Serra, Espírito Santo. Para coleta de dados utilizou-se questionário denominado de Instrumento de Avaliação da Atenção Primária (PCATool). O instrumento foi aplicado a 205 profissionais atuantes nas equipes de saúde da família. Para verificar associações realizaram-se os testes Exato de Fisher e Qui-quadrado de Pearson. **Resultado:** As dimensões melhor avaliadas foram: a orientação familiar e a longitudinalidade. A associação entre o atributo essencial e o nível de instrução e experiência anterior na ESF foi significativa. **Conclusão:** Os profissionais percebem a atenção ofertada de maneira positiva, contribuindo para o fortalecimento e humanização da atenção básica.

**Palavras-chave:** Atenção primária à saúde; Saúde da família; Enfermagem.

## Resumen

**Objetivo:** Evaluar la calidad de la Estrategia Salud de la Familia a través de los atributos de la Atención Primaria en la perspectiva de los profesionales de la salud y verificar la asociación entre eses atributos y las características sociodemográficas y profesionales del equipo. **Métodos:** Estudio seccional, realizado en las unidades de salud de la familia del municipio de Serra, Espírito Santo. Para colecta de datos se utilizó 'Herramienta de Evaluación de los Cuidados Primarios'(PCATool). Fue aplicado a 205 profesionales en los equipos de salud de la familia. Para verificar asociaciones, se realizaron los testes Exacto de Fisher y Qui-quadrado de Pearson. **Resultado:** Las dimensiones mejor evaluadas han sido: la instrucción familiar y la longitudinalidad. La asociación entre el atributo esencial y el nivel de instrucción y experiencia anterior en la ESF fue significativa. **Conclusión:** Los profesionales ven la atención ofrecida de manera positiva, contribuyendo para el fortalecimiento y la humanización de la atención básica.

**Palabras clave:** Atención Primaria de Salud; Salud de la familia; Enfermería.

**Corresponding author:**
Eliane de Fátima Almeida Lima
E-mail: elianelima66@gmail.com

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## INTRODUCTION

In Brazil, after the creation of the Unified Health System (SUS), there was a reinforcement of primary health care (PHC). This level of care is now configured and the base to determine the work of all other levels of health systems, promoting the organization and rationalization of the use of resources, not only basic but also specialized, focusing on the promotion, maintenance and improvement of health[1]. So with the implementation and organization of APS, the Ministry of Health (MOH) establishes a reordering model of health care as SUS principles, called the Family Health Strategy (ESF), which prioritizes care actions to the health of individuals, family and community, continuously and comprehensively[2].

The ESF team consists of different professionals, with the minimum medical staff, nurse, technician or nursing assistant and community health worker, other professionals that may be necessary to municipalities may also be added, as to reality and local need. Remember that the team should be able to solve community health problems with the promotion of health care in the Basic Health Unit (BHU) and, when required, deliver care in households[3].

The maintenance of guidelines and principles of the SUS, as well as the favorable impact on the health conditions of the registered population, should be the basic concern of the ESF. It is essential that the team work in order to know their area, expanding the relationship with the community, quality and access to services and actions to develop strategies and interventions to trigger improvements in population health[4].

It is true that, over the past few years, the ESF has contributed significantly to the improvement of health indicators in the country, changing the population's morbidity and mortality profile in addition to the reduction of unnecessary admissions[5]. Therefore evaluation of the quality of care provided by the ESF is crucial as it enables new investments in improving the quality of services offered within each health area, new forms of management and care more affordable actions, resolving and humanizing users. Including health professionals in health care evaluation process means having the look of those inside the service or program, with care management, experiencing the realities and difficulties of health services and the territory[6].

In this context, this study aimed to evaluate the quality of the ESF through the attributes of primary care from the perspective of health professionals, and the association between these attributes and socio-demographic characteristics and team members.

## METHODS

It is a cross-sectional study carried out in health facilities in the city of Serra, Espírito Santo, which has ESF. Among the municipalities of the state, Serra showed the widest variation in the human development index, from 0.390 in 1991 to 0.761 in 2010, regarded as a medium human development. The municipality has the organization of the proposed health care network to APS as the preferred gateway through UBS and ESF. To do this, UBS has 33, 39 and 11 FHS teams of Community Health Agents (EACS) reaching a 41.1% population coverage. Each team consists of physician, nurse, nursing assistant and community health workers (CHW).

The study population was formed out of health professionals from primary FHS teams. The inclusion criterion was to belong to the same unit of FHS for over a year and not be on vacation or on leave that could lead to removal from service. For top-level professionals (doctors and nurses), no sample calculation was carried out, since we opted for the inclusion of the entire population (n = 67), and in the process there were only three refusals, ending the collection of data with 64 top-level professionals. For mid-level professionals, ACS and auxiliary, we calculated the random sample. The confidence level was set at 90%, with an error margin of 7% and was taken to ensure representatives to the ratio = 0.5, where it maximizes the size of the sample. Thus, the sample amounted to 141 auxiliary and ACS professionals.

For data collection two instruments were used, the first to assess the socio-demographic and professional profile of the group of professionals from the ESF (gender, education, time of work and previous experience in the FHS and encouraging professional training). The second was applied to the Primary Care Assessment Tool (Primary Care Assessment Tool - PCA Tool) version for professionals which has 77 items divided into eight components: Access to First Contact (9 items); longitudinality (13 items); coordination - integration of care (6 items); coordination - information system (3 items); completeness - available services (22 items); comprehensiveness - services (15 items); family orientation (3 items) and community-oriented (6 items). The answers are Likert-type with an interval of one to four (1-4) for each attribute. Possible answers to each of the items were "definitely yes" (value = 4), "probably yes" (value = 3), "probably not" (value = 2), "certainly not" (value = 1 ) and "do not know/can not remember" (value = 9)[7].

The data collection phase started in August 2013 and ended in September of the same year. The interviews took place in health facilities selected during operating periods. Interviewers were four nurses and one nutritionist who participated in a training lasting 40 hours. We conducted a pilot test with 14 health workers and two top-level professionals, and it was found that the instrument had become clear with an exposure time of 40 minutes.

The quality score of the ESF, was averaged for each value of the items that make up the dimensions and sub-dimensions, and after we calculated the essential scores (obtained from the average of the essential attributes), the derivative (obtained by averaging the derived attributes) and the overall score of APS (average value of the essential attributes and derivatives).

After the consolidation of the data of each attribute, the values were transformed into a continuous scale ranging from zero to ten, using the following formula: Range = [(score obtained - 1) x 10]/3. Values scores ≥ 6.6 were defined as high

and equivalent to the value of three or more in Likert scale, while values ≤ 6.6 were considered low[7].

To evaluate the association between the primary care attributes and characteristics of professionals made up the Fisher's exact test and chi-square test. The tests took on a significance level of 5% and 95% confidence interval. For the tabulation of the data, we used the program Microsoft Excel, and the processing and analysis of data were performed using software SPSS for Windows, Version 19.0.

The professionals were informed about the research objectives and signed a consent form. This study was approved by the Research Ethics of Nursing Anna Nery School Counselling Committee number: 315 266.

## RESULTS

Table 1 presents the mean scores in all dimensions. It is found that the scale showed the lowest average (2.84) for accessibility. Although some dimensions submit high scores (score ≥ 6.6), such as coordination of the information system (7.82; SD = 1.93), completeness of service available (6.71; SD = 1.145); community orientation (7.32; SD = 1.86), and coordination and integration of care (6.83, SD: 1.75) present standard deviations around the mean that can lead to change in scores leading to unsatisfactory results (score ≤ 6.6). Standing out among the best dimensions assessed by professionals: family orientation (9.07) and longitudinality (7.99).

It was found that the municipality of Sierra presents a homogeneous distribution of units in relation to the more populous suburbs, either areas of vulnerability or not, comprehensive coverage of the municipal transport system and opening hours. However, the accessibility criteria evaluated by the instrument punctuate issues not covered by the entire health system of this municipality, such as opening hours until 20 hours and on weekends, phone contact for the supply of health professionals and telephone counseling.

The analysis of the essential attributes (accessibility, longitudinality, integration of care, coordination and comprehensiveness), derivative (family and community orientation) and overall, we note that to the professionals all three attributes showed satisfactory values (score ≥ 6.6), with an essential score, 6.69; score derivative, 8.14; and overall score, 8.19.

Table 2 presents values for the essential, derived and general scores. There has been a satisfactory evaluation of all attributes (score ≥ 6.6) from the perspective of professionals.

Table 3 is the association between sociodemographic characteristics, training and performance of professionals and the essential attribute, derived and general. It is observed that there was no association between the essential and general attributes and the variable age, receiving encouragement from the municipality to qualify, and the service time ($p > 0.05$). But by combining the essential and general attribute with the level of education and previous experience in the ESF, there was statistical significance ($p < 0.05$). In relation to the derived attribute there was no statistical significance for the variables studied.

## DISCUSSION

Note that, to the health professionals perspective, accessibility had the lowest assigned value, a result that indicates a problem in the health service, since it is through access, first contact, that the professional has the time to welcome, listen and meet the needs, increasing the link between professional, user and service, but also will direct all care if needed. It is then that build relationships of trust, respect and increase the bond, which will make a difference in the future treatment, including the adherence to treatment, and of course to provide accessibility, longitudinality, and complete care[8].

This attribute is not only access or arrival of users to the service, but permeates various points related to the reception and humanization of care offered. For some authors, accessibility is considered a match between supply and demand for services, and includes the availability, geographical accessibility, convenience or socio-organizational access and ability to pay, affordability and acceptability[9,10].

Corroborating our results, a study with 123 doctors and nurses in a medium-sized municipality in southern Brazil used the PCA Tool and found that the score for "first contact access"

**Table 1.** Scores attributed to the dimensions of APS by the professionals interviewed in the units of the Family Health Strategy. Serra - ES, 2014

| | n | Minimum | Maximum | Average | Standard deviation |
|---|---|---|---|---|---|
| Accessibility | 205 | 0.00 | 7.03 | 2.84 | 1.08 |
| Longitudinality | 205 | 2.53 | 10.00 | 7.99 | 1.07 |
| Care coordination Integration | 205 | 0.00 | 10.00 | 6.83 | 1.75 |
| Coordination Information System | 205 | 3.33 | 10.00 | 7.82 | 1.93 |
| Completeness Available services | 205 | 2.27 | 9.83 | 6.71 | 1.14 |
| Completeness Services provided | 205 | 3.33 | 9.77 | 7.96 | 1.26 |
| Family counseling | 205 | 3.33 | 10.00 | 9.07 | 1.45 |
| Community orientation | 205 | 1.67 | 10:00 | 7.32 | 1.86 |

**Table 2.** Scores attributed to the PHC attributes by professionals interviewed in the units of the Family Health Strategy. Serra - ES, 2014

| APS Attributes | Professional |
|---|---|
| Essential score | 6.69 |
| Derived score | 8.14 |
| Overall score | 8.19 |

had the lowest score, with 3.65 (IC 3.4-3.9)[11]. Likewise, one evaluation of the ESF in Porto Alegre found that "first contact access" received the lowest scores in all services from health professionals[12]. As for accessibility, in all municipalities surveyed in northeastern Brazil, difficulties were observed to reach specialist consultations, and diagnostic and therapeutic support services in medium and high complexity attention, and long waiting times, queues (also virtual), delay in the receipt surveys, among others[13]. Another study that confirms our research shows the failure in the assessment of this dimension was held in the FHS in São Luís, Maranhão[14].

Proper longitudinality presence is a key factor in the health system, as this attribute tends to produce diagnoses that are more accurate and treatments, as well as reducing unnecessary referrals to specialists and to perform more complex procedures[15]. Unlike our results, research in the municipality of Santa Catarina, in southern Brazil, obtained longitudinality score of 6.0 (CI 5.83 to 6.34)[11]. The development of longitudinality in daily work requires important points of the ESF, as the monitoring of users in different stages of life, comprehensive care to the individual and family, considering her biopsychosocial context, and acting through aggravations preventive actions and health promotion, seeking positive results in the population's health situation[16].

The coordination of care is defined as the relationship between the various services that make up the network of health care and actions related to this attention, so that regardless of where it is provided is synchronized and focused on achieving a common goal, that is the best attention to user[17]. The coordination of primary care appears among the responsibility of health teams needs careful management, since the FHS teams must accompany users in therapeutic projects along the Care Network Health (RAS). And they must organize flows between the different points of attention, acting as a communications center as well as being responsible for users along this network in a horizontal, continuous and comprehensive manner, thereby producing a shared management of the integral action[18].

Similar to our study, a research conducted in the Central-West Region, Brazil[19] found a coordination deemed appropriate in the assessment of traditional health centers, family health teams and between users and professionals. Similarly, a study conducted in health centers of Sobral Family (EC) with 98 professionals of ESF noted that the coordination attribute was well evaluated, however, there is still deficient counter- for primary care[20].

As for comprehensive care, research in Minas Gerais found that 89.2% of respondents highlighted the resoluteness of the service offered by the Family Health Program (PSF), especially due to home visits and diseases prevention actions[21]. On the other hand, the results of a study carried out with workers of family health teams in a city in the southeast Goiás revealed that the fragmentation of actions and the disconnection between the workers hinder the completeness[22].

It is worth noting that family and community orientation had the highest score of all other attributes evaluated by the ESF professionals. The family focus happens when the team

**Table 3.** Is the association between sociodemographic characteristics, training and performance of professionals and the essential attribute, derived and general. Serra - ES, 2014

| Variables | | Essential attribute | Derived attribute | Attribute General |
|---|---|---|---|---|
| | | *p*-value | *p*-value | *p*-value |
| Gender | Male<br>Female | 0.999[2] | 0.999[1] | 0.999[1] |
| level of education | Elementary complete<br>Secondary education complete<br>University graduates<br>Full specialization and/or resident | < 0.001[1] | 0.072[1] | 0.002[1] |
| Previous Experience | Yes<br>No | < 0.001[1] | 0.018[1] | 0.001[1] |
| Municipality offered encouragement | Yes<br>No | 0.202[2] | 0.999[2] | 0.166[2] |

[1] Fisher's exact test; [2] Pearson chi-square.

is able to interact with families, thus having greater facility to recognize problems and needs, in their uniqueness, as the subject of attention. The community orientation would promote recognition of family needs through social, economic and cultural environment in which they operate. Thus, the health demands would be designed by the family and individual representations of health and disease, and also of community support systems[1].

Study that has assessed the APS through their attributes has shown differences in relation to the results presented here because the dimensions family focus and community orientation have received low scores in the evaluation from[19,23,24].

As for the results of the essential and general scores, study in Porto Alegre, assessing the quality of primary care by doctors and nurses, found, for the essential score, 7.36, and to the general, 7.80, corroborating our findings[12]. Also an agreeing survey, conducted in primary care in Chapecó (SC) presented an APS overall score estimated by PCA Tool - Brazil 7.09 (CI 6.95 to 7.24), and a high score guidance for the APS, and the essential APS score was 6.86 (CI 6.91 -7.01)[11].

The essential link scores to the soft technologies. So, once surpassed the stage of access, negotiations will be established between professionals and users, aiming to identify needs and establish a bond of production and offer better care[1,10].

Teams must establish bonds of commitment and responsibility to the community and should encourage the organization of communities to exercise social control over the actions and health services. They should also establish cross-sector partnerships between different social and institutional segments so that they can intervene in situations that transcend the specificity of the health sector and have determining effects on the lives and health of individuals, families, community[17].

Regarding the associations between the sociodemographic profile and the professional, there was statistical significance between the level of education and having previously worked in the FHS. Corroborating with our results, research conducted in the municipality of Minas Gerais found that teams which were active professionals with best qualification as a residence in family health and family medicine residency and community had scores of general and essential attributes of APS higher than the scores of the teams where professionals did not have such a qualification[25].

Given these findings, it is pointed out the importance of training of health professionals dedicated to the field of family health, for the health care model in the FHS requires the professionals expertise and staff assignments are complex and multiple. In addition, persistence of biomedical and fragmented models in health care focuses actions in medical consultations and offers little opening for educational activities, promotion and health prevention[26].

Finally, the ESF should consist of multidisciplinary teams that work in an interdisciplinary logic, should prioritize the territory as the focus of interventions and guidelines for health promotion and disease prevention. By extending the intervention beyond the clinical and individual contemplating the community and its surroundings, the professional needs to build new ways of working within a collective working process that includes and integrates the knowledge.

## CONCLUSION

In this research, all attributes showed satisfactory scores (score ≤ 6.6). It is noteworthy that the best dimensions assessed by professionals are family orientation (9.07) and longitudinality (7.99). It is also worth noting that, by combining the essential attribute with the level of education and previous experience in the ESF, there was statistical significance ($p < 0.05$). In this sense, the investment is evident in vocational training can be a qualification strategy of attention to all services. Overall, from the perspective of professionals, the experience of the municipality of Sierra ESF (ES) can be considered successful, contributing to the strengthening and humanization of primary care.

One limitation of this study is recorded that the evaluation took place in a single city, but with the lack of studies on the subject highlights the relevance of similar evaluations.

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## ERRATUM

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