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ORIGINAL ARTICLE

INTEGRAL CARE IN THE PERCEPTION OF FAMILY HEALTH STRATEGY PROFESSIONALS*

ATENÇÃO INTEGRAL NA PERCEPÇÃO DOS PROFISSIONAIS DA ESTRATÉGIA SAÚDE DA FAMÍLIA

ATENCIÓN COMPLETA SOBRE LA PERCEPCIÓN DE PROFESIONALES DE LA ESTRATEGIA DE SALUD FAMILIAR

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ABSTRACT

Objective: to describe the perception of a multiprofessional team of the Family Health Strategy about integral care in its unit. ***Method:*** this is a qualitative, descriptive study, developed in a health unit with 11 professionals of the multidisciplinary team. Data was collected using the focus group technique guided by the Self-Assessment tool to improve access and quality of primary care. The technique of Content Analysis was used. ***Results:*** it is noteworthy that the team judged satisfactory the full attention in the woman cycle and unsatisfactory in the child and adolescent, adult and elderly cycles. Little familiarity with the ministerial evaluation program was noted. ***Conclusion:*** it was noted the need to institute a routine reflection on comprehensive care based on the attributes of Primary Health Care. ***Descriptors***: Primary Health Care; Integrality in Health; Family Health; Health Management; Health Evaluation; Nursing.

RESUMO

Objetivo*:** descrever a percepção de uma equipe multiprofissional da Estratégia Saúde da Família sobre a atenção integral na sua unidade. ***Método*:** trata-se de um estudo qualitativo, descritivo, desenvolvido em uma unidade de saúde com 11 profissionais da equipe multiprofissional. Coletaram-se os dados utilizando a técnica de grupo focal norteada pelo instrumento de Autoavaliação para Melhoria do Acesso e da Qualidade da Atenção Básica. Utilizou-se a técnica de Análise de Conteúdo. ***Resultados*:** destaca-se que a equipe julgou satisfatória a atenção integral no ciclo da mulher e insatisfatória nos ciclos da criança e do adolescente, adulto e idoso. Percebeu-se a pouca familiaridade com o programa de avaliação ministerial. ***Conclusão: constatou-se a necessidade de se instituir uma reflexão rotineira sobre a atenção integral pautada nos atributos da Atenção Primária à Saúde. ***Descritores*:** Atenção Primária à Saúde; Integralidade em Saúde; Saúde da Família; Gestão em Saúde; Avaliação em Saúde, Enfermagem.

RESUMEN

Objetivo: describir la percepción de un equipo multiprofesional de la Estrategia de Salud Familiar sobre la atención integral en su unidad. ***Método:*** estudio cualitativo, descriptivo, desarrollado en una unidad de salud con 11 profesionales del equipo multiprofesional. Los datos se recolectaron utilizando la técnica de grupos focales guiada por la herramienta de Autoevaluación para Mejorar el Acceso y la Calidad de la Atención Primaria. Se utilizó la técnica de Análisis de Contenido. ***Resultados:*** es digno de mención que el equipo consideró satisfactoria la atención total en el ciclo de la mujer e insatisfactorio en los ciclos de niños y adolescentes, adultos y ancianos. Se observó poca familiaridad con el programa de evaluación ministerial. ***Conclusión:*** se señaló la necesidad de instituir una reflexión de rutina sobre la atención integral basada en los atributos de la Atención Primaria de Salud. ***Descriptores***: Atención Primaria de Salud; Integralidad en Salud; Salud de la Familia; Gestión en Salud; Evaluación en Salud; Enfermería.

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INTRODUCTION

Primary Health Care (PHC) is the main gateway to the health system, encompassing a set of individual and collective actions related to the promotion, prevention, protection, diagnosis, treatment, rehabilitation, harm reduction, palliative care and health surveillance.[1]

Since the Ordinance MS No. 2488/2011, which establishes the NPCP, are the terms Basic Care and Primary Health Care in Brazil, as equivalent, and Family Health is the priority strategy for operationalization.[2] It is known that PHC actions should be guided by essential attributes of first contact attention, longitudinality, care coordination and comprehensiveness[3] whose actions are the decisive basis for the organization of health care networks.[1]

In recent years, in the Unified Health System (UHS), PHC has progressed substantially, highlighting the importance of this level of care[4] to strengthen integrality and articulate health actions and services for individual and/or collective care, considering the peculiarities of the territory.[5] However, it is noteworthy that these advances have been shown to be fragile after the changes in the norms that lead to the National Primary Care Policy (NPCP).

It is argued, in relation to the growing expansion of PHC services in the Brazilian territory, that the evaluation may favor cooperative mechanisms for the teams' work, in the understanding of individual and collective actions to establish the essentiality of care. It is considered, within the scope of health policies and programs, that the evaluation of health systems and services is becoming increasingly relevant, as an important planning and management tool for decision making.[6]

In 2012, the Ministry of Health, with a view to strengthening monitoring and evaluation actions under PHC, implemented the National Program for Access and Quality Improvement of Primary Care (PMAQ-AB), in which one of the steps is the Self-Assessment for Improving Access and Quality of Primary Care (AMAQ).

Pontua-se que o uso de instrumentos autoavaliativos tem sido recomendado por qualificar os processos gerenciais e assistenciais e por possibilitar o agir reflexivo nas ações das equipes para se reconhecer as conexões intrínsecas entre o planejamento e a avaliação, bem como a sua importância como norteadores do processo de trabalho, em uma perspectiva dinâmica para se romper a tradição do planejamento e da avaliação como práticas fragmentadas e burocratizadas.[7]

In this study, the conception of comprehensive care used by the PMAQ is assumed, analyzing the actions of welcoming the demand in the phases of human development, individual and collective, health promotion, disease prevention, health surveillance, treatment and rehabilitation, considering also the psychological suffering and the social conditions of health.[1]

Based on these considerations, this research is justified by the relevance of capturing the perception of professionals about their work practice in health and reflections on the strengths and weaknesses for comprehensive care whose results can contribute to the evaluation in the FHS as well as the possibility of using evaluation as a management tool.

OBJECTIVE

- To describe the perception of a multiprofessional Family Health Strategy team about integral care in their unit.

METHOD

This is a qualitative, descriptive study, developed in a municipality located in the southwest of the state of Mato Grosso. In 2016, this municipality exponentially accelerated the process of expansion of primary care, reaching 100% coverage[8] following the adhesion to the Mais Médicos Program and the establishment of managers at the management level of the Municipal Health Secretariat and the Primary Care Coordination, a situation that triggered, in 2016, the first adherence to the PMAQ evaluation.

For the selection of the participating service, the mapping of health units distributed in geographical regions of the municipality was performed, applying the following inclusion criteria: being registered in PMAQ, having a complete multidisciplinary team and being located at a geographical extreme that makes access difficult. From the total of 12 units, three met the inclusion criteria and were visited for the presentation of the project and the invitation to participate in the research, and the team from one unit accepted the invitation.

Participants were all professionals of the multidisciplinary team (nurse, doctor, nursing technicians, receptionist, community health agents, dentist and oral hygiene technician), totaling 11 professionals.

With the participants' acceptance, a schedule was created for the team, which was made available with the possible dates for meetings, which allowed the consensual choice of the date, a strategy used to favor the participation of as many professionals as possible and to capture the looks involved in the work process.

Data was collected by the researchers in September 2016 using the focus group technique[9-

[10] conducted with the presence of a moderator and two observers.

A script constructed by the researchers was applied to know the socioeconomic and professional profile of the participants.

The focus group was guided by a roadmap based on the Self-Assessment Tool for Improving Access and Quality of Primary Care (AMAQ), used by the Ministry of Health to evaluate the National Program for Improving Access and Quality of Primary Care (PMAQ).[11] For this study, the dimension related to comprehensive care, which fits the proposed objective, was used. The items of the instrument are evaluated by a scale, where the zero point indicates non-compliance with the standard and point ten, the total adequacy, and the intervals between these values are degrees of conformity/compliance of the situation analyzed in relation to desired quality. It was found that the participants scored according to the value they considered appropriate to the reality experienced regarding each question and, at each score, the justification of the assigned value was requested. Then, as a group, the value attributed to the question was questioned with the standard that the AMAQ instrument indicates as an evaluation parameter, contextualizing the scenario of the study health unit.

The instrument was made available in hard copy to each participant, projecting also in a multimedia device. A banner with punctuation was constructed to be consulted if necessary. These resources were adopted to facilitate the follow-up of the instrument.

Note that the meeting was audio recorded and lasted for two hours and thirty minutes. The transcribed material was subjected in full to exploratory reading for the appropriation of the totality of the content and, afterwards, the exhaustive reading was performed in order to grasp, in depth, the content of the material. In the analysis and interpretation, the thematic representational aspect of Bardin.[12] It is noted that the results were organized according to the life cycle for a better understanding of the care approach.

All ethical aspects in research were respected in accordance with Resolution 466/12, with the appreciation and approval of the UNEMAT Research Ethics Committee (REC), CAEE No. 51340215.0.00005166.

RESULTS

The most frequent characteristics of the participants' socioeconomic profile are: 33.3% are over 40 years old; 55.5% are female; 66.6% are white; 55.5% are married; 55.5% have children; 55.5% have a statutory employment relationship and 55.5% are Community Health Agents (CHA). It is noteworthy that this multiprofessional team had the participation of a physician from the More Doctors Program (MDP).

It is registered that 77.7% of professionals joined the unit in 2015; 77.7% received admission training; 66.6% have regular satisfaction with the salary; 77.7% reported satisfaction with the employment relationship; 88.8% demonstrated satisfaction with the 40-hour weekly workload; 77.7% have a previous professional experience relationship; 88.8% had a professional qualification and 100% never received financial bonus for reaching goals. It is noted that 55.5% reported that there is an adequate relationship between scheduled and spontaneous consultations.

The team's lack of familiarity with the Ministry of Health's evaluation program was identified.

> *People here have never heard of PMAQ or this self-assessment notebook. Does this really have to do? Because so far, they haven't said anything to us, not even a memo has come here. (Nurse)*
>
> *Now you have to do that, because you haven't spoken yet to fill in anything. (CHA 2)*
>
> *I am not reminded of PMAQ in meeting with the supervisor. (Doctor)*

It is noteworthy that this research was a trigger to initiate the dialogues about the evaluation in PHC in the municipality. It is understood that by producing a self-assessment based on the AMAQ, which provides standards of practice and organization of the health unit, a diagnosis of the work process situation is generated based on what is expected for comprehensive care. Considering this proposal, it is observed that the results were organized by life cycle in the possibility of looking at each cycle and giving rise, in a participatory manner, to the possibility of building structured processes for comprehensive care.

It is noteworthy that comprehensive attention to children and adolescents was considered unsatisfactory because it did not include the monitoring of all children and adolescents. It is noticed that the nurse and the doctor use the Child Health Handbook in the practice of monitoring growth and development.

> *The nurse and doctor are the ones who usually make the growth and development of the child. (CHA 2)*
>
> *Filling out the child book we don't do because we don't have the skills to do that. It really goes in the matter of orientation; that we do. (CHA 4)*

It is imperative that the entire staff of the unit be able to identify children in vulnerable situations, visit those who are absent in predefined calendar appointments and properly detect changes in the child's weight curve and neuropsychomotor development. However, the following statements express a limited focus on child care focused on immunization.

Usually, we go for this part: immunization. (CHA 1)

[...] but they come more because of the vaccine, right? (Nursing Technician 1)

The vaccine is complete. (Nursing Technician 2)

It was found that the participants value the biomedical model in the practices, with the prioritization of goals and age groups that correspond to the programs and indicators agreed with the municipal management, which directs focused actions.

This age group, over five years old, only look here when they have a problem. (Nurse)

[...] the child comes with tonsillitis, we don't even ask for the book. (Doctor)

Child above five years and teenager. This is pretty precarious. The child care has, but is prioritized more children, because of the goal. (Receptionist)

Comprehensive care was rated as satisfactory; however, women's health highlights the fragmentation in care, with a focus on spontaneous demand to the detriment of the determinant aspects of health promotion.

We keep changing areas, I've already changed about four times, so there's no team action that looks at potential women who might get pregnant. (CHA 2)

Never had a mapping of women of childbearing age, only comes to the pregnant group. (CHA 3)

The identification of the pregnant woman is not always so early, when she comes here, is already in the fourth month or more. (Nurse)

We do not use much planning and live map, in fact, we only detect the pregnant woman in the first trimester, if she comments or comes looking for, we need to look more at the mapping of the territory. (Doctor)

It is identified that comprehensive adult health care was assessed as unsatisfactory. The strengths of follow-up actions, such as chronic noncommunicable diseases and the need for emerging articulation to monitor chronic cases of tuberculosis, leprosy and sexually transmitted infections, are highlighted.

Every month, the team passes the file to me and their production. We can talk about how many hypertensive and diabetic people are visited in the area per month, for example. We know all hypertensive people from the consultation we make. (Nurse)

We had a patient in my area, had tuberculosis, followed up, followed the treatment, now will have to do new tests to confirm if it is really cured. I went out of my work schedule, took the medicine for him to take. (CHA 1)

There are weaknesses and limitations of the team to deal with situations of psychological distress, alcohol, tobacco and other drugs and prevention of violence. It is noteworthy that the items related to this theme spent a longer discussion time, which may signal the need to adopt strategic training actions for professionals to care for users and their families in the mental health field. In this sense, the following statements indicate the fragmented approach, without the full focus on actions and/or follow-up of users with mental health needs.

The team is not very careful because it is referred to PSCC, they assume. I do not follow. There is the lady of your Valdomiro, who is psychiatric, we went there and took care of her? No, I didn't go there. We follow, but in parts, understand? (Nurse)

We just identify and already forward to PSCC, they do the monitoring. Has the treatment of PSCC, but not in the unit. (Doctor)

This is very flawed because, with regard to drugs, drug addiction and people with mental problems, they are kind of afraid to deal because they don't have a treatment and we don't know what to say. We just omit ourselves for this reason. (Dentist)

Violence is difficult, it escapes our purview, it seems that [pause] I need to go after and study, there are manuals that talk about the approach, but if I arrive, I will answer, but I need to train myself, I need to. (Doctor)

It is understood that the actions of professionals have been limited to practices aimed at medicalization and emergency response to the demands brought about in consultations, signaling poor resolution actions, with frequent referral to referral services, which do not establish singular therapeutic projects to care monitoring, as pointed out in the following statements.

So many depressive patients come here just to change prescriptions and we don't follow anything. Just come, exchange revenue and that's it, we don't do the Singular Therapeutic Plan, I think some here don't even know it exists. (Nurse)

There are some patients who don't even come, just send their son or a relative to bring the old prescription to change, when they don't ask me to change the prescription for him. (CHA 2)

I know you should work with the referral, but the demand is high, there are many assignments, so you end up referring or asking the patient to go to the service. (Doctor)

Needs an assessment and has no psychiatrist. (Doctor)

From the perspective of the participants, it is necessary to commit to the formulation, execution and evaluation of the policy of attention to users of alcohol and other drugs, as presented in the following statements.

It has no action for tobacco, alcohol and other drugs. (Nurse)

We identify some cases, yes, but do not develop actions, sometimes it is dangerous, right? (Doctor)

It was observed that comprehensive health care for the elderly has activities focused on individual care and restricted to follow-up in consultation. This cycle is considered unsatisfactory.

We have the elderly day in the unit, we have the monitoring that day or if any of them come to the unit with any complaints. (Receptionist)

We follow the elderly a lot, especially when they have wounds or accompanying medication. (Nurse)

> *We monitor the visits. The CHA, when you need guidance, warns us. (Doctor)*
>
> *It can be seen from the speeches that it is not a routine for the professionals to use the passbook.*
>
> *I do not use the passbook of the elderly in every care situation because there are people who do not have, is missing. (Doctor)*
>
> *The booklet is not coming, the last one that came in 2014. (CHA 3)*

It is identified that there are no training, follow-up for guidance or supervision in caregiver practices.

> *I know who the caregiver is; or is a family member or guardian that the family pays for care, but training I do not perform. (Doctor)*
>
> *We have never had a discussion about this caregiver empowerment issue here at the unit. (CHA1)*
>
> *Look, we even orient individually in a view or here in the unit, but this is more for bedridden elderly. (Nurse)*

DISCUSSION

From the set of speeches, weaknesses in the health promotion approach are evidenced, with fragmented and poorly articulated actions among professionals, factors that can compromise the coordination of care, the resolution, the creation of bonds and the integral attention, according to the needs of different life cycles and the particularities of the territory.

PHC is considered relevant in comprehensive health care for children and adolescents to produce actions for the promotion and prevention of diseases in children and youth development. Regarding the expansion of access to care for children and, especially, adolescents, it is evaluated that the guarantee of comprehensive care still lacks in prevention, assistance to injuries and harm reduction, with a view to social vulnerability.[13]

It is verified, by the conception of integral attention proposed in the AMAQ in the health unit, that there are actions of reception to the programmed demand, however, with greater focus to the actions that are in the national health calendar focused on campaigns.

It is observed that health actions for priority groups are centered on consultations with higher education professionals and do not encourage collective actions that promote the sharing of care experience. It is understood that spontaneous demand has representativeness in the unit's agenda, which points to a considerable portion of care provided without a look at the diagnosis of the territory and with the great challenge of turning into longitudinal care that responds to health problems, meeting the organization of the work process and surpassing the need-centered technical assistance projects, in a health promotion perspective.

It is noteworthy that immunization is part of the historical process in the consolidation of public health policies for children even before the creation of UHS. It is a world reference in the promotion of child health with direct impact on social indicators in the country. Attendance to the vaccine room is an opportunity to establish a bond with the family and/or guardians of children and adolescents from the perspective of comprehensive care.

The importance of this action is verified in the national calendar of child care, which can be associated with practice in the health unit for the organization of the integrated agenda of multiprofessional actions, in order to optimize the children's going and strengthen the bond of the caregiver. the child in an approach to health promotion, healthy living habits, vaccination, prevention of problems and diseases, as well as providing timely care.[14]

Data logging is known to be part of the comprehensive health assessment of the child and involves assessment items and guidance to the mother/family/caregiver regarding care in monitoring growth and development, and the quality of growth records and development can reveal the workings of the services and the performance of their professionals.[15]

It is emphasized that the closer approach to the guidelines of comprehensive care requires the transformation of the traditional approach based on aspects exclusively related to anatomophysiological issues to a practice directed to gender peculiarities, social and cultural conditions, individual and community needs and the quality of life.[16]

It is argued that the acceptance of women's demands, meetings with groups, as well as home visits are actions that enhance comprehensive care and closer ties, which are essential to recognize the risks present in the evolution of pregnancy.[17]

It is observed that the issues of the women's health care cycle address the public policies of the female population, the organization of the service and the practice of health professionals. The results revealed a greater focus on pregnant

women, with the prioritization of prenatal actions and little appreciation of care in family planning, cervical cancer prevention, climacteric and violence against women.

It is important to highlight the importance of PHC in stimulating and supporting preventive care and promotion of women's health, since the activities carried out include consultations, educational actions, management and provision of material and technical resources, quality control. examinations, verification, communication of results and reference and counter-referral actions to ensure completeness and continuity of care.[18] Thus, the need to restructure is reinforced, in order to provide working conditions compatible with PHC conformation and the performance of health professionals, who should act as promoters and co-responsible for care, superseding the clinical approach.[19]

Mental health is defined as a public health bottleneck marked by strong remnants of the flexnerian paradigm based on the curative and biomedical care model, fragmented care, segregation and stigma and, even after the Brazilian psychiatric reform, remains a challenge in aspects such as poor articulation between health services and the low reception of this demand at the primary care level.[20]

It is pointed out that integrated and intersectoral projects to overcome these challenges are essential in reference and counter-referral procedures in order to invest in the care network as a care producer.[21]

It is understood that health care managers and coordinators need to look at PHC as a care organizer to provide, through the promotion and actions of articulation of the mental health network, skills that enable care, but stimulate family care through activities that include prevention and promotion in strengthening social links and citizenship of the mentally ill.[22] Acrescenta-se que a integração das ações e a organização dos serviços no território e na rede de atenção psicossocial favorecem a desinstitucionalização dos portadores de transtorno mental severo e persistente.

It is understood that PHC care and treatment strategies should strengthen/guarantee access to care, medicines, community care and health education that involves the community/families/users, forming human resources capable of providing support to policy strategies for attention to users of alcohol and other drugs, as well as breaking the rigidly delineated logic based on the intense association of drugs with antisocial and/or criminal behavior.[23]

It is clear that one of the greatest challenges for health teams has been to find the right way to promote self-care.[24] In this sense, it is verified that the activities of health education, the welcoming of the subject and the teamwork with an interdisciplinary look must be present in the team routine in primary care,[25] both because they facilitate the perception of the individual/family/professionals and because they are relevant strategies to increase the demand for treatment and control health indicators.[26]

It is noteworthy that one of the strategies to qualify attention to the elderly is the health record of the elderly, an instrument proposed to assist the good management of care. It is intended to be used by health teams, the elderly and their families and caregivers for integrating a set of initiatives that aims to expand and add attention.[27]

It is noteworthy that the higher level health professionals are the most suitable to guide the caregivers of the elderly.[1] It can be seen that care services for the elderly have been inadequate, insufficient or incomplete, which reveals, in a health policy dimension for the elderly, the emerging need for services to focus on disease prevention and invest in multidisciplinary care.[28]

It is apprehended that, in the unit studied, there is a strong influence of the biomedical model determined in the logic of a technical operational format of actions focusing on simplified medicine practices, directed to the mainly spontaneous demands, which corroborate the successive changes in the scope design and turnover of professionals. In this perspective, it is required to invest in the knowledge of epidemiological instruments and the care network, with the proposal of looking at health promotion, understanding it in the composition of the team's work process to advance in integral care.

In the work process of the multidisciplinary team, it is argued that comprehensive care should permeate life cycle care practices, considering the concept of territory and the opportunity to take individual and collective actions for health promotion.

It is assessed that the weaknesses found in this study may result from the practice of professionals who do not permeate the health promotion model, recognizing the social, economic, cultural, ethnic/racial, psychological and behavioral determinants in the health-disease process. It is understood that the limiting factors for the development of comprehensive care exposed go beyond the scope of the work process for care in this unit, bypassing political arrangements, financial mechanisms, management tools of the organization of care and the evaluation of services themselves, beyond human resources training for PHC.

It is necessary, in the field of practice of comprehensive care, that the relationships between individual and collective actions are subsidized in knowledge of expanded clinic, epidemiology, care management from the perspective of PHC attributes aimed at health promotion and surveillance in health.

CONCLUSION

It is understood that the participants considered the full attention in the woman cycle satisfactory and unsatisfactory in the child and adolescent, adult and elderly cycles. Professional unpreparedness in dealing with the stipulated standards for quality assessment is noted. It is pointed out that the difficulties encountered in the integral care of each life cycle may present ways to change the work process of these professionals.

It is inferred that the focus of biomedical care, which runs through all life cycles as a daily trend in professional practice, is a hindrance to comprehensive care from the perspective of health promotion. The lack of self-assessment and monitoring of work practices is indicated as a trend towards the low resolution of PHC in the researched unit.

It is verified that the non-internalization of the evaluative culture in the unit derives from the lack of initiatives by the municipal management to institutionalize this practice. Continuity of routine evaluation, incentives for guiding self-assessment in the planning of team actions and interventions, and systematic analysis of their results are pertinent interventions that can positively affect the quality of actions offered to users.

It is pointed out that for integral care to be effective in care, it is necessarily necessary to review the work processes and that the multidisciplinary field of work acts in primary care in a co-responsibility, respecting the particularities and specificities of the activities that enhance the work added to the multiple views on the subject's real context and their participation and understanding in therapeutic decision.

It is concluded that the practices are fragmented and focused. It is considered improbable to integrate, in a balanced way, clinical care, prevention and health promotion based on the in-depth analysis of the information in this study.

One limitation of this study is the on-site verification of only one unit, which may not reflect, even with defined selection criteria, the reality of the health service, considering local specificities. It is necessary to carry out studies that measure, more accurately, the quality predicted by the PMAQ in these units and a look at the use of national and regional parameters that evaluate the guidelines of the National Policy of Primary Care.

REFERENCES

1. Ministério da Saúde (BR), Gabinete do Ministro. Portaria nº 2.436, de 21 de setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS) [Internet]. Brasília: Ministério da Saúde; 2017 [cited 2018 Aug 10]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html

2. Ministério da Saúde (BR), Gabinete do Ministro. Portaria nº 2.488, de 21 de outubro 2011. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica, para a Estratégia Saúde da Família (ESF) e o Programa de Agentes Comunitários de Saúde (PACS) [Internet]. Brasilia: Ministério da Saúde; 2011 [cited 2018 Aug 10]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt2488_21_10_2011.html

3. Mendes EV. A construção social da atenção primária à saúde [Internet]. Brasília: Conselho Nacional dos Secretários de Saúde; 2015 [cited 2018 Aug 10]. Available from: https://www.conass.org.br/biblioteca/pdf/A-CONSTR-SOC-ATEN-PRIM-SAUDE.pdf

4. Ceccon RF, Meneghel SN, Viecili PRN. Hospitalization due to conditions sensitive to primary care and expansion of the Family Health Program in Brazil: an ecological study. Rev Bras Epidemiol. 2014 Oct/Dec;17(4):968-77. DOI: http://dx.doi.org/10.1590/1809-4503201400040014

5. Camargo RAA, FMGC, Toneti AN, Silva MAI, Gonçalves MFC, Andrade LS. Forming the integrality in health concept based on the historical-cultural approach. Rev eletrônica enferm. 2015 Oct/Dec;17(4). DOI: https://doi.org/10.5216/ree.v17i4.34415

6. Almeida CAL, Tanaka OY. Evaluation in health: participatory methodology and involvement of municipal managers. Rev Saúde Pública. 2016 Aug;50:45. DOI: http://dx.doi.org/10.1590/S1518-8787.2016050006251

7. Cruz MM, Souza RBC, Torres RMC, Abreu DMF, Reis AC, Gonçalves AL. Uses of the planning and self-evaluation in the working processes of Family Health teams in Primary Care. Saúde Debate. 2014 Oct; 38:124-39. DOI: 10.5935/0103-1104.2014S010

8. Gleriano JS, Lucietto GC, Reis JB, Teixeira VM, Chaves LDP. The perception of the family health strategy nurses on the evaluation concept and practic. CuidArte Enferm [Internet]. 2017

July/Dec [cited 2018 Aug 10];11(2):248-56. Available from: http://bases.bireme.br/cgi-bin/wxislind.exe/iah/online/?IsisScript=iah/iah.xis&src=google&base=BDENF&lang=p&nextAction=lnk&exprSearch=32953&indexSearch=ID

9. Carlini-Cotrin B. Qualitative research methods in drug abuse research: discussing the potential use of focus group in Brazil. Rev Saúde Pública. 1996 June;30(3):285-93. DOI: http://dx.doi.org/10.1590/S0034-89101996000300013

10. Morgan DL, Kruger RA. The focus group kit. Thousands Oaks: Sage Publications; 1998.

11. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Atenção Básica. Autoavaliação para melhoria do acesso e da qualidade da atenção básica [Internet]. Brasília: Ministério da Saúde; 2016 [cited 2018 Apr 6]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/autoavaliacao_melhoria_acesso_qualidade_amaq_2ed.pdf

12. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2011.

13. Araujo JP, Viera CS, Oliveira BRG, Gaiva MA, Rodrigues RM. Assessment of the essential attributes of Primary Health Care for children. Rev Bras Enferm. 2018;71(Suppl 3):1366-72. DOI: http://dx.doi.org/10.1590/0034-7167-2017-0569

14. Araujo Filho ACA, Rocha SR, Gouveia MTO. Possibilities for the integrality of care the child in primary care. Rev Cubana de Enferm [Internet]. 2019 [cited 2018 Aug 10];35(1):772-80. Available from: http://www.revenfermeria.sld.cu/index.php/enf/article/view/1765/419

15. Amorim LP, Senna MIB, Gomes VE, Amaral JHLD, Vasconcelos M, Silva AGD, et al. Filling process of the Child Health Record in health care services of Belo Horizonte, Minas Gerais, Brazil. Epidemiol Serv Saúde. 2018; 27(1):e201701116. DOI: 10.5123/s1679-49742018000100016

16. Nasser MA, Nemes MIB, Andrade MC, Prado RR, Castanheira ERL. Assessment in the primary care of the State of São Paulo, Brazil: incipient actions in sexual and reproductive health. Rev Saúde Pública. 2017 Jan;51:01-12. DOI: https://doi.org/10.11606/S1518-8787.2017051006711

17. Silva MZN, Andrade AB, Bosi MLM. Access and user embracement in prenatal care through the experiences of pregnant women in Primary Care. Saúde Debate. 2014 Oct/Dec;38(103):805-16. DOI: http://dx.doi.org/10.5935/0103-1104.20140073

18. Melo MCSC, Vilela F,Salimena AMO, Souza IEO. The nurse in uterine cervical cancer prevention: the daily care in health primary attention. Rev Bras Cancerol [Internet]. 2012 [cited 2012 Aug 10]; 58(3):389-98. Available from: http://www1.inca.gov.br/rbc/n_58/v03/pdf/08_artigo_enfermeiro_prevencao_cancer_colo_utero_cotidiano_atencao_primaria.pdf

19. Porto RTS, Junior Bispo JP, Lima EC. Domestic and sexual violence in the Family Health Strategy: professional performance and barriers to coping Physis. 2014 July/Sept;24(3):787-807. DOI: http://dx.doi.org/10.1590/S0103-73312014000300007

20. Silva GR, Reis HFT, Santos EM, Souza MPA, Azevedo RL. Mental health in primary care: perceptions of the family health care team. Cogitare Enferm. 2016 Apr/June;21(2):1-8. DOI: http://dx.doi.org/10.5380/ce.v21i2.43861

21. Silveira CB, Costa LSP, Jorge MSB. Health Care Networks as producers of mental health care: a reflective analysis. Rev port enferm saúde mental. 2018 June;19:61-70. DOI: http://dx.doi.org/10.19131/rpesm.0203

22. Serejo EVS, Cunha MC, Carvalho ME, Negreiros JA, Oliveira EN, Ximenes Neto FRG. Mental Health in Primary Care: weaving family approach tool. Cultura de los Cuidados [Internet]. 2018 [cited 2019 July 15];(51):133-4. Available from: http://ciberindex.com/index.php/cc/article/view/51133cc

23. Lopes GP, Maraschin C. Cognitive policies and proposals for intervention and treatment of drug users and drug addicts. Psicol clin [Internet]. 2008 [cited 2018 Aug 10]; 20(2):149-61. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S0103-56652008000200011

24. Lima CR, Menezes IHCF, Peixoto MRG. Health education: educational intervention assessment with diabetic patients based on social cognitive theory. Ciênc Educ Bauru. 2018 Jan/Mar; 24(1):141-56. DOI: http://dx.doi.org/10.1590/1516-731320180010010

25. Popim RC, Coutinho AT, Carregã K, Spiri WC. Integrality of care for the aged in the family health strategy: the vision of the team. Esc Anna Nery Rev Enferm. 2013 Sept/Dec;17(4):628-37. DOI: http://dx.doi.org/10.5935/1414-8145.20130005

26. Lima MG, Ceccato MGB, Braga DS, Silva FMB, Gonçalves MA, Gajo MM, et al. Operative groups in hypertensives and diabetics in pet-saúde program. Rev Bras Pesq Saúde [Internet]. 2014 Jan/Mar [cited 2019 Jan 15];16(3):133-8. Available from: http://periodicos.ufes.br/RBPS/article/view/8501/5997

27. Torres KRBO, Luiza VL, Campos MR. Distant learning in the context of the brazilian national elderly health policy: a course egressed study. Trab educ saúde. 2018 Apr;16(1):337-60. DOI: http://dx.doi.org/10.1590/1981-7746-sol00103

28. Minayo MCS. The imperative of caring for the dependent elderly person. Ciênc saúde coletiva. 2019 Jan;24(1):247-52. DOI:

http://dx.doi.org/10.1590/1413-81232018241.29912018

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