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CONCEPTS AND EVALUATION OF THE FAMILY HEALTH STRATEGY IN BRAZIL

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ABSTRACT

Introduction: The Family Health Strategy was implement in Brazil in the early 1990's by the Ministry of Health and focused on the success of international experiences and in accordance with the criteria established at the Alma Ata Conference for Primary Health Care. **Material and Methods:** An exploratory and descriptive research has carried out on the literature to date. **Results:** The foundations have found to support and legitimize this strategy at the national level as a way to improve the quality of public health through qualified agents. **Discussion:** Family Health Strategy promoted changes in the focus of attention, which ceases to be exclusively the focus on the individual and the disease, passing also to the collective, with the family in the privileged space of action in the social context. **Conclusion:** It was point out that, to be successful, this initiative needs to be adapted and adapted to the social and economic differences of each region of the country.

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INTRODUCTION

The Family Health Strategy (FHS) was implement by the Ministry of Health (MH) in the early 1990s. It was focus on successful international experiences related to the criteria established at the Alma Ata Conference for Primary Health Care (PHC), based on the principles of universal access, on the continuous, integral and coordinated care in the communities, through programmed actions, therapeutic groups, visits, home hospitalizations, among others, going beyond individual medical care. This initiative is configured as a proposal for reorganization of Basic Health Care (AB) in Health and consolidation of the principles of the Unified Health System (SUS), impelling changes in the way services are organized, care practices, family centered in context physical, social and in expanding the network of care services (Soratto *et al.,* 2015). The implementation of the ESF, with a view to the reorganization of the care model, had innovative characteristics, which unlike the traditional health model. The organization of the work process, from a multiprofessional team, assumes responsibility for a maximum of 4,000 people, with a recommended average of 3,000 people in a geographic area. This team has expanded the bond and co-responsibility between families and the community through humanized and integral care practices (Brasil, 2012; Motta, Siqueira-Batista, 2015). It acts in basic care in a continuous and holistic way with a focus on family and community. In the development of its activities, the family health team prepares reports with information regarding the health situation and work process. These data was been recorded in the Basic Health Information System (Siab), becoming health indicators that will support the planning of priority actions for health needs (Senna, Andrade, 2015). In order to monitor and monitor the health actions

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carried out in the AB, whose results reflect on the health of the population, as of 2006, through the Pact for Health, there was agreement on basic health indicators that are related to the priority areas of the Pact by Life and the Management Pac. These indicators allow visualizing changes in the socioeconomic context, in the performance of health services, living conditions and health of the population. Although the FHS was formulate and implement by the federal sphere (MS) this did not occur homogeneously in the different Brazilian municipalities, acquiring different configurations. They has limited its progress towards the consolidation and effective reorganization of the UHS, once that its execution depends on the support of the federal, state, municipal, adherence and performance of family health care professionals (Motta, Siqueira-Batista, 2015). It is worth mentioning that FHS has expanded rapidly throughout the Brazilian territory. According to data from the Basic Attention Department of the MS, in April 2018, 20 years after its implementation, the program's situation was 43,226 teams, covering 64.51% of the total population (Brazil, 2018). The data, although quantitative, show the importance of the strategy in broadening the coverage of actions and access to health services for the population. Given the heterogeneity of implantation and rapid expansion, this strategy has become a rich field of studies and evaluative research. In special for those with the capacity to evaluate the effectiveness, efficiency and effectiveness of their actions in the health of a population, contributing to the consolidation of the program as a strategic management tool, since it assists in the planning, control of activities, increasing the responsiveness and resilience of health services.

In the bibliographic survey carried out on the evaluation of the FHS implementation, it is possible to perceive that this strategy undergoes different assessments regarding its characteristics related to the Political-Institutional, Organizational and Technical-Assistance dimensions (Arantes *et al*, 2016). In the view of the authors, the political-institutional dimension includes elements such as expansion, equity, financing, training and management of the professionals involved. For this reason, they attest that the organizational dimension should be composed of access, integrality and integration to the public health care network. In the case of the technical-assistance dimension, it is also necessary to introduce the multidisciplinary work, the reception and the bond, as well as all the aspects that involve the care process with a focus on the family as a basic structure of action. In this circumstance, it is relevant to evaluate the FHT using the components of the structure (organization of services), process (services produced) and results (service effectiveness), in order to reflect possible interventions in management and care practice. The studies found demonstrate the effect of the FHT on the health sector with advances in accessibility, reduction of inequities in health services and satisfaction of users with the program. However, they still present difficulties and limitations regarding the changes in care practices, precarious physical structures, to scarcity of human and material resources (Motta, Siqueira-Batista, 2015, Oliveira *et al*., 2012). From this perspective, this article has as its central objective to define the theoretical bases of the Family Health Strategy by means of a survey of the history of this program from the normative point of view. Since its creation to its implementation in several regions of the national territory, with a view to the reasons for its introduction in terms of efficiency in the provision of services. Based on these basic premises, the study will also focus on the evaluative aspects of the FHT regarding the improvement of public care in primary health care.

MATERIALS AND METHODS

As a structural methodological tool, bibliographical and documentary research on the subject was included, including the official publications that normalize this initiative since its origin and those that approach and serve as support to validate and evaluate the set of actions proposed by the ESF. This vast field of study also includes a series of theoretical references exposed in books, theses and dissertations, as well as numerous specialized websites that aim to provide up-to-date and dynamic information about this initiative in its application in practice, pointing out the main obstacles encountered and how it is possible to get over them.

The Family Health Strategy as an organization of health services: The change in the care model is a challenge to the consolidation of the Single Health System (HUS) from the new proposal of the Federal Constitution. The Family Health Program (FHP) was the most widely held strategy in Brazil to reorganize AB as a care model, guided by the principles of health surveillance, aimed at promoting, protecting and recovering health, provoking levels of the system (Arantes *et al*., 2016). The implementation of the FHP was based on the international experiences of successful health systems based on primary health care and on the proposals of the Alma Ata Conference, with the principles of universal access, continued care, integral and coordinated with other levels of attention to community health in its social context (Macinko, Lima, 2012; Silva, 2011). The PSF was create in 1994 by the Ministry of Health and promoted by the Community Health Agent Program (CHAP), which had successfully managed cholera control, reducing maternal and child mortality in the North and Northeast regions. The FHP emerged as a family and community health assistance program in basic care to develop promotion and protection actions (Brasil, 2010). At first, it was notice as a medicine that was poor for the poor, because it had the characteristics of a vertical program of the National Health Foundation (NHF). It alsowas intended to cover areas of risk selected from the Hunger Map of the Institute of Applied Economic Research (IAER). In 1997, the Ministry of Health approves the rules and guidelines of the program, through Administrative Rule number 1.886, prioritizing its expansion to the municipalities, defining the characteristics of the family health units, teams and work process (Arantes *et al*., 2016).
After the institution of financial regulations and incentives that promoted and expanded access to health care through the consolidation of family health, the MH ceased to consider it as a program and began to recognize it as a strategy for reorienting health and for the consolidation of primary health care. In this proposal, the Basic Family Health Units (BFHU) should act according to the following organizational principles (Brasil, 2012):

Substitutive character: does not necessarily mean the construction of new service structures in places that have a wide network of health units, but the replacement of the way to produce the service through a new work process.

Integrality and coordination of care: the UBSF is insert in the first level of action, configuring the door of entry to the service. This unit must be insert in the network, guaranteeing access to the other levels of assistance complexity, if this need

is identify, ensuring an effective referral and counter-referral, guaranteeing integral attention to individuals and the family.

Territorialization and ascription of the clientele: defined that each family health team must have an area of activity, with a number of families under its responsibility, which can vary from 800 to 1000 families, reaching 3,500 people. The team should develop activities that include both individual actions (consultations, guidelines) and collective health surveillance, with emphasis ontheenrolled population namely family registration, home visit for follow-up, local planning and educational groups.

Multiprofessional team: the family health team should be composed of doctors, nurses, nursing technicians and community health agents, and otherprofessionals can be incorporate according to demand and local needs.

With the need for multidisciplinarity andmultiprofessionality, the Family Health Support Centers (NHSC) were created in 2008, with the entry of new health professionals from other areas of knowledge, enabling qualification of assistance to the family and community, with the purpose of offering support, exchange of experiences, knowledge between the teams and NHSC (Brasil, 2010). The positive results of the FHP are been pointed out in evaluative studies as evidence of changes in the care model, contributing to verify the effectiveness of the program (Arantes *et al*, 2016; Oliveira *et al*, 2012). The advances of the FHPcan be observedin the health and life conditions of the population, especially in the priority areas, such as child health, women's health andchronic non-infectious diseases. There are many challenges for the consolidation of the program, such as the financing of primary care, teamwork to respond to the complexity of primary care problems, the work of system management through the technical support of the State Health Secretariats and their regional structures, as well as the valorization of Regional Management Colleges (Brasil, 2010).

The Health Information System: The origin of the production of health information is date from 1931 when the General Directorate of Information, Statistics and Disclosures of the Ministry of Education and Health began to work with information at the federal level. In 1975, the Informatics Nucleus of the General Secretariat of the Ministry of Health was implementedto the Health Information System (Brasil, 2000). The legal framework of the UHS provides that the municipality should be responsible for producing, organizing and coordinating the production of health information in its region. Thus, this information is a strategy that helps both to strengthen state objectives and goals and to increase the effectiveness of health services and social control (Pinheiro *et al*., 2016). The Pact for Health, published in 2006 by the GM Ordinance No. 399, presents significant changes to the implementation of the health system, respecting loco-regional differences, strengthening the organization of health regions and redefining instruments of regulation, programming and evaluation. He presented 57 indicators that provided information on the health and life conditions of the population (Brasil, 2006). Through the Health Pact, signed between the three spheres (federal, state and municipal), municipal managers have the challenge of strengthening the HUS at the local level by implementing actions in a timely manner through the regional health diagnosis by using the health systems provided by the Ministry of Health. The health information system can be understood as an instrument to acquire,organize and analyze data needed to define health problems and risks,evaluate the effectiveness, efficiency and influence that the services provided may have on the health status of the population, in addition to contributing to the production of knowledge about health and related issues (Marin, 2010, p.21). From this perspective, it can be affirmed that health information systems have the purpose of assisting municipal, state and federal management in the administration, planning and maintenance of health, generating real and accurate information about social, economic and epidemiological conditions, making possible define necessary interventions for the population (Santos *et al*., 2014). Brazil has a wide range of health information systems that are fragment, with an emphasis on specialty and disease management. Many of them have identical data. However, the information is mismatched and divergent, which makes the use of this data insecure and not in keeping with the local reality.

These systems are available for public consultation and the MH provides training and manuals available to managers and health professionals who will handle these programs.In spite of it, the studies indicate that the professionals are unaware of the use of this tool in the activities developed by them due to the lack of technical preparation, which end up compromising the viability of the system (Oliveira *et al*., 2011). One of the challenges in using the data generated by the information system is in the quality of the information, since there is no policy that encourages the correct completion of the information. In addition, another problem is in the local sphere: the difficulty that managers encounter in assembling infrastructure (material resources), adequate definition of collection procedures, and the lack or lack of qualified human resources to analyze the information obtained (Santos *et al*., 2014).

The Basic Attention Information System: In 1998, the Basic Care Information System (BCIS) was create due to the implementation of the Family Health Program, considered as the main monitoring instrument of the actions developed by the family health teams to provide population indicators of a specific area of coverage (Carreno *et al*., 2015). It is an idealized system for aggregating and processing the information of the attached population. This information was obtained through the completion of records of registration and monitoring of families and analyzed from data consolidation reports. These reports allow us to know the socio-sanitary reality of the population monitored, and also to evaluate the adequacy of the health services offered and to re-adjust all of them (Oliveira *et al*., 2012). This system was implemented to support health teams and to manage the information produced by family health teams, making use of concepts present in the FHS principles: territorialization, population assignment and multiprofessional work team (Senna, Andrade, 2015. Its structure is based on data divided into three blocks as:

- Family registration (socioeconomic conditions of the individuals and sanitary situation of the households),
- Monitoring of risk groups (pregnant women, hypertensive patients, diabetics, tuberculosis, leprosy and children under 2 years) and
- Record of activities developed by the team (production and coverage of actions and basic services, notification of injuries, deaths and hospitalizations). This bank has been consider an important tool for microlocation and intervention of health problems.

RESULTS

Health indicators were developed to help quantify certain attributes and dimensions of health status, as well as health system performance. They are excellent tools for managing and for evaluating the health situation. Their results highlight the health situation and its trends, contributing to the elaboration of policies and priorities for the health needs of the population (Ripsa, 2008). For this reason, knowing and monitoring health indicators over time is essential to evaluate the performance of the health system, since it makes it possible to strengthen the organization of health care, defining priorities for intervention, planning and management of services. In addition, this control is a means of creating conditions for the temporal evolution of these indicators, analyzing the quality of care, the implementation of health programs and their effectiveness (Santos *et al*., 2014).

In order to evaluate, monitor and measure health effects, the Ministry of Health initiated in 1999 the Pact for Indicators of Primary Care, which was improved and incorporated into the Pact for Health, and listed 54 priority indicators of the Pact for Life and the Pact for Health. Management that the municipalities should compose, consisting of one of the main instruments of monitoring and evaluation of national scope (Brasil, 2010). The Pact for Life is a set of health commitments, expressed in objectives of processes and results, derived from the analysis of thecountry's situation and the priorities defined by federal, state and municipal governments. It means a priority action in the field ofhealth, which should be implement with a focus on results and with the unambiguous specification of budgetary and financial commitments to achieve these results. One of these priorities wasdirect to Basic Health Care, consolidating and qualifying the Family Health Strategy as the coordinating center of HUS health care networks (Brasil, 2006). At first, the agreement was been made up of the following indicators: health care for the elderly, control of cervical and breast cancer, reduction of maternal and infant mortality, strengthening of the capacity to respond to emerging and endemic diseases, health promotion and strengthening of basic care (Brasil, 2012). Subsequently, with the publication of Administrative Rule GM 325 of 2008, new indicators were included: worker health, mental health, strengthening of the capacity of the health system to respond to people with disabilities, integral care of the person in situation or risk of violence and health of man. In 2013, the MH, the National Council of Health Secretaries (NCHS) and the National Council of Municipal Health Secretaries (NCMHS) established Guidelines, Objectives, Targets and Indicators for the period of 2013-2015, defining 67 indicators that should be agree upon by the federated entities. This was made with a view to strengthening the Integrated Planning of the HUS and the implementing of the Organizing Contract for Public Health Action (OCPH), (Brasil, 2014). Two types of indicators were defined, universal and specific, whose composition is:

Universal Indicators: Express the access and quality of the organization in networks, besides considering the epidemiological indicators of national scope and performance of the system (IDSUS), being of common and obligatory agreement nationally.

Specific indicators: They express the local epidemiological and organizational characteristics of the system and system performance (IDSUS), and are obligatory when specificities are been observed in the territory (Brasil, 2014). In 2014, some changes were made, excluding one indicator and changing the typology of three others. It was also defined that municipalities should monitor and evaluate 66 indicators, 30 of which are universal and 36 specifics. For the purposes of this study, the following indicators of basic care were select: Population coverage estimated by the family health teams (Universal Indicator 1); Rate of hospitalization for causes sensitive to basic care (Universal Indicator 2); Proportion of live births of mothers with more than seven prenatal visits (Universal Indicator 21); and Infant Mortality Coefficient (Universal Indicator 24). These indicators have as guidelines to guarantee the population's access to quality services, with fairness and, in a timely manner to meet the health needs, through improvement of the Primary Care policy and specialized attention and promotion of integral attention to women's health and implementation of the Stork Network, with emphasis on the most vulnerable areas and populations (Brasil, 2014). Considering the work process of the family health teams, which distinguishes it from the attributions of health professionals of basic health units, the following indicators were select: medical consultation, home visit of the doctor and nurse, referral to the specialist and request for clinical pathology exams (Brasil, 2012). Therefore, the monitoring and evaluation of these health indicators over time are paramount for the planning of actions and interventions, and their monitoring allows creating conditions for the temporal evolution of these indicators knowing the effectiveness of health programs (Reis *et al*., 2016).

DISCUSSION

In Brazil, the practice of evaluation in health services and systems is recent. The interest in this area began in the 1980s, with the reform of social policies and the employment of the evaluation of selected programs, aiming to improve the program and the organizations involved in the process (Brouselle *et al*., 2011). The evaluation has been appearing in the health area in a procedural way. In this context, the evaluation of basic care has been increasing since the end of the 1990s through the Basic Attention Department of the MS in order to contribute to the qualification of health care. In this scenario, the ESF is an inducer of this evaluation process, with the challenge of conducting research that points to the impact of the innovations proposed by the program in the organization of the system and in the health of the population. (Furtado, Vieira-da-Silva, 2014). From the conceptual point of view, there is still no single definition regarding the exact meaning of the term evaluation, conceptualizing it in a different way, indicating dilemmas and controversies, although there is a consensus that all evaluation implies value judgment. To evaluate is basically to make a value judgment about an intervention, implementing a device capable of providing scientifically valid and socially legitimate information about this intervention or any of its components, in order to proceed so that the different actors involved, whose judgment camps are sometimes different, are able to position themselves on intervention so that they can individually or collectively construct a judgment that can translate into action (Brouselle *et al*., 2011). In addition to defining the concept of evaluation, it is necessary to define what to evaluate, for which to evaluate, for whom and who will evaluate. These responses should be clear to the evaluator, knowing the object, purpose, potential stakeholders and who deems the assessment necessary. The objective of the assessment is according to the question that is

ask and it depends on the owner of the question, because for a manager, a researcher or user has different views. This will depend on the question asked because for a manager the evaluation can determine whether a program is working or not, for a researcher it may be the production of knowledge that does not aim for immediate use but rather a potential to be discuss in the medium and long term. For the user can be an accountability to know if the services are being rendered (Hartz, Vieira-da-Silva, 2014). Health assessment of the type of implementation analysis is complex and seeks to analyze the effectiveness, effectiveness and efficiency of health programs and services so that services offered are in line with demand. This perspective refers us to the idea of quality as an object of analysis, having as reference for this methodology the evaluation of quality in health care of the author Donabedian (1991). This author was the first to suggest the evaluation of the quality of health services through quality assurance methods systematized in a triad of components: structure-process, structure-result. Its merit resided, among other reasons, in the capacity to systematize the appropriation of quality in terms of services, actions and health programs. In this way, he asserted that "quality should represent a positive judgment regarding the technique involved in health care and the interpersonal relationship between client and provider" (Donabedian, 1991, p.61). He also talks about amenity as a relevant element for the quality of care. This pronounced amenity refers to the setting, the decoration of the workroom, the air conditioning and the details of the facilities. On the other hand, Hartz and Vieira-da-Silva (2014) point out that there is no point in having the best practice, if there is no availability of a professional that guarantees adequate and quality assistance. In this sense, evaluation is characterized as an integral part of the management of Primary Care, functioning as an important tool that should include aspects of the implementation of FHS programs and projects, the process and its results, assisting in feedback for health professionals and community.

Conclusion

It is possible to conclude that the FHS introduced a new model of health intervention in order not to wait for the demand to intervene, but rather to act on it in a preventive way, thus constituting an effective instrument to reorganize the need for medical and outpatient care of each population. Another factor to be highlight and makes the difference is the conceptions of integration with the community, as well as a more comprehensive approach to health, not only focused on medical intervention as the upshot. In this sense, this strategy reveals the multiprofessional and interdisciplinary character of the family health teams, promoting the breakdown of paradigms regarding integral, humanized, continuous, quality care, committed to care, according to individual and collective demands. It is also due to the referrals to the specialists and their accompaniment to the total recovery of the individual's health. The place for this care may be in the health unit, in the home, in the school or in community centers, thus crossing the walls of the basic health units. The changes in care practices and the organization of basic care are able to solve 85% of the health cases in their area of activity. The MH has developed an evaluation proposal on the applicability of the FHS in Brazil, titled "Evaluation for Quality Improvement of the Family Health Strategy". This evaluation brings together the conceptual, methodological and operational references for the elaboration of a quality improvement model based on identified consensus. It is therefore a self-assessment, with voluntary adherence, oriented to specific agents and spaces, such as manager, coordination, health units and teams. The results demonstrate the existence of a variety of models of this strategy at the municipal level, some approaching and others distancing themselves from the original proposal of the program.

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