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Avaliação da Estratégia Saúde da Família em Natal a partir das crenças dos seus usuários

Evaluation of Family Health Strategy in Natal from the beliefs of its users

Evaluación de la Estrategia Salud de la Familia en Natal de las creencias de usuarios

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ABSTRACT

Objective: To evaluate the Family Health Strategy in Natal/Rio Grande do Norte, through the beliefs of its members, to verify the successes and barriers of the strategy, to provide feedback to their managers and community and to obtain an effective health service. **Methods:** Exploratory and descriptive research of qualitative nature, where there were five focus groups, one in each Sanitary District (DS), 26 users of the Family Health Strategy. **Results:** We identified a positive assessment of the location and identification of the Family Health Units (USF). Stood out, however, problems in several areas: physical infrastructure, material resources, human resources, accessibility of services, preventive care, referral system, understanding of the community on the ESF, districting, link between community and professional and Municipal Health Council. **Conclusion:** These factors contribute to the search for particular services.

Descriptors: Family Health Strategy, Program Evaluation, Public Opinion.

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RESUMO

Objetivo: Avaliar a Estratégia Saúde da Família em Natal, Rio Grande do Norte, através das crenças de seus usuários, para verificar os acertos e entraves da estratégia, para fornecer *feedback* aos seus gestores e comunidade e para obtenção de um serviço de saúde eficaz. **Métodos:** Pesquisa exploratória e descritiva, de cunho qualitativo, onde foram realizados cinco grupos focais, um em cada Distrito Sanitário (DS), totalizando 26 usuários da Estratégia Saúde da Família. **Resultados:** Identificou-se uma avaliação positiva da localização e identificação das Unidades de Saúde da Família (USF). Destacaram-se, entretanto, problemas em diversos setores: infraestrutura física, recursos materiais, recursos humanos, acessibilidade aos serviços, atendimento preventivo, sistema de referência, compreensão da comunidade sobre a ESF, distritalização, vínculo entre comunidade e profissionais e Conselho Municipal de Saúde. **Conclusão:** Esses fatores contribuem para a busca por serviços particulares.

Descritores: Estratégia Saúde da Família, Avaliação de Programas e Projetos de Saúde, Opinião Pública.

RESUMEN

Objetivo: Evaluar la Estrategia Salud de la Familia en Natal, Rio Grande do Norte, a través de las creencias de sus miembros, para verificar los éxitos y las barreras de la estrategia, para proporcionar retroalimentación a sus directivos y comunidad y para obtener un servicio de salud eficaz. **Métodos:** Estudio exploratorio y descriptivo de naturaleza cualitativa, donde había cinco grupos de enfoque, uno en cada Distrito Sanitario (DS), un total de 26 usuarios de la Estrategia Salud de la Familia. **Resultados:** Se identificó un balance positivo de la localización e identificación de las Unidades de Salud de la Familia (USF). Se destacó, sin embargo, los problemas en varias áreas: infraestructura física, recursos materiales, recursos humanos, accesibilidad de los servicios, la atención preventiva, sistema de referencia, la comprensión de la comunidad sobre el FSE, de distritos, enlace entre la comunidad y profesional y Consejo Municipal de Salud. **Conclusión:**Estos factores contribuyen a la búsqueda de servicios particulares.

Descriptores: Estrategia de Salud Familiar, Evaluación de Programas y Proyectos de Salud, Opinión Pública.

INTRODUCTION

Created in 1994, since the Family Health Program (FHP), the Family Health Strategy was legitimized through Administrative Rule 648/06 as a structuring action to reorient and reorganize Basic Health Care of the Unified Health System (SUS). The main gateway to access the system. It follows the doctrinal principles (universality, completeness and equity) and organizational (decentralization, hierarchization/regionalization and popular participation) of SUS.[1-3] Therefore, it must be linked to the service network, so that comprehensive care is guaranteed to individuals and families, as well as ensuring reference and counter-referencing for services of greater complexity, whenever the user's state requires.[4] Likewise, it must work with a territory of defined scope, being responsible for the monitoring of 600 to 1,000 families by Family Health Team (FHT), not exceeding a maximum of 4,500 people.[4-5]

However, these criteria are not always respected, with a greater proportion of people being cared for by a single Family Health Unit (FHU). Coupled with the precarious health and infrastructure conditions, the quality of service provided to the population tends to be unsatisfactory, since a demand that goes beyond the service capacity generates a service of low quality and unattainable, or not very effective.[6-7] This creates a crisis that begins in Primary Care and has repercussions throughout the SUS, widely disseminated in the media and academic community, at all levels of execution: 1) in its formulation and management;[8-11] 2) they go through the operationalization of the services of professionals;[8,11-4] 3) and in the final stage of the process, in the health services offered to its users.[2,8,11,15-6]

Thus, although they emerge from the population's demand as instruments of change in social reality, programs are created and implemented by trial and error, and the population that pays for services follows a daily practice that It differs, and distances, from its theoretical and legislative formulations. In this scenario, the evaluation of social policies, programs and projects functions as a fundamental tool to assist, through feedback, the managers' decisions, regarding the implementation, the process and the results achieved by the governmental programs and the systematic information that can Be used in their improvements.[17]

Brazilian psychologists have little interest in linking knowledge in behavior assessment with public policy evaluation, although they are knowledgeable about content about intergroup relations, collective beliefs, attitudes, individual and group behaviors, psychometry, among other fundamental tools for this type of task.[18] Thus, having this theoretical framework as a background, we used the belief theory of Social Psychology, understanding that the users have beliefs about ESF, assertive that are acquired in the direct contact with the object of belief, in their daily life of Care within the Family Health Units (FHU).[19-20] And that, although they are intervening variables, they can be inferred and integrate empirical hypotheses, since they are accessible to the measurement although indirectly.[21]

In view of the above, the present study aimed to evaluate the Family Health Strategy in Natal, Rio Grande do Norte, through the beliefs of its users, to verify the correctness and obstacles of the strategy, in order to provide feedback to its managers and community, to obtain effective, efficient and effective health service.

METHODS

It is an exploratory and descriptive qualitative study, where five focus groups were carried out, one in each Health District (SD) (South-SD, East-DL, West-DO, North 1-DN1 and North 2- DN2), composed of 4 to 7 people, in a total of 26 users of the Family Health Strategy, among men and women, young adults and the elderly, coded by the initial letter of the Sanitary District and by a numbering (e.g. DS, P1 - District South, Person 1).

To conduct the focus groups, an open interview script was used, divided into five categories of analysis: 1) accessibility; 2) service efficiency; 3) system integration; And 4) subjective issues. These were carried out in places within the Sanitary Districts (public schools, snack bars, veranda), with subjects that were invited from approaches in the streets, in the mediations of the Family Health Units. It is also contemplated that the groups were mediated by a researcher, counting on an assistant who was responsible for the filming, respecting the ethical aspects required by Resolution 466/12 for research involving human beings. The study was approved by the Ethics Committee of the CEP/HUOL/RN, under Protocol No 440/2010. Finally, it is emphasized that the interviews were transcribed with trustworthiness and the data were refined by a Content Analysis, according to model Bardin.[22]

RESULTS

From the focus groups, it was possible to uncover the relevant aspects for the FHS evaluation. Through the friendly "conversations," the subjects were allowed to freely talk about the proposed guiding questions, because the control of impressions is reduced with the confidence they have in the researcher, slowly easing the secrecy of their thoughts and, Declaring their feelings more and more internal. The subjects' memory was also contemplated, as a fundamental source for the work of reconstruction of reality and of lived experiences. These materialized through the subjects' speech, because there is an emergence of the subjective, where actors narrate the lived. [23]

Following this proposal, in the contact with the user groups, it was possible to apprehend 1,111 Elementary Context Units (UCEs), divided into 19 thematic nuclei: 1) physical infrastructure of the FHU; 2) FHU material resources; 3) FHU location and identification; 4) ESF human resources; 5) accessibility to ESF services; 6) preventive care; 7) reference system; 8) understanding of the FHS community; 9) target population of the FHT; 10) disqualification of the FHS; 11) link EqSF-community; 12) Municipal Health Council (CMS); 13) need for financial resources to continue treatment; 14) awareness of their role as contributor; 15) responsible for the difficulties of the FHT; 16) evolution of FHS; 17) importance of the FHT; 18) use of private health services; And 19) distinction between theory and practice, described below.

USF physical infrastructure

In this first thematic class, 55 Elementary Content Units (UCEs) have emerged, reflecting users' beliefs about Family Health Units (FHUs) regarding physical infrastructure, facilities and maintenance of permanent And equipment), made available by municipal health managers to optimize care at the FHS. These were divided into two subclasses: 1.1 negative evaluation (f = 31; 57.41%) "The vaccine room was closed because health came and closed, interdicted because it had mold" (P3, DL); And 1.2 positive evaluation (f = 24; 43.59%) "Suffers the infrastructure of the station has nothing to complain about" (P4, DO), highlighting the predominance of problems.

USF material resources

In this class emerged the beliefs that ESF users have about the availability of inputs to perform their work; Vaccines for immunization work; And medicines and contraceptives to distribute to users. It presents 89 UCEs, which are divided into four subclasses: 2.1 remedies (with 45 UCEs; 40; 88.89% with negative evaluations) "Remedy is very difficult" (P4, DO); 2.2 inputs (with 32 UCEs, 30 being negative - 93.75%) "Material not having" (P1, DN1); 2.3 instruments and equipment (with all 6 negative UCEs) "The dental appliances are broken" (P5, DN1); And 2.4 general evaluation of material resources (with all 6 negative UCEs) "Not enough conditions to meet a person who needs" (P1, DN2).

Location and identification of USF

It consists of 39 UCEs that are divided into two subclasses: 3.1 negative evaluation (f = 14; 35.90%) "It has been nominated for more than 2 years" (P6, DN2); And 3.2 positive evaluation (f = 25; 64.10%) "It is easy to locate; It is the first building of the complex, at the entrance of the complex" (P6, DN2), highlighting the predominance of positive evaluations. It reflects the beliefs that ESF users have about distance and physical access to USF and the identification of their façade, to facilitate access to people who do not know it.

ESF human resources

It includes the beliefs that ESF users have about the professionals who work at the ESF, regarding quality of care, number of professionals, frequency of these at FHU, evaluation of HCAs, and the participants' complaints about the short Permanence of these servers, also alerting themselves to the speculations for causes of bad attendance of these, punctuating, finally, the complaints about the inexistence of substitutes for the moments of removal of these professionals, be it vacations or leave. It consists of 224 UCEs that are divided into seven subclasses: 4.1 quality of care (with 88 UCE, with negative evaluations predominating, f = 60; 68.18%) "The doctor seems to be disgusted by patients

because she does not look at anyone" (P4, OD); 4.2 number of professionals (with 46 UCEs, critics reigning, f = 39; 84.78%) "Now doctor is very little" (P5, DN1); 4.3 Frequency of professionals (with 20 UCEs, with prevailing complaints, f = 12; 60%) "Sometimes when they are marked they are missing" (P6, DN2); 4.4 assessment of the ACSs (with 25 CEUs, with negative evaluations jumping, f = 16; 64%) "The health agent no longer exists in the community" (P6, DN2); "The nurses are permanent because they are here from the neighborhood, but the doctor, usually when a new university takes out; there they send" (P4, DS); 4.6 It is a cause for poor service of the professionals (with 18 UCEs that point out the lack of training of the doctors and the lack of interest generated by the unsatisfactory salaries) "It is not every physician who is trained even" (P5, DN2); And 4.7 complaint about the lack of substitution of absent professionals with 11 UCEs "If he has a vacation, then there is no other" (P4, DS).

Accessibility to ESF services

It represents the beliefs that the users of the ESF have the accessibility to the services offered by the ESF, regarding the hours of attendance and quantity of chips. 210 UCEs divided into two subclasses: 5.1 Negative evaluation (with 204 UCEs) [It must arrive at 3 o'clock in the morning. There, it delivers 50 tokens for the whole week (P5, DN1)], [Pay. (P5, DN1)], [Because sometimes we get there for 10 hours to take care of something and are not taking care of more (P2, DO)]; And 5.2 positive evaluation (with 06 UCEs) [It was fast (P2, DS)], highlighting the predominance of negative evaluations (99.03%).

Preventive care

In this category, the users' beliefs about the existence of preventive work, advocated by MS as one of the main activities of the strategy, are highlighted in this category through discussions, lectures, school visits and home visits. It contemplates 49 UCEs, which are divided into two subclasses: 6.1 negative evaluation of preventive work (f = 30; 61.22%) "Now discussion group with employee has not. It has no" (P4, DS); And 6.2 positive evaluation of preventive work (f = 19; 38.88%) "They came trainees, people who have not yet graduated, came to explain, on examination, how it is done, that kind of thing" (P5, DN1).

Reference system

It covers referrals to other levels of complexity. They are beliefs that deal with the quality of the FHU's integration with the rest of the municipal health services, which should guarantee the continuation of community service, referring users from the most basic level to the most specialized levels of health care. A class consisting of 82 UCEs, divided into two subclasses: 7.1 reference (with 79 UCEs, of which 70 with negative evaluations "My mother-in-law died and until now has an ultrasound of her there to mark" (P4, DO) and 7.2 against reference, Where only the existence of feedback is narrated, without evaluating it (only 3 UCEs) "We always show more than one exam, for a nurse" (P5, DN1).

Understanding the community about ESF

It reflects the participants' beliefs about the community's understanding of the guidelines and functioning of the Family Health Strategy as well as the existence of information provided to them by the Family Health Team. Formed by 22 UCES, divided into subclasses: 8.1 lack of knowledge-information (16; 72.72% UCEs) "The services that are offered by the SUS no one knows, no one knows how to say" (P4, DS); And 8.2 positive evaluation of access to information (6; 27.28% UCEs) "I believe that [the community knows the functioning of the ESF" (P2, DO), highlighting the predominance of negative evaluation.

ESF target population

It reflects the belief about the population to which ESF services are destined, because although it is known that its use is universal, regardless of sex, religion, socioeconomic class, it is used predominantly by marginalized segments. 21 UCEs are present, distributed in three subclasses: 9.1 low class (13 UCEs) "Because the SUS is the Unified Health System to cover the population of less, low income" (P6, DN2); 9.2 middle class (2 UCEs) "Mean Pros" (P6, DN1); And 9.3 no one (6 UCEs) "Neither rich, nor poor, nor middle class A, C or B. For no one" (P6, DN2). Of particular note is the confirmation of the predominance of the belief that the FHS is destined to the poor (f = 13; 61.90%).

Distritalization of ESF

This thematic class refers to the organizational principle of districting, through which the city should be divided into Sanitary Districts, with units operating in specific regions, in which each Family Health Team is responsible for the predetermined families belonging to Its area of coverage. There are 41 UCEs that are divided into two subclasses: 10.1 understanding about the district, which addresses the beliefs of how it works "It is by area: green area, blue area, yellow" (P2, DO); And 10.2 negative aspects of the district, which addresses the damages arising from this "I mean I can not choose the doctor that I want to be attended to" (P2, DL), highlighting the lack of positive factors score.

EqSF-community link

It addresses the beliefs that users present about the link that users who use the Family Health Units have with the professionals that provide care in them, highlighting 39 categories, which comprise two subcategories: 11.1 knowledge about professionals (with 20 UCEs , 12 of which are unknown about the team) "We do not know who the medical professionals of this post are" (P6, DN2); And 11.2 trust in

professionals (with 19 UCEs, 11 of which are reliable on staff) "Overall, I rely on the work of the physician" (P5, DN1).

Municipal Health Council (CMS)

This thematic class is represented by 42 UCEs that highlight users' beliefs about three subclasses: 12.1 knowledge about CMS (with 22 UCEs, 18 of which about CMS ignorance) "I've never heard of this advice business" (P2, DN1); 12.2 Participation in CMS (with 4 UCEs, only 1 participation report) "I have participated in 2 meetings here" (P3, DL); And 12.3 Reasons for failure of the CMS (with 16 UCEs), considering as main factor the accommodation of the population.

Need for financial resources to continue treatment

It contemplates users' beliefs about the financial condition of the population to continue the treatment initiated in the ESF, about possible necessary expenses, such as transportation, medicines, tests, which are not always efficiently covered by SUS. There are 27 UCEs divided into two opinions: 13.1 users have financial conditions to continue treatment (13 UCEs) "When I will have it, but when not, I buy" (P4, DN2); And 13.2 users do not have the financial means to continue treatment (14 UCEs) "She did not take the drug because she passed the drug to buy and I could not buy" (P2, DO).

Consciousness of its role of contributor

This thematic class presents 9 UCEs that emerged from users' beliefs about the awareness of their rightful role in public health services as something paid for their taxes rather than as a favor offered by rulers. "People do not have to ask, right? Because we pay taxes is for that. To be taken care of. In addition, be well attended" (P3, DL). Responsible for the difficulties of ESFS, there are still 20 UCEs that constitute a thematic class that contains the users' beliefs about those responsible for the problems of the strategy, with three targets: 15.1 local power (10 UCEs) "For the rulers, they think this station is working. You do not think you are wearing makeup. The population is that it does not have service. However, it comes from the money" (P6, DN2); 15.2 federal power (01 UCEs) "It comes from above, from the rulers" (P3, DL); And 15.3 population (09 UCEs) "That is why I am blaming it all on people" (P6, DN1).

Evolution of ESF

Reflects users' beliefs about the evolution of the Family Health Strategy. There are 32 UCEs that are divided into three subclasses: 16.1 evolution (06 UCEs) "The station set" (P6, DN1); 16.2 return (08 UCEs) "I think it's getting worse" (P5, DN1); 16.3 Desire for change (08 UCEs) "We only want improvements" (P2, DN2). The importance of the ESF consists of 53 UCEs that reflect the users' beliefs about the use and importance of the ESF to the community. It is divided into two subclasses: 17.1 important (16 UCEs) "It is important, why do we need it right?" (P2, DO); And 17.2 unimportant (with the highest number of records: 37 UCEs) "If it were a building to give, that the homeless people would live there, it was better for me" (P6, DN2). Composed of 48 UCEs that emerged through the narrative of users' experiences about the appeal to the use of private health services, as a substitute for SUS difficult services. There are three subclasses: 18.1 The use of private services (16 UCEs) "I paid 65.00 in a private consultation" (P6, DN1); 18.2 Comparisons between public and private services (13 UCEs with equally distributed preferences) "You know you will, because you are paying. In the state, you do not receive it." (P6, DN1), "And even so paying is the same thing. You have to depend on all this" (P1, DS0); And 18.3 financial variances for private service use (19 UCEs) "People sometimes have to stop buying some food, something they need for children to maintain a health plan (P6, DN2).

Distinction between theory and practice

This last thematic class is composed by 9 UCEs that present the beliefs of the users of the Family Health Strategy about the distinction between the theoretical guidelines of its operation, as recommended by the Ministry of Health in the legislation, and the practical reality in the daily life of its actions: "But Brazil does not comply with its laws [...] Because there is a facade. There it does not exist" (P6, DN2).

DISCUSSION

The primary purpose of the Family Health Strategy is to act as the main gateway to the Unified Health System, allowing and facilitating its main guidelines: universal access to health, regardless of gender, race, religion or socioeconomic level; And the integrality, that through the integration of all the levels of the system provide an integral health care to its users, seeing them in totality.[1] For everything to function as governed by the constitution, through the laws and guidelines established by the Ministry of Health, it is necessary that in the operationalization of health services provided to the population the minimum quality standard required, in the material conditions (infrastructure of the building, materials, equipment), human resources (with quantity and quality in their professionals), accessibility (physical, financial, organizational) and integrality of the system (both in reference and in counter reference).

The data found in the present study show in the Family Health Strategy in Natal an adverse reality of the ideals advocated. Among the poorly evaluated aspects, the first to be highlighted is the physical infrastructure of the building, criticized in 57.41% of the UCEs of this first thematic class, and material resources, with 92.13%. Structural problems were identified, such as mold, infiltration, culminating in the closure of buildings by Sanitary Surveillance; Being

detected including organizational problems, such as the excessive reforms in some units that are constantly closed and, consequently, without care. In addition, there is a lack of medicines, supplies, vaccines (theme class 2), as opposed to what the guidelines propose for the Family Health Units.[1]

The location, physical access and identification of the building (thematic class 3) were well evaluated in 64.10% of the UCEs, since in general it is visible and close to the residence of its users, complying with the guideline that it must be A distance of 15 minutes on foot.[1] Their professionals were also poorly evaluated (class 4), with failure rates above 60% in the different requirements: quantity, quality of care, frequency. These problems contribute to the high negative indexes (99.03%) on accessibility (class 5), which is difficult, especially due to the large number of users and a small number of records, confirming the main problem of SUS: high demand from users,[6] which in addition to generating fast and low-quality care, suffocates the Family Health team in curative care, marginalizing what should be its main focus: health promotion and disease prevention,[2] classified as non-existent in most of the speeches of Natal users (class 6, 61.22%). Concluding with a referencing for more complex levels of care that also does not work (class 7, 88.61%).

It should also be noted that, as already mentioned in the literature,[2,14] the community does not understand the functioning of the ESF (class 8) and states that it does not have access to explanations about its work format, available schedules and services (72.72%), understood, is poorly evaluated. Also identifying in class 9 is the persistence of the Brazilian belief that public health services were made for the poor.[2,14]

It was also observed that the community, although aware of its role as a taxpayer and paying the SUS services (thematic class 14; f = 9), is not present in the Family Health Units, both in services, once (class 11), as well as in the supervision, with the participation of the community in Municipal Health Councils (class 12), being one of the main problems punctuated by the literature of Program evaluation.[17]

As a consequence of the various problems that exist in the operational reality of the FHT, the population has needed to use its own financial resources for access to health (class 13), which by law is free.[1] Confirming the growing trend in Brazil of the search for the population by private services (class 18). Now available not only to the middle and upper class, but also to the most needy population through the low-cost services offered by private polyclinics.[2] Thus, lessening the importance of the strategy for the population (class 17), which before the health service margins, appreciated the ESF, even though it was unsatisfied with its services, today they no longer value it as much (f = 37, 66.07%), Since they have other alternatives.

With so many problems and disbeliefs, the Family Health Strategy in Natal has been highlighted by the desire for change in its users (class 16), who recognize that their problems are predominantly due to causes of local management (50%) and omission (45%), freeing the fault of the federal government (class 15), that distant from the operationalization of the strategy, are uninformed about the distinction between the legal guidelines of the daily reality strategy of the operationalization of their actions (class 19), as presented in several ESF evaluation studies.[2,6,14]

CONCLUSION

Brazil does not have the developed culture of evaluating social programs and the quality of the public services offered, especially those directed to the health area. These are idealized and implemented, but most of the time their results are not evaluated. There is a gap between the principles that regulate it and those that manage it, and of these with the daily operation of the program with society. The Family Health Strategy (ESF) is one of those governmental actions that involve sources of funding, professional groups and public opinion, and that needs to be verified its effective contribution in solving social problems. Lacking that the Brazilian psychologists, as holders of tools capable of assisting these evaluative procedures, are interested in this type of task.

Users point to several faults in the operationalization of the ESF in Natal, which hinder universal access to health, often imposing the need for financial resources for the continuity of healthcare in the SUS (having to buy inputs for procedures, medicines, or pay for Examinations in the absence of referencing). Consequently, the search for the private health sector, which is increasingly adapted to the demand of low-income classes, grows. This population, following a conformism of "is better than nothing", marginalized in the access to health, were satisfied with the ESF, although they pointed out their failures. But that now, more aware of its role of paying and the possibilities of access to private, becomes more demanding with the quality and effectiveness of services. Considering the need for community awareness about its role as inspector of a system that in theory is ideal, but that needs to have an operation consistent with its guidelines.

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