



FAMILY HEALTH STRATEGY: MEANING FOR FAMILIES FACING THE CARE PROVIDED BY HEALTH PROFESSIONALS

ESTRATÉGIA SAÚDE DA FAMÍLIA: SIGNIFICADOS PARA FAMÍLIAS EM FACE AOS CUIDADOS PRESTADOS PELOS PROFISSIONAIS DA SAÚDE

ESTRATEGIA SALUD DE LA FAMILIA: SIGNIFICADOS PARA FAMILIAS FRENTE A LOS CUIDADOS PRESTADOS POR LOS PROFESIONALES DE LA SALUD

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ABSTRACT

Objective: to identify the meanings of care for families by the professionals of the Family Health Strategies. **Method:** it is a qualitative, exploratory, descriptive, cross-sectional study, with intentional sampling among 20 families. The data were produced using semi-structured interviews and analyzed by the technique of the Collective Subject Speech, based on the Theory of Social Representations. **Results:** for families, the meanings opposite the care provided by health professionals are: improvement, many negative meanings, good service, practical, change, very good and satisfaction. **Conclusion:** the creation of the ESF made more convenient the access to care professionals, facilitating the appointments and home visits. It is necessary that the ESF will continue looking for ways to solve the problems that generate dissatisfaction to the patients, thus providing a quality service. **Descriptors:** Family Health Strategy; Health Staff; Family.

RESUMO

Objetivo: identificar os significados dos cuidados prestados às famílias pelos profissionais das Estratégias Saúde da Família. **Método:** estudo de abordagem qualitativa, exploratória, descritiva, transversal, de amostragem intencional, realizada com 20 famílias. Os dados foram produzidos utilizando roteiro de entrevista semiestruturada e analisados pela Técnica do Discurso Sujeito Coletivo, como base na Teoria das Representações Sociais. **Resultados:** para as famílias, os significados em face aos cuidados prestados pelos profissionais de saúde são: melhora, significados negativos diversos, bom atendimento, prático, mudança, muito bom e satisfação. **Conclusão:** a criação da ESF tornou mais prático o acesso ao atendimento dos profissionais, facilitando a marcação de consulta e visita domiciliar. É necessário que a ESF continue buscando meios para solucionar os problemas que geram insatisfação aos usuários, proporcionando, assim, um atendimento de qualidade. **Descritores:** Estratégia Saúde da Família; Pessoal de Saúde; Família.

RESUMEN

Objetivo: identificar los significados de los cuidados prestados a las familias por los profesionales de las Estrategias Salud de la Familia. **Método:** estudio de enfoque cualitativo, exploratorio, descriptivo, transversal, de muestra intencional, realizada con 20 familias, los datos fueron producidos utilizando guía de entrevista semi-estructurada y analizados por la Técnica de Discurso Sujeto Colectivo, como base en la Teoría de las Representaciones Sociales. **Resultados:** para las familias los significados frente a los cuidados prestados por los profesionales de salud son: mejoría, significados negativos diversos, buena atención, práctico, cambio, muy bueno y satisfacción. **Conclusión:** la creación de la ESF tornó más práctico el acceso al atendimento de los profesionales, facilitando la marcación de consulta y visita domiciliar. Es necesario que la ESF continúe buscando medios para solucionar los problemas que generan insatisfacción a los usuarios, proporcionando así, un atendimento de calidad. **Descriptores:** Estrategia Salud de la Familia; Personal de Salud; Familia.

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INTRODUCTION

Brazil is a country constantly developing and over the years trying to organize its economic, educational system and especially health system. It consists of a largely privileged territory with numerous municipalities and is challenged to structure and organize them for better use of their resources to ensure the quality of life of the population and adhere the developed country's status.¹

The creation of the Program of Community Health Agents (PACS) started in 1991, being a transition strategy between the traditional old system of health service delivery and the Family Health Program (PSF), aiming to contribute to the reorganization of the municipal health services for the integration of activities among the different professionals and their articulation with real demands and needs of the community. With its evolution, the need for expansion of skills was demonstrated to meet the family's needs resulting in the creation of PSF.²

In this context and aiming the improvement of health services to the population context, arises then the PSF, which was implemented in Brazil in 1994 to refocus, reorganize and restructure the care model in health, which was previously centered on the disease and the doctor, not the individual as a subject of rights and the health team as it should be.³

Since 2006, the PSF stopped being a program and became the Family Health Strategy (ESF), a primary health care program in health, precisely because of PSF having a certain time. The strategy is ongoing and continuous. It was implemented together with the Health pact and it is divided into three main components: Pact for life, in defense of the SUS and management. The pact in Health is intended to consolidate the SUS, seeking to strengthen primary care and focusing on actions for health promotion.³

The ESF is highlighted as an innovative device and rebuilder of actions and health services to overcome the fragmented vision of the human being, considering their singularity/subjectivity, complexity, in full and sociocultural insertion.^{4:47}

And finally, for better performance of the ESF, the Family Health Support Center (NASF) was created by the Ministry of Health with the Ordinance GM number 154, of January 24, 2008, republished on March 4, 2008, aiming to support the inclusion of the Family Health Program in the service network and expand its coverage beyond the territorial processes and regionalization. It should be composed of

professionals from different areas to work with health practices together with professional teams of PSF⁵

The family is understood to a system that can be defined as a complex of elements interacting with each other. When this definition is applied to the family, it is possible to see each of them as a unit and focus on the interaction between its members and not in just one individual.⁶

For years, the family had the Basic Health Unit (UBS) as a way, to meet 80% of the population's health problems, providing efficient service and improving the population's quality of life, without the need for referring to the more complex services. Until September 2011, Brazil had 38,000 UBSs, where people could perform from doctor visits, dental care, dressing, among other health services.^{5,7}

Increased patients' satisfaction with the care received by the ESF is the result of changes in the care provided by health teams, becoming a model for the Health Care of Brazil and international reference. A study by the Ministry of Health in partnership with the University of São Paulo and New York University is similar to the changes occurred, in which every 10% of coverage increasing, the infant mortality rate fell by 4.6%.⁸

OBJECTIVE

- To identify the meanings of care for families by the professionals of the Family Health Strategies.

METHOD

The article was taken from scientific initiation research fostered by the Foundation for Research of the State of Minas Gerais (FAPEMIG).

A qualitative, exploratory, descriptive and cross-sectional study, based on the Theory of Social Representations (TRS).

The participants were the families of the ESF of Cruzeiro and Rebourgeon I and II neighborhoods of the city of Itajubá - MG, Cruzeiro, ESF Reborgenon I and II. There were 20 families interviewed, 10 of Cruzeiro ESF, five from Rebourgeon I ESF and five from Rebourgeon II ESF, and the sampling was a deliberate or intentional type.

On November 24, 2012, Luiz Sérgio Dias Miranda UBS was inaugurated, which has a large waiting room; meeting room; hall of ACSs; four doctors' offices; four dental offices; a gynecological clinic; vaccination room; sterilization room; collection materials room; basic care room; dressings; warehouse;

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female and male locker room for employees; male and female bathroom; garden and ramp outside to the ambulance access, suitable for receiving elderly and disabled patients.⁹

From this date, the units started to work together within the Luiz Sérgio Dias Miranda UBS, the being Rebourgeon I ESF having a general physician and one nurse, five ACS assisting five micro areas, which have a range of about 2,700 people assisted. The Rebourgeon II ESF has the same team of Unit I and assists approximately 2,600 people registered. The units are also attended by doctors of Gasrpar Lisbon Foundation (FUGALI), which have two general practitioners, a pediatrician and two gynecologists also assisting the population of unregistered units in surrounding neighborhoods.

Dona Lourdes Anselmo UBS from Cruzeiro neighborhood had its current unit inaugurated on March 19, 2007, through the ESF on 01 June 2010. It is currently a mixed unit, consisting of a nurse, a general physician, a dentist, three nursing technicians and seven ACS assisting five micro areas with about 2,600 people registered, and also having the care of three doctors of FUGALI, being a pediatrician, an obstetrician and a general practitioner. The unit has an immunization room, dressing room, doctor's office and a dental and sterilization room.

The study was approved by the Research Ethics Committee (CEP), with Opinion 462.362 on 6 November 2013. Also, the procedures to ensure the reliability, the anonymity of information, privacy and image protection of the participants were provided, assuring them that the information obtained will not be used to the detriment of any kind, being respected all their values. Each participant was identified by encoding F1, F2, F3, from families and so on, according to the number of respondents.

Families were indicated by the ACS of Rebourgeon I and II and Cruzeiro ESF. The participants did not receive any payment or reward for participating.

A questionnaire featuring the participating families of the study and a script containing two questions to be answered by them were applied.

RESULTS

The results are presented in three different phases: first, data relating to the characterization of the families on the type, the socioeconomic characteristics and health problems. The second phase was carried out

by the group and exposed the central ideas to the meanings for families in the face of care provided by health professionals who worked at UBSs and now work in the ESF.

It was found that from a total of 20 families interviewed, 40% of respondents are of the nuclear family type; 95% have their own homes; 40% have family income between R\$ 1,100 to R\$ 1,500; 100% have sanitation; 65% have five rooms in the house; 60% of the number of people in the family are between 3 and 4; 36.84% of respondents members were mothers; 90% have some health problem; and 52% of interviewees had hypertension.

For families interviewed who received care from professionals who worked at UBSs and now receive care from professionals working in the ESF, when being asked if any difference in the services were noticed, 75% said yes and 25% said no.

For them, the meanings of the care provided by health professionals who worked before in UBS and currently work in the ESF are: improvement, many negative meanings, good service, practical, change, very good and satisfaction.

DISCUSSION

When we analyze the central ideas of the theme “What does it mean to you today receiving care from the ESF professionals?” we can see that the central idea, improvement, was quite common among families, as evidenced in the following DSC:

I found it better, because we do not have time right, for example I have no time to go there, so I liked it because it comes to you, she asks if it's okay, it's [...] until my mother was sick, she [...] my mother was hospitalized, she came and asked, is it all right, I liked it but I thought it was better. (F13)

The ESF has demonstrated an improvement in the effectiveness and quality of care provided in primary care in cities where it was implemented, even with a large number of ESFs with a poor physical structure and often improvised.¹⁰

The central idea “many negative meanings” was quite frequent, as can be seen in the DSC:

I did not notice any changes, and because at least for me no, they do not come in my house, when she comes I ask for an appointment, she says he has no vacancy, you know? [...] There's a girl, we go but not the nurse, ah I think the agent should know how to measure pressure, measure blood sugar, I think [...] Because it takes a lot [...] and it takes to be attended to, I'd rather go in private doctor to go there [...] There in Piedade they walk ten kilometers on foot and they assist everyone, do visits, take medicine and the doctor

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goes to the houses, and the doctor did not come here at home, they come and when he goes there he meets very badly [...] Ah for me it is bad. It needs to improve much even as the secretary, we talk to him, he says he speaks for the girls to come, and they do not come, understand? and the girls who work there, walk down and up by car without doing anything, you know [...] Oh now says that from a height there from my house down, from a neighbor, down will not most belong to here, for the health center. It will belong there to nursing, in nursing school, so for me it is more difficult, because right there in nursing, it is close. (F15, F7, F2, F12, F5)

The difficulties encountered in accessing the PSF were: the delay in setting up appointments, inappropriate operation of the system of reference and counter reference, and poor access to specialists; large number of people registered in the hosting area; delays to receive care in the unit; delays in the receipt of test results and low resolution of the problems, especially lack of care in small emergencies, causing an increase in demand in the medium and high complexity services.¹¹

ACS functions are just: register all members of their micro-area and keep them up to date; perform mapping of their micro-area; guide all families on the correct use of health services; follow through home visit all the families of their micro-area performing on average one visit per month, considering the risk criteria and susceptibility, causing the needy families are visited more often by home visits; and develop diseases prevention activities, promotion and surveillance in health.¹²

The delay to schedule medical appointments and how they are scheduled results in a precarious assistance, difficult to access to comprehensive care and continuous assistance to the population.¹³

The population is still adjusting to the ESF, where many patients request the presence of a doctor specializing in gynecology or pediatrics and also a frequent complaint to the delay in being assisted, causing many of them to seek care outside the unit.¹⁴

The difficulty relating to the means of locomotion directly affects the family care because they cannot move to the coverage areas, and further, the teams are responsible for an area often far from the unit. /there is usually a large number of households to be visited, which requires professionals to carefully select the cases to be visited. Because of this situation, it is often necessary to prioritize the visits to more needed families.¹⁵

In the ESF there are still some limitations in efficient service, due to factors such as: inadequate academic training of professionals, decrease in the number of doctors, insufficient resources and lack of understanding of managers on ESF.¹⁶

Regarding the assistance offered in the ESF, many patients feel dissatisfied regarding the absence of medical professionals in the ESF and scheduling appointments, damaging solving the problems presented by the population.¹³

The area covered contributes to a good knowledge of both political and social reality of the families established for each ESF team and to link training between the team and the family. Each team is responsible for registering and monitoring the population living within the defined area and should have around 600-1000 families and on average 3,465 people.¹⁶

The central idea "Good service" was quite common among families, as evidenced in the following DSC:

We note that people seem to treat the happiest people because it's bad when we go somewhere we note that people looks like, you know, with that all ill will, and we realize all these things. (F3)

Many ESF professionals treat patients of their area in a different manner, in which multiple patients consider professionals as a member of their family or friends. Differentiating the care of other health care facilities that report a poor service by these units.¹⁷

It is important in the first contact with the patient call him by his name and greet him for the formation of bond. The communication between professionals and patients of the ESF should not be only in offices, but a permanent and continuously be in the waiting room or elsewhere, hearing what he has to say, valuing their grievances and needs.¹⁸

Another central idea that was common between the families was practical, being evidenced by the DSC:

So, in setting up appointments they even mark the girls coming facilitated, I'd not thought vague, as I told you, right, we will in the morning, then when they arrive in time from us over the vacancies, but not for them, they scheduled the right day, you do not lose or anything, you know it was good. (F20)

Os ACS através das visitas domiciliares são capazes de identificar os problemas das famílias e levam para a equipe para serem solucionados.¹⁹

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The ACS through home visits are able to identify family problems and lead for the team to be solved.¹⁹

The central idea "Change" was common in the statements, as can be seen in the DSC:

Ah very good right, because you do not need to search the hospital, so I think it's very good! So it's a very nice change! (F1)

In recent years, the ESF has been contributing significantly to the improvement of health indicators in Brazil, and the expansion of the ESF, provided greater access to health services and made professionals stay closer to the population.²⁰

The ESF represents a significant change in the healthcare model, with a more humanized care, reaching one of the goals of the National Program of Humanization of care. This has increased the relationship between work and the patient to create bonds, an essential factor in achieving effective health actions.¹⁷

The central idea "Very Good" was quite common among families, as evidenced in the following DSC:

Ah very good right, because you do not need to search the hospital, so I think it's very good! So it's a very nice change! (F1)

The families are significantly happy with health professionals in their home, not needing to travel from their homes to the units because these professionals can solve most of the problems presented by them and still performing pressure measurement and blood glucose test, decreasing spending on transportation.²¹

The central idea "Satisfaction" was uncommon among families being reported only by a family, as we can see:

They come in our house, today that girl came here, and we care about there, we talk, you ask if there is a doctor or not, they tell everything right, that's it, we're very satisfied! (F1)

Patients' satisfaction has occupied a significant position in assessing the quality of service. This shows that patients' satisfaction is directly linked to their adherence to treatment and care for their health, resulting in influencing their behavior in health and disease.²²

CONCLUSION

The population, when experiencing the UBS change to ESF, noted a significant improvement in attendance from professionals who work at this location. With the creation of the ESF, it has become more convenient access to care by professionals, and greater ease in setting up appointments, possible care and home visit by the doctor, nurse and ACS,

facilitating access to the ESF, due to proximity to the population and solving most of the problems.

The ESF, by meeting the families throughout their service area, enable the care of professionals to be very good, so that families do not need to move from their residence to the hospital or specialized area, managing most of their problems in the unit.

The ESF has a maximum number of people to be assisted, determined by the Ministry of Health, where it cannot exceed the number, because if it does, it can generate an overload of functions, so that they cannot meet all families, creating dissatisfaction and making it more difficult access to care.

The ESF have the appropriate number of families enrolled asked by the Ministry of Health, which is 3,465 people, and these are with a range of about 2600 to 2700 people. It was also clear that many families complained about the fact that the doctor does not visit their homes, have no vacancies to consult and there is a delay to be assisted. The number of professionals is according to asked by the Ministry of Health. Why even with the number of which is recommended by the Ministry of Health, the ESF are failing to serve the entire population effectively? Why, these professionals are failing to serve the entire population? Is it necessary to create the NASF to support and support to the ESF?

Some families even do not know the difference between UBS and ESF. It is necessary for professionals working in these ESF to guide the families about what they mean, what is the difference between the two of them and what is the role of each team member, through posters, lectures, brochures, among others.

The interaction between the patient and professionals may be affected when they are delayed to be met, generating a great dissatisfaction among them, causing many fail to seek care because of the delay.

Patients' satisfaction is related to good care of professionals, giving them attention, respect, good care and resolution of health problems, and providing better quality of life, since when there are satisfied patients, they tend to adhere to treatment, provide adequate information and to continue using the ESF.

It is necessary that the ESF continue to seek by these means to solve the problems that generate dissatisfaction to the patients, such as continuing education, enabling the visit to all families enrolled efficiently and faster service and appointments so that they

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feel satisfied with the change and the ESF provide quality care for all.

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