Articulated Actions of the Family Health Strategy Teams and Their Centres of Support in the State of Piauí, Brazil

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Abstract

Objective: From the perspective of professionals acting in the Family Health Strategy (FHS) in the state of Piauí, Brazil, the aim of this study was to assess the articulated actions of technical-pedagogical and clinical-care support offered by the Family Health Support Centres (FHSC) to the FHS’s professionals.

Methods: This is an analytical census retrospective study, with a cross-sectional design developed in a quantitative approach with a descriptive and exploratory nature. The research data was collected through the Program of Improvement in Quality of Access in Primary Care (PIAQ-PC) in Brazil, on its second cycle in 2013, and were analysed by using descriptive statistics.

Results: The actions of clinical-care support has been further developed by FHSC, all with frequency greater than 85%. In Piauí, the fields where FHSC acts has shown to be the nutritional care, rehabilitation and maternal and child care and also non-communicative diseases (NCD) that showed frequency higher than 85%.

Conclusion: The FHSC initiative contributes significantly with their services to the FHS to achieve its goals. However, to make the work of these teams more effective there must be ownership of Primary Care Services by its users and appreciation of it by the managers. The actions developed in the FHS are being supported and agreed on among the matrix support teams.

Keywords
Primary Health Care; Health Promotion; Family Health.
Introduction

In practice, the Brazilian Unified Health System (SUS) has proven to be a system organized to operate in reaction to the social demand, which occurs occasionally and primarily concerned to acute conditions and episodes of acute exacerbations of chronic disorders. This configuration of Health System has proven to be unsuccessful in Brazil and even in developed countries. A possible solution to this crisis is to precipitate the changes of the health care system through deep reforms that might modify professional practices, and definitively consolidate the Networks of Health Care (NHC), coordinated by the Primary Care Teams [1].

The Family Health Strategy (FHS) is included in different social contexts in Brazil and covers virtually all municipalities in states like Piauí. However, its effects are not well understood, particularly regarding the impacts on the health conditions of the general population [2].

In 2015 there was 32,498 FHS teams present in 5,428 Brazilian municipalities covering an estimated population of 62.54% [3]. The services of Primary Care in 221 municipalities of Piauí rely on the 1,225 FHS teams that cover 3,020,958 users in the state, reaching 95.58% of the population coverage [3].

Despite the equal presence of the FHS, there are not an established pattern of access and quality of health services in Piauí. However, it is clear that there was a total adherence of Piauí municipalities to the FSH during the 2000s [2].

The significant increase in coverage by the FHS might be directly linked to the fact that the population access to health care has also increased [4]. Nevertheless, there are still many difficulties to be faced that need structured actions to mitigate the impact of some diseases that are still prevalent.

The implementation process of the Family Health Support Centre (FHSC) was based in strategies to overcome barriers related to health promotion in Primary Care and provide management information that would assist the decision-making process in health, overcoming challenges of primary care in the country [5].

The FHSCs were created through Ordinance No. 154, in January 24, 2008, signed by the Brazilian Ministry of Health, in order to support the introduction of the FHS in the health service network specifying the territory and regionalization, as well as the expansion of its activities, and to expand the scope and efficiency power of the project [6].

Piauí is one of the states where FHSC shows statistics close to 90%, regarding the execution of activities of planning and the scheduling of these actions [5]. This fact, in addition to the satisfactory FHS coverage in the country, especially in Piauí, rises questions about how FHSC and FHS teams organize their actions, considering the development of their roles in the Networks of Health Care.

The aim of this study was to assess the articulated actions of technical-pedagogical and clinical care support offered by FHSC to the FHS professionals. It was considered the centre’s perspective to two different dimensions of performance. The actions regarding support in training of constructive and formative order are part of the technical-pedagogical dimension offered to professional teams, while the clinical care actions focus on the users [7].

Methods

This is an analytical census retrospective study, with a cross sectional design developed in a quantitative approach of descriptive and exploratory nature. As a census retrospective study, the selection criteria aimed to analyse the articulated actions of FHSC in the whole scenario of the state of Piauí. Thus, the sample was composed by all the 628 Health Units in Piauí where the Family Health Strategy Program is implemented.

The data for its development come from the database of the Program of improvement in Qua-
lity of Access in Primary Care (PIAQ-PC) in Brazil, for the second cycle, when the information was made available, by the municipal managers of 217 participating municipalities in the state Piauí, on PIAQ-PC website and also made available by the department of Primary Care/ Ministry of Health.

The PIAQ-PC was established by ordinance of the Brazilian Ministry of Health No. 1,654, of July 19, 2011, the product of a process of negotiation and agreement involving the three levels of management of the the Brazilian Unified Health System. It was designed in a process guided by the Ministry of Health and other administration spheres with the objective of improve and expand the access of the primary care services. It also, ensure a new standard of quality that can compare national, regional and local realities in order to provide greater transparency and effectiveness of the government actions for this level of care, thus fulfilling its main objective [8].

PIAQ-PC consists of four stages that complement each other forming a continuous cycle. The four stages are: Adhesion and contract of commitments and indicators; development of actions (phase guided by the self-assessment, monitoring, permanent education and institutional support); External Evaluation, and Recontracting [9, 8].

In the second cycle of PIAQ, the Primary Care teams (Family Health Teams, Parameterized Primary Care Teams, Oral Health Teams and Centres of Support for Family Health) and specialized dental clinics universally joined the program [10].

In order that the interview could be answered, the interviewer in PIAQ-PC had previous contact with the professionals that would answer it. These professional would be the ones with the most knowledge about the team work process, nominated by the team before the evaluation [11].

The questionnaire of the PIAQ-PC Module II was applied to health professionals who receive support from the FHSC in the FHSs where they work. The instrument of data collection and external evaluation for the program includes information related to:

- The structural features of the Basic Health Units (BHU), as well as equipment and working conditions.
- The quality of the working relationship and investment in permanent education for workers.
- The users’ satisfaction and participation in the health services of the units evaluated in this study.

The external evaluation of the instrument was organized into four modules, according to the method of data collection.

In this study we used part of the Module II (Interview with the Professionals acting in the FHS teams) and Document Verification at the Health Unit, included in the variables that contains components aimed at these aspects:

- Articulation of Actions of Technical-Pedagogical and Clinical-Care Support (III.33.17 variables N and N III.33.19).

The variables were coded by the Ministry of Health of Brazil, that also provides dictionary to decode them. The data were organized in spreadsheets in Microsoft Excel format and all variables with more than 10% of losses were excluded from the databank in this study.

The available data about PIAQ-PC were collected by a team from the Federal University of Piauí (UFPI) where 03 professionals performed the external evaluation in each Basic Health Unit: The first researcher evaluated the oral health team, the other assessed the FHS team, and the last one evaluated the unit’s physical structure.

The amount of financial resources each team and each professional would receive was decreed based on the perspective of financial investments to the municipality according to the contracts and certifications that the team owned.

The codification of the variables and its decoding procedure is performed by the Ministry of Health, through the questionnaire and the variables.
The Ministry of Health provided the data through spreadsheets of Microsoft Excel software version 2010. Initially, only the researcher leader had access to the data, considering his participation in the program of group management in the state of Paraíba, where he is part of the Study Group in the Department of Health Promotion, Health Sciences Centre of the Federal University of Paraíba (UFPB). Nowadays, the decoded data is publicly available at the homepage of the Ministry of Health, the data of interest to the public, professionals and managers of Primary Care.

The spreadsheets were imported into the Statistical Package for Social Sciences - SPSS version 20.0 for the development of descriptive statistics with presentation of the proportion (p) of events.

Following to Resolution No. 466 of 2012, determined by the National Commission of Ethics in Research of the National Board of Health, which address the ethical principles of research involving human beings, the external evaluation of PIAQ-PC was submitted and approved by the Ethics Committee of the Federal University of Rio Grande do Sul (UFRGS) [11]. However, the data used in this study are in public domain, as the PIAQ-PC project establishes itself as a multicentre project entitled "Evaluation of Primary Care in Brazil: Integrated multicentre studies on access, quality and satisfaction of its user", developed by UFRGS.

Results

Table 1 shows the data for the coordinated actions of technical-pedagogical and clinical-care support performed by the teams of Family Health Support Centre (FHSC teams).

It is recommended that FHSC teams act together with the FHS teams performing the so-called matrix support, where there are several supporting actions that are performed according to Table 2.

Considering the execution of technical-pedagogical actions developed by FHSC, the most notable articulated actions have been the ones related to planning and evaluation of actions (77.5%, N = 487), meetings in therapeutic groups or health education (74.7%, N = 469), Management referrals and/or waiting lists for specialists (56.1%, N = 352).

<table>
<thead>
<tr>
<th>Support actions</th>
<th>Performs</th>
<th>Does not perform</th>
</tr>
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<tbody>
<tr>
<td>Shared consultations</td>
<td>363</td>
<td>265</td>
</tr>
<tr>
<td>Individual consultations by FHSC professional</td>
<td>559</td>
<td>69</td>
</tr>
<tr>
<td>Home visiting</td>
<td>539</td>
<td>89</td>
</tr>
<tr>
<td>Interventions in the community</td>
<td>474</td>
<td>154</td>
</tr>
<tr>
<td>Organization of demand for individual assistance to be performed by professionals of FHSC</td>
<td>452</td>
<td>176</td>
</tr>
</tbody>
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Table 1. Distribution of articulated actions of technical-pedagogical and clinical-care support performed by FHSC teams.

<table>
<thead>
<tr>
<th>Support actions</th>
<th>Respostas</th>
<th>Does not perform</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning and evaluation of actions</td>
<td>487</td>
<td>141</td>
</tr>
<tr>
<td>Therapeutic or health education groups</td>
<td>469</td>
<td>159</td>
</tr>
<tr>
<td>Discussion of cases and construction of treatment plans (individual therapeutic projects)</td>
<td>379</td>
<td>249</td>
</tr>
<tr>
<td>Management of referrals and / or waiting lists for specialists</td>
<td>352</td>
<td>276</td>
</tr>
<tr>
<td>Discussion of current issues/ Actions of permanente education</td>
<td>435</td>
<td>193</td>
</tr>
<tr>
<td>Definition of criteria for acess, and attributions of each professional</td>
<td>442</td>
<td>186</td>
</tr>
<tr>
<td>Monitoring and evaluation of results of articulated attention</td>
<td>380</td>
<td>248</td>
</tr>
<tr>
<td>Support for the organization of the team work process</td>
<td>454</td>
<td>174</td>
</tr>
<tr>
<td>Interventions in the community</td>
<td>474</td>
<td>154</td>
</tr>
</tbody>
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Table 2. Distribution of matrix support by actions performed.
A large percentage of teams (77.5%, N = 487) performs planning and evaluation of actions, which becomes crucial for every professional in the FHS teams that is involved in the process to know how to perform actions that are their responsibility when faced with different realities, as well as being useful in the management of time. It must be evaluated to check if the methods used are effective and to discover where to improve.

The variable ‘Management of referrals and / or waiting lists for specialists’ has only over 50% of accomplishments, which shows the prevalence and persistence of a strong thought guided by the biomedical model of clinical-assistance.

Befitting the professional profile of the professionals working in the FHSC teams in Piauí, Figure 1 shows the fields of practice of FHSC in Piauí, according to the frequency of execution of articulated activities.

The activities developed by FHSC teams emphasize nutritional care (90.80%) followed by attention to people with disabilities and rehabilitation (89.30%), care for people with chronic diseases, while the pharmaceutical care (19.40%) and other activities (8.40%), together, reach the lowest percentage of FHSC areas of practice.

It is observed from the data and types of activities presented that they converge with the professional category supporter of FHSC teams. Among the most common professionals in Piauí are Physiotherapists, Dieticians and Psychologists, which demonstrates a service attempt in suit the epidemiological reality of the FHS coverage area. Another aspect to explain this fact lies in the possibility of trying to install an expanded clinical practice. Professional supported has only one extra member on their team, not to promote matrix support, but to share service.

Discussion

The direct and individualized assistance offered by FHSC team professionals to the families might be performed, but only with a referral from the FHS professional involving discussions and negotiations between the professionals responsible for the case. This type of care by FHSC can only occur in extremely necessary cases. However, neither the Note- book of Primary Care No 39 or Ordinance No. 154, which define the criteria of assistance in FHSC and FHS, distinguish what the "specific cases" would be [12].

One of the disadvantages of FHSC teams is that the professionals often return to performing only outpatient care, which results in the lack of integration with the professionals from FHS teams and other sectors that could come to ensure the targeting of intersectional actions [13].

In Campina Grande, State of Paraíba, Sampaio et al [12] found that there is a predominance of care

Figure 1: Fields of action of FHSC teams with the FHS teams.
practice being performed by professionals from the FHSC in that municipality. Their actions often consist in the execution of individual and collective consultations, which end up establishing a new relationship with users and assuming the management of practices of care.

In João Pessoa, State of Paraiba, assistance activities were not observed over the research period, nor were technical and pedagogical action developed by FHSC teams, but only several action of managerial nature. However, it was identified in the register form for supporters of that municipality that there are some indications to the execution of activities such as: conducting individual care, no specific individual consultation, pre-consultation, vaccination, dressings, injectable medications, cytological examination, exchange of catheters, blood glucose checking, anthropometric measurements and checking of vital signs [12].

About the actions of technical assistance support, physiotherapists, for example, perform an average of 36 home visits per month and related to working hours reported by each municipality there is an average of 1.2 visits per hour/weekly of work. About 64.0% of physiotherapists participate in these activities holding meetings with health teams, home visits in schools and elderly groups, and demand relevant surveys to physiotherapy [14].

The results presented in a study developed in the municipality of Parnaiba, Piauí pointed that other actions are performed among a population where drug users and various other population segments are prevalent: education, collective activities and home visits, which became the main strategy of contact with the population [15].

Health indicators of PIAQ-PC are often questionable. There are ambiguous cases such as the coefficient of preventive examinations of cervical cancer conducted in women who are 15 years old or older than it. The National Institute of Cancer recommends screening only in women who are between 25 to 64 years old, which is not clear in PIAQ-PC methodology, the way it is added on the instrument. In addition, looking at the technical point of view, it is difficult to understand the need to create a new instrument, although based on pre-existing instruments and even if there are already established and validated instruments such as the AMAQ and the Primary Care Assessment Tool (PCATool) [16].

Technical and pedagogical matrix support seek to provide permanent education to the FHS team, intending to ensure greater resoluteness about the health issues faced in their service’s territory [12].

With regard to collective actions, the work of the FHSC professionals is focused mainly in the production and implementation of educational workshops. In the discussions in team meetings, there are requests for FHSC professionals to perform in situ monitoring situations that are more complex and the FHS teams have difficulties handling. Overall, from these actions, the home visits are executed in a campaign model and implemented by community health agents [17].

The work of FHSC teams and rehabilitation teams of FHS are collaborative and shared manner. Both are held in collective and clinical actions as guidelines related to the daily life of the population in need of their care. These teams define when and who refer to the performance of procedures and public programs of social assistance. Also, plan and execute health projects in the territory, aimed at health promotion and disease prevention that require rehabilitation for the most vulnerable populations [18].

One of FHSC’s duties is to conduct activities of care directed to the population, only those actions that are in accordance with the matrix logic and the responsibility of the teams. It is crucial that FHS teams show interest in the conduct of activities and continued monitoring [19].

The professionals said that there are difficulties to properly execute the assistance, especially developing home visits. When it was possible to perform the service, priority was given to users with mobility
issues. It must be emphasized that these visits had a clinical-curative focus [19].

The FHS teams act with activities of promotion and prevention more restricted and targeted to specific groups, focusing on women, especially in the prenatal and postpartum period; the children through child and infant care and the elderly, in addition to users with specific conditions such as diabetes, hypertension, leprosy and tuberculosis [20].

Despite all the benefits of teamwork, there is also the fact that it is a difficult job to run because the team members are not always enthusiastic to work together and this has an influence on work processes to be developed and, especially in the final product [21].

Conclusion

The FHSC services contribute significantly for the Primary Health teams to achieve their goals. However, it is necessary that the population assume their role of users and owners of these services, as well as the Health System authorities must value and support FHSC, so that, Primary Care teams will be allowed to act more effectively in the community.

It is necessary to enable the FHSC teams to seek innovative strategies, that can potentiate the actions of FHS teams and face challenges, such as the responsibility of care, the functional link between the various levels of care, ensuring space on the agenda to discuss cases, the development of shared care and planning of action. However, these other actions and the consolidation of FHSC’s role as trainer of human resources are still challenges that need to be further worked.

Both clinical care and technical-pedagogical activities showed an occurrence rate higher than 55%, focusing on the clinical interventions that represents a frequency greater than 85%. The Brazilian Ministry of Health does not recommend this pattern of frequency, as in these terms FHSC teams would be acting as an expanded FHS team. It is recommended that FHSC teams promote more actions regarding the technical-pedagogical dimension.

In Piauí, FHSC has attend mainly the population affected by non-communicable diseases (NCD), children and women. Nutritional care, rehabilitation, reproductive health (maternal and infant care) and NCDs require a frequency as high as 85% of the FHSC teams’ operations in field.

The FHSC has worked in a larger scale. The main operations of the nucleus are planning and evaluating actions with the FHS teams, developing therapeutic or educational groups in health and supporting the organization of the work process of the referral teams.

The FHSC teams, from the point of view of FHS professionals in Piauí, have played a satisfactory role regarding the matrix support. However, the main limitation of this study lies in the bias of relevant information to their own external evaluation instrument for PIAQ-PC, where many variables (survey questions) nurture dubiousness. This might have been intentional, as the regulation ordinances of FHSC allow multiple interpretations about the forms of construction and also because some of them are not directed to strategic points suggested by the Ministry of Health. Moreover, the limitations of the instrument, which is out of the researcher’s control, offer a limited scope of response.

The results show a real need for studies about the issues evaluated by the PIAQ-PC and the FHSC process of work in different areas of Brazil, as well as to assess the demands of FHS professional categories in general.

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