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The meanings about the family health strategy for a community

ABSTRACT | Objectives: to identify the meanings about the Family Health Strategy for a community. Method: the study is a qualitative, exploratory, cross-sectional, non probabilistic and intentional sampling, composed with 20 participants using two instruments. The data from the interviews were evaluated considering the collective subject discourse approach based on the Theory of Social Representations. Regarding the data from the questionnaire, they were treated in a percentage way. The study was approved by the Research Ethics Committee. Results: 75% were female, aged 61 to 70 years, 30% had completed high school and 6 months to 10 years in which they live near the ESF. Two central ideas emerged "very good" and "none". Conclusion: the most of the interviewees attributed positive meanings to the insertion of the unit in their housing area. However, despite the ease of access, they still emphasize the need for improvements in services.
Keywords: Family Health Strategy; Primary Health Care; Qualitative Research.

RESUMEN | Objetivos: Identificar los significados sobre la Estrategia de Salud Familiar para una comunidad. Método: Estudio de enfoque cualitativo, exploratorio, descriptivo y transversal, muestreo no probabilístico e intencional, con un total de 20 participantes, con el uso de dos instrumentos. Los datos de las entrevistas fueron evaluados considerando el enfoque del discurso de sujeto colectivo basado en la Teoría de las Representaciones Sociales. En cuanto a los datos del cuestionario, fueron tratados de manera porcentual. El estudio fue aprobado por el Comité de ética de la investigación. Resultados: el 75% eran mujeres, de 61 a 70 años, el 30% habían completado la escuela secundaria y 6 meses a 10 años en los que viven cerca del FSE. Dos ideas centrales surgieron "muy buenas" y "ninguna". Conclusión: La mayoría de los entrevistados atribuyeron significados positivos a la inserción de la unidad en su área de vivienda. Sin embargo, a pesar de la facilidad de acceso, siguen insistiendo en la necesidad de mejorar los servicios.
Palabras claves: Estrategia de Salud Familiar; Atención Primaria de Salud; Investigación Cualitativa.

RESUMO | Objetivos: identificar os significados acerca da Estratégia Saúde da Família para uma comunidade. Método: estudo qualitativo, exploratório, descritivo e transversal, amostragem não probabilística e intencional, realizado com 20 participantes, com a utilização de dois instrumentos. Os dados das entrevistas foram avaliados considerando a abordagem do Discurso do Sujeito Coletivo pautados na Teoria das Representações Sociais. Quanto aos dados do questionário foram tratados de forma percentual. O estudo foi aprovado pelo Comitê de Ética em Pesquisa. Resultados: 75% eram do gênero feminino, faixa etária de 61 a 70 anos, 30% possuem ensino médio completo e 6 meses a 10 anos em que residem próximo a ESF. Emergiram duas ideias centrais "muito bom" e "nenhum". Conclusão: a maioria dos entrevistados atribuiu significados positivos diante da inserção da unidade em sua área de moradia. Porém, apesar da facilidade de acesso, ressaltam a necessidade de melhorias nos serviços.
Palavras-chaves: Estratégia Saúde da Família; Atenção Primária à Saúde; Pesquisa Qualitativa.

Fábio Luiz Piedade

Graduating in Nursing at Faculdade Wenceslau Braz.
ORCID: 0000-0001-5347-8225

Pâmela Alves dos Santos

Graduating in Nursing at Faculdade Wenceslau Braz.
ORCID: 0000-0003-1223-056X

Jerusa Gomes Vasconcellos Haddad

Nurse. Master of Science from the School of Nursing, University of São Paulo. Professor and Academic Coordinator of the Nursing Course at Faculdade Wenceslau Braz.
ORCID: 0000-0001-6170-064X

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INTRODUCTION

The Family Health Strategy (FHS) is a public policy that demonstrates the movement to expand the care network in the Unified Health System (SUS), by strengthening the proposal for Primary Health Care (PHC). [1] During this expansion of PHC services, the Family Health Centers (Centros de Saúde da Família - CSF) have been molding themselves with new spaces for the development of different professional practices.

The FHS is characterized by a territorialized care, developed by multiprofessional teams responsible for planning actions according to the local needs of a community. [2]

The unit has broad concepts when it comes to health and understanding the determinants of the health-disease process. Proposing a form of articulation between the technical knowledge and from the population and the mobilization of institutional and community resources so that health problems are faced.

As a new model, it is fully responsible for the health needs of a given location, just as it dictates a reorganization of the Brazilian health care model, based on principles of universality, equity and integrality.

The proposal brought by the ESF produces different assistance results for incorporating new health actions in the field of individual and collective action, including the promotion, protection, prevention, diagnosis, treatment, rehabilitation, harm reduction and the maintenan-

ce of the health of its users. [3]

However, the dichotomy and opposition between assistance and health promotion is still a challenge for this assistance model. The understanding that health has multiple determinants and conditions and that the improvement of the health conditions of people and communities depends on several factors, which are appropriate to be addressed in the FHS, refers to overcoming this challenge. [4]

The study is of great relevance for health professionals, as the data obtained in this research will contribute to their performance in order to guide their actions, contributing to the improvement of the assistance provided. Where the whole society will benefit since the improvement of the assistance provided directly implies in improving the quality of life of the population.

Given the above, this research aimed to identify the meanings about the Family Health Strategy for a community in a city in the south of Minas Gerais.

METHODS

It is a qualitative, exploratory, descriptive and transversal research. The sample was intentional, composed of twenty residents of the area covered by the Family Health Strategy (ESF) in a city in the south of Minas Gerais, who met the following inclusion criteria: having lived in the area covered by the ESF for at least six months, be a user of the FHS; be 18 years or older, accept to participate in the study by signing the Free and Informed Consent Form (ICF).

Data collection was performed with the aid of two instruments: semi-structured interview, containing a guiding question: "If a friend asked you what ESF means to you, what would you answer? And, a questionnaire to record the sociodemographic characteristics of the participants. Data were collected between June and July 2017.

The responses derived from the interviews were interpreted using the Collective Subject Discourse (CSD) technique. The DSC is a method of organizing and tabulation of qualitative data resulting from a summarized speech, written in the first person singular and organized according to similar testimonies. [5] The following methodological figures were applied: the key expression (Expressão chave - E-Ch); the central idea (CI); and the Collective Subject Discourse (CSD). The E-Ch reveal the testimonies about the investigated theme, and from them the CIs were evidenced, which described the meaning of each analyzed speech.

The CSD is based on the Theory of Social Representations and is limited to analyzing the central ideas, anchors and similar key expressions of the speeches. [6]

The interviews were recorded and transcribed, maintaining the reliability of the information collected. Sociodemographic data were analyzed and described in a percentage.

This study respected the ethical precepts of Resolution 466/12 [7] and obtained approval from the Research Ethics Committee of Faculdade Wenceslau Braz, under protocol no. 2,358,117, CAAE: 78871317.3.0000.5099.

RESULTS

Twenty participants took part in the study with the following characteristics: 75% were female, the most prevalent age group was 61 to 70 years old, relative frequency was 35%, 30% had completed high school, 25% had completed elementary school and 10% have higher education. Regarding the time they live in the vicinity of the FHS area, the most prevalent was 6 months to 10 years, a relative frequency of 30%.

In evaluating the qualitative data, they highlighted the following central ideas: "Very good"; "None".

1st CI – Very good

The first CI derived from the participants' speeches stated that the proximity of the unit to the place where they live facilitates the community's access to health services. Thus, avoiding the congestion of other units and helping users who have chronic diseases and need daily control, as described in the following CSD:

> "Really good, the best thing they did is the post near my home [...]. When the post came here, it improved a lot [...]. It is a good thing, because it facilitates access for residents [...]. [...] I'm doing a diabetes control that I discovered here. So this is all good too. The population depends a lot on here, it helps mainly older people. [...] At the beginning it was a bit complicated, because it took me a while to get an appointment. Not now. Then, as is the return, show the exams, they make appointments for us [...]. The problems that we face here are usually the lack of vacancies and if we manage to make an appointment it is attended to, but the service is good, and when they have an emergency, we come and do a screening [...]. For me, who am hypertensive and diabetic, I find it easy [...]. [...] I think this is a right for all of us citizens. [...] the implementation was good, but we need improvement, both as an available pharmacy and as the specialist doctors that all posts have."

2ª CI – None

The second CI obtained from the meaning of the Family Health Strategy for the community was "None". This idea was evidenced by the CSD:

> "None. I haven't been able to see a doctor in a year. Now I came here to talk to the head nurse, because I'm going to transfer my children. With this thing, you live here it has to be here, I think that's wrong. Consultation, for

example, for me I was never able to book. It's been a year, every time I get here, there is no vacancy, it starts to book 1 hour, but you arrive here 10 hours already it is packed. Complicated, here it is rolled up."

DISCUSSION

In the present study, the "very good" CI is evidenced by the participants, who state that the FHS near the residence favors access to health services, avoids overcrowding in other units, facilitates for those who need continuous care and help to treat diseases chronic.

Primary care is a fundamental element of the health system. Being consolidated through its indexes and impacts that show improvements in the health of the population of countries that have adopted its policies. Within the evidence can be cited the best health indicators, better dynamics of the flow of users in the system, improvement in the treatment of chronic diseases, advancement of preventive practices, increased satisfaction of its users and reduction of difficulties as well as inequities regarding access services. In addition to increasing the efficiency of care. [8]

The FHS has acted, since its implementation, in the prevention of chronic non-communicable diseases, with an emphasis on hypertension, diabetes and gynecological cancer. Having an important role in strengthening health promotion actions with regard to comprehensive care. Since its implementation, the FHS has pointed out several advances in assistance, especially when referring to the health actions offered, access and use of services, drop in death rates due to parasitic infectious diseases and infant mortality, along with hospitalizations caused by diarrhea. Evidence indicates that this positive impact on the indicators has been sustained over time [9], being able to play a central role in the global epidemic of cardiovascular diseases that has been growing lately. Both in promoting the improvement of cardiovascular health and in combating pathologies that affect the cardiac system. [10]

Primary care is a fundamental element of the health system. Being consolidated through its indexes and impacts that show improvements in the health of the population of countries that have adopted its policies.

The implementation of the FHS facilitates the population's access to health services, as they bring a multidisciplinary team closer to its users, with the implementation of community agents who go to the residents and make sure that they are registered and regularized in the Basic Health System. The work process aims and guarantees the greatest possible access to the population, in addition to strengthening the bond between its users and professionals. In this way, it allows the continuity and coordination of care, making the user monitored by the health team over time. Its guidelines establish parameters that determine the maximum number of families to be covered, thus avoiding overcrowding of units and wear and tear on professionals working in the areas. [2]

Still referring to the first CI, the participants highlighted the importance of the ESF for elderly residents who make up the area covered by the unit.

Still referring to the first CI, the participants highlighted the importance of the FHS for elderly residents who make up the area covered by the unit. [11] Which points to the need for more agility in the health system, as aging brings with it a reduced expedient for the search for health services and travel to different levels of care. For the elderly, especially the most needy, simple difficulties end up blocking and interrupting the continuity of health care. [12]

Despite attributing positive characteristics to the service, some study participants refer to the delay and little availability of places in the unit.

SUS suffers from a chronic problem linked to an inadequate personnel policy in general and in particular the lack of medical professionals. Keeping the doors open for those looking for primary care services should not be confused with guaranteeing access. Despite being, generally, characterized by obtaining resolutive actions for the type of problem that interferes in the user's health. The difficulties in making appointments with specialists associated with the delay in carrying out tests ends up causing a disbelief in the role of organizing primary care. Sin-

ce a large part of the demand is linked to the biomedical paradigm, in which users always look for curative actions and centered on the figure of the medical professional. [13]

There is then a need for planning to be carried out that matches the needs of the target population and facilitates community access to the unit. [14]

Associated with this, the change in the population's conception regarding the biomedical paradigm, requires users to understand the importance of different clinics in the health field. This change must come from pedagogical actions developed by the team that demonstrate the effectiveness of practices that confront biomedical logic. [13]

In this sense, there is an urgent need to promote actions aimed at public policies that improve the quality of life of users. In other words, advise the population about addictions such as smoking, encourage physical activities, among several other health education activities. These are measures that can be explored and bring positive results when combined. However, we must consider that the effectiveness of individual and community orientations is restricted to cultural, social and existential conditions in the different regions of the country. [14]

It was also reported in the first CI regarding the distribution of medicines and the lack of specialist doctors in the unit.

The FHS has its structure unrelated to the medical assistance model centered on the disease. The organization of primary care services through the FHS has as a priority the actions of promotion, prevention and recovery of health in an integral and continuous way. Its expansion in the Brazilian territory is defined by a set of actions and services that aim far beyond medical assistance, based on the need to recognize the needs of the population through the formation of bonds between users and professionals. It proposes the family as a central point, being understood through its physical and social environment. It leads professionals to have an expanded view of the health-disease process and the needs for interventions, which are not only aimed at curative practice. [8]

According to the National Primary Care Policy (Política Nacional de Atenção Básica - PNAB), the presence of a pharmacist as well as medical specialists, except general practitioners or family health specialists, is not part of the specificities of the Family Health team.

According to the National Primary Care Policy (Política Nacional de Atenção Básica - PNAB), the presence of a pharmacist as well as medical specialists, except general practitioners or family health specialists, is not part of the specificities of the Family Health team. These professionals are usually part of teams working in Extended Family Health Centers (Núcleos Ampliado de Saúde da Família - NASF). The NASF aims to expand the scope and direct the actions of Primary Care, as well as its resolution. The teams working in these units are composed of professionals from different areas of knowledge, who must work in an integrated manner complementing the services offered by primary care. [4]

Research carried out with the aim of exploring the perception of ESF users and professionals about the NASF confirms the need to complement the services provided by the ESF when concluding that the incorporation of other professionals, through the NASF, was necessary to expand the actions in health and contribute to greater resolution in PHC. Since family health represents a priority strategy for the reformulation of the care model, with the aim of strengthening primary care in the country and guaranteeing universality and comprehensiveness in health care. [15]

The second CI "none" was extracted from the testimonies and reported that they never got a medical appointment at the FHS.

Reception in Primary Care is one of the main guidelines regarding the policy, ethics and aesthetics of the SUS National Humanization Policy in Brazil. It is defined as the reception of the client in health services. Including the act of the professional to take responsibility for the client, listening to their complaints and anxieties in a qualified way, inserting limits when necessary, ensuring resolution and articulating the user in the best way to other health services so that care is maintained on an ongoing basis. [16]

However, there are obstacles that prevent the reception from being carried out as it should. Some of the main obstacles are: limitations in the structure of the unit; ethical issues such as the absence of secrecy and privacy between the professional and the user; inadequate posture, lack of commitment by the professional to lis-

ten to the client looking for his services in the unit and shortage of professionals. The points presented end up restricting the reception due to the lack of basic conditions for receiving those who seek the units. Disrespecting their private assets, along with their individual needs. [17] The shortage of professionals is also mentioned in a study carried out with professionals from the Family Health Strategy, where they point out as important weaknesses in addition to low wages, lack of infrastructure and lack of work inputs, overwork due to lack of professionals. [18]

The reception is not yet completely systematized in the models proposed by the government in Primary Health Care. This may be one of the main justifications for the dissatisfaction of users dependent on the public health system. User embracement is a tool created to work collaboratively with the qualification of health systems, enabling user access to care provided in a fair and comprehensive manner by different professionals and sectors. It brings with it the possibility of SUS to implement its constitutional principles, but there is still a need for qualification in the way it has been worked. Because, if worked in a disjointed and punctual way, it can end up becoming a simple screening, being uncharacterized from its main function, which is projected as the humanization of health services. In this way it ends up not achieving its purposes. [17]

CONCLUSION

The study participants, despite recognizing the actions of professionals working in the FHS and consider the proximity of the unit to housing a great benefit, facilitating access, still emphasize the need for improvements in the conditions and services offered. The implementation of NASF can contribute to a better service and satisfaction of these users.

It is noticeable that a portion of the community is focused on assistance centered on the medical assistance model. There is an urgent need to make the population aware of the purpose of the FHS, with health education being a potent tool to achieve this goal and nurses who are active in this process.

The study participants who claim to benefit most from the FHS are those who have chronic diseases such as diabetes and high blood pressure, while other participants report difficulties in access. It is possible to consider that although it plays an important role in health promotion and disease prevention, the FHS still fails to include the entire community.

The nurse, for playing a fundamental role in health promotion, needs, together with the other professionals, to create a bond with the families in their area of coverage. Because from the creation of a bond, it is possible for the professional nurse to better understand the context experienced by individuals, family and community and, in view of that, develop strategies that are consistent with the local reality.

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