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RESEARCH

Cobertura das estratégias de fortalecimento da atenção básica em saúde

Coverage of strategies for strengthening the basic health care

Cobertura de las estrategias de fortalecimiento de la atencion básica de salud

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ABSTRACT

Objectives: Analyzing the coverage of strategies to strengthen Primary Care in the municipalities of the 4th Regional Health Management of Santa Catarina, Brazil. **Method:** A cross-sectional descriptive study conducted at the bank of indicators covering of Family Health teams (SF), Community Health Agents teams (ACS), National Programme for Improving Access and Quality of Primary Care (PMAQ) Professional Enhancement Program of AB (PROVAB), Psychosocial Care Centers (CAPS) and Stork Network of 25 municipalities. **Results:** 88% of the municipalities are suitable for the quantity of SF teams; 100% of the population is covered by ACS; 95,5% of SF teams joined the PMAQ; 48% did not join the PROVAB; 64% do not have CAPS; 32% did not join the Stork Network. **Conclusion:** These findings suggest the search for qualification and solving teams and health services, but show difficulties in expansion and articulation of actions. **Descriptors:** Primary health care, Coverage of health services, Family health, Health promotion.

RESUMO

Objetivos: Analisar a cobertura das estratégias para o fortalecimento da Atenção Básica nos municípios da 4a Gerência Regional de Saúde de Santa Catarina, Brasil. **Método:** Estudo transversal descritivo realizado no banco de indicadores de cobertura de equipes de Saúde da Família (SF), equipes de Agentes Comunitários de Saúde (ACS), Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica (PMAQ), Programa de Valorização do Profissional da AB (PROVAB), Centros de Atenção Psicossocial (CAPS) e Rede Cegonha, de 25 municípios. **Resultados:** 88% dos municípios estão adequados em relação à quantidade de equipes de SF; 100% da população estão cobertas por ACS; 95,5% das equipes de SF aderiram ao PMAQ; 48% não aderiram ao PROVAB; 64% não possuem CAPS; 32% não aderiram à Rede Cegonha. **Conclusão:** Os achados sinalizam a busca pela qualificação e resolubilidade das equipes e serviços de saúde, mas revelam dificuldades na expansão e articulação das ações. **Descritores:** Atenção primária à saúde, Cobertura de serviços de saúde, Saúde da família, Promoção da saúde.

RESUMEN

Objetivos: Analizar la cobertura de las estrategias para fortalecer la Atención Primaria en los municipios de la cuarta Gerencia Regional de Salud de Santa Catarina, Brasil. **Método**: Estudio transversal descriptivo realizado en el banco de indicadores de cobertura de equipos de Salud de la Familia (SF), equipos de Agentes Comunitarios de Salud (ACS), el Programa Nacional para el Mejoramiento del Acceso y Calidad de la Atención Primaria (PMAQ) Programa de Mejoramiento Profesional AB (PROVAB), los Centros de Atención Psicosocial (CAPS) y Red Cigüeña de 25 municipios. **Resultados:** el 88% de los municipios están adecuados en relación a la cantidad de equipos de SF; 100% de la población está cubierta por ACS; 95,5% de los equipos de SF se unió a la PMAQ; 48% no se unió a la PROVAB; 64% no tiene CAPS; 32% no se unió a la Red Cigüeña. **Conclusión:** Los resultados indican la búsqueda de calificación y resolución de los equipos y los servicios de salud, pero muestran dificultades en la expansión y articulación de acciones.**Descriptores:** Atención Primaria de Salud, La Cobertura de Servicios de Salud, La Salud de la Familia, Promoción de la Salud.

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INTRODUCTION

The construction of the Unified Health System (SUS) has advanced significantly in recent years and rescued the evidence of the importance the Basic Health Care Service (ABS) has in this process. It can define ABS as a form of organization of health services, integrating all aspects, and aims to meeting the health needs of the population.[1]

The ABS should establish itself as the main gateway to the Health System, being a set of actions in the individual or collective level, covering the promotion, health protection, prevention of injuries, diagnosis, treatment and rehabilitation, as well as harm reduction and health maintenance. The ABS aims to developing a comprehensive care, which impacts positively on the health situation, on the promotion of individuals' autonomy and in the determinants and the conditions of health of collectivities.[2]

In Brazil, the ABS is organized by the National Primary Care Policy (BANP), approved by Decree 2.488 of October 21st, 2011, which restores a review of guidelines and standards for its organization, supported by the Health Family Strategy (FHS) and the Program of Community Health Agents (PACS). This policy articulates such strategies, fundamental to meeting the guidelines of SUS, focused on the expansion of intersectoral actions and health promotion.[3]

Over the years, the needs and difficulties that arise in the daily life of health teams make the Ministry of Health (MOH) think and perform actions, strategies and programs in accordance with the health needs of the population for different populations, considering their diversity and specificities. Thus, it seeks to increase the population's access to health services and improving the quality of care, prioritizing a full and equitable assistance.

One strategy used to reorganize primary health care was the creation of the PACS in the early 90s and effectively implemented and regulated since 1997 and that, currently works articulated to the FHS. The Community Health Agent (CHA) has an important role in the FHS work process, because it acts as a link between the community and the other members of the Family Health team, remaining in constant contact with the families, what facilitates the work of surveillance and health promotion carried out by the whole team.[4]

In line with PACS came the Family Health Program (FHP), later transformed into FHS and aims at a holistic, comprehensive and preventive care, turned to the family and its uniqueness and cultural aspects. Thus, BANP has the FHS as a strategic priority for the expansion, qualification and consolidation of BHC and its reorganization. This policy provides for the reorientation of the work process with the greatest potential to further the principles, guidelines and foundations of SUS, thus extending the resolution and impact on the health status of individuals and communities, as well as providing an important cost / effectiveness.[3]

In the same perspective of strengthening BHC, emerges in 2011, the National Program for Improving Access and Quality of Primary Care (PMAQ), this demand induce increased access and the improvement of basic health services quality assurance a pattern of national comparable quality, regionally and locally, so as to allow greater transparency and effectiveness of government actions aimed at BHC in Brazil. The PMAQ is organized into four phases that complement and conform a continuous cycle of improvement of access and quality AB (Accession and Contracts, Development, External Evaluation, and Recontractualization).[5]

In this context, it also proposes the Professional Enhancement Program Primary Care (PROVAB), approved by Decree 2.087 of 2011, which aims to promote the recovery of health professionals (doctors, nurses and dentists) who work in BHA. The program is committed to the qualification of the shares of SUS from encouraging the formation of its professionals, as well as encouraging them to remain in localities with greater shortage of professionals and health services.[6]

Another aspect of BHA that is emerging is displayed on investments related to the health of individuals suffering or mental disorder and needs arising from the use of crack, alcohol or other drugs. The main strategy in this context was the implementation and development of Psychosocial Care Centers (CAPS).[7]

CAPS is divided into the following categories of psychosocial care services: CAPS I, operational capacity to care in municipalities with a population between 20.000 and 70.000; CAPS II, operational capacity to care in municipalities with populations between 70.000 and 200.000; CAPS III, operational capacity to care in municipalities with a population in excess of 200.000; CAPS Alcohol and Drugs (AD), the treatment of patients with disorders arising from the use and dependence on psychoactive substances, with operational capacity to care in municipalities with populations greater than 70,000; and CAPS for the Child (I), assisted children and adolescents, constituting in reference to a population of about 200,000 inhabitants.[7]

It is worth remembering, as an improvement strategy and strengthening of ABS, the Stork Network, established under the SUS through the concierge 1.459 June 2011. Consisting of a network of care that aims to ensure women's right to reproductive planning and humanized care in pregnancy, childbirth and the postpartum period, as well as the child's right to safe birth and growth and healthy development.[8]

Together and individually, these strategies have been the main actions of orientation of BHA and capture much of the financial, technical and organizations to strengthen the SUS and change the health care setting in health in Brazil.

Given these perspectives, this study aimed to analyzing the coverage of the FHS teams, PACS, adherence to PMAQ, PROVAB, CAPS and the Stork Network, by municipalities that receive assistance for the 4th Regional Health (GERSA) of the West of Santa Catarina (SC) in relation to Primary Health Programs.

METHOD

This is a cross-sectional descriptive study with a quantitative approach performed based on data compiled for coordinating the SC State Health Department on the coverage of the strategies for strengthening of Primary municipalities served by the 4th Region Health Management west of Santa Catarina. There were analyzed the coverage of the FHS, PACS, adherence to PMAQ, the PROVAB, to the centers, and the Stork Network, these municipalities, recorded in 2012.

The targets municipalities in this study belong to the following Regional Development Offices (SDR): 4th SDR of Chapeco, 29th SDR of Palmitos and 32nd SDR of Quilombo, which together form the Commission of the West Regional Inter-managers (CIR WEST). However, when it comes to issues related to health, municipalities receive Regional Health Support the 4th SDR.

Together are composed of 25 municipalities, with a population reference of 322,741 inhabitants. These municipalities are located in the Western Region of the State of SC, and its population accounted for 5% of the total state population.[9]

The State of SC is located in the southern region of the country and has a Human Development Index (HDI) of 0,831, considered high and higher than the national average. With regard to the State HDI reached 0,840, the second highest position in Brazil.[10]

The data on the coverage of these programs have been made available for coordinating the SC State Health Department upon request of Nursing Academic State University of Santa Catarina who developed the final stage of the course in 4th GERSA. This data is updated in December of each year by the State Health Department.

Data analysis about the coverage of strategies of strengthening the basic attention of 25 municipalities served by 4th GERSA was held in May 2013 through information already condensed in table form issued by the State Health Department in March 2013. From these data were carried out percentage calculations for knowledge of general and specific situation of each municipality. These data are public domain, which eliminates the evaluation of the proposal by a Research Ethics Committee.

RESULTS AND DISCUSSION

When analyzing the coverage of strategies to strengthen the BHA of municipalities served by the 4th GERSA in relation to health issues, it was found that 88% of the municipalities were compliant with the Ordinance 2488/11[2] on the amount of implanted FHS

teams. However, 8% of these municipalities, although complying with the rules do not cover 100% of its population. Thus, added to the municipalities that may not qualify Ordinance, are 20% who do not have full coverage, making an average of 14.7% of the population unattended by the FHS, which requires as the requirements of MS, the implementation of 15 more health teams in the Family CIR West, distributed in five municipalities vulnerable in this regard.

Regarding the number of CHA, according to the estimated population of each city, there was an amount sufficient to cover 100% of the population registered as required by Ordinance 2488/11.[2]

Regarding PMAQ accession of the 89 Family Health teams of the CIR West, 95,5% joined the Program. The teams that have not adopted concentrated in its entirety in a polo and most populous municipality in West CIR.

Analyzing the accession of the municipalities of the CIR West to PROVAB as Ordinance 2.087/11[6] it was found that 48% of the municipalities did not adhere to this incentive program.

Regarding the implementation of CAPS, four municipalities of West CIM were awarded a service of this type. Among these are two CAPS I covering 13,4% of the population CIR West; CAPS II, a children's and youth CAPS (CAPSi) and an alcohol and drug CAPS (CAPSad) assisting the 57,7% of this population. Thus, 64% of the municipalities of CIR West are without coverage CAPS, which corresponds to 28,9% of the population of this Regional that remains unattended in relation to specialized psychosocial care.

Finally, we tried to analyze the adhesion of municipalities to program the Stork Network. It was found that 32% had not yet acceded to this health strategy by the end of 2012.

From the analysis of the information issued by the Secretary of Health of the SC State, one realizes that this part follows the rules instituted by the own State. The Deliberation 457 of Bipartite Inter-managers Commission (CIR) of 2012[11], establishing a new setting and name of the 16 Regions of SC State Health.

In this sense, the data table provided by the State Health Department has for the CIR West Region municipalities that do not match what proposes Deliberation 457/CIR /12. It can be seen that it does not follow the new configuration of CIR West.

Coverage of teams of the Family Health Strategy

With the various economic, political, social and cultural changes, which produced significant changes to life in society, leading to health transformation process and health problems[12], emerges a new reorganization of the health system model, from Unified Health System (SUS), with emphasis on primary health care or primary care.[11]

The Primary Health Care (PHC) has a priority strategy to Health for the restructuring of the health sector, and organization of primary care, contributing further to the reorganization of the other levels of complexity which includes the NHS, according to the health needs of the population.[3]

So, analyzing joining the FHS and its coverage in the municipalities of the Regional Health West SC, the data show us that this develops satisfactorily generating a positive

assessment of the quantitative teams. It is noticed that most municipalities complies with proposing the 2.488/11 legislation, which approves the National Policy of Primary Care, respecting the maximum number of people covered by each FHS team.[2]

As the decree 2.488/11 is among the items needed for the implementation of the Family Health Strategy.[2:17]

> Each family health team should be responsible for more than 4.000 people, being the recommended average 3.000 people, respecting equality criteria for this setting. It is recommended that the number of people per team consider the level of vulnerability of families from that territory, and the higher the level of vulnerability should be the smallest amount of people per team.

However, it was found that even municipalities that comply with MOH recommendations regarding the number of people to be covered by FHS, some of them do not cover the total population.

As the authors[14:18], "the FHS has an important role as an instrument that allows the construction of assumptions that go beyond the traditional clinical, based on the curative model". It was constituted as true gateway to health services and has reduced the number of hospitalizations, strengthening of preventive and health promotion, monitoring and monitoring of health/disease individual and collective, being a key strategy the improvement of population health indicators.[14]

However, several difficulties underlie the implementation and consolidation of the FHS, a strategy to redirect health actions, collaborating with the replacement of hegemonic care model.[13] There are limitations to its operation due to insufficient financial human resources.[13,15] According to Nascimento et al.[16] there are problems with the physical space to accommodate the structure of a health care facility which often prevents its strategic location in the community, especially in urban areas.

It is noteworthy that, the poor conditions of professional work, the lack of coordination between the core network and other sectors related to health, the distance ratio staff/patient, the little community participation are important obstacles to the functioning of the FHS as recommended. Problems stemming from lack of understanding of the function of the Strategy, coverage and lack of awareness of the professionals who make up the teams, are also factors to be considered.[17]

It is perceived as still challenges to overcome the reduced support of municipal managers in the qualification of professionals. It appears that in the conduct of FHS many managers have been based on keeping the amount of teams. Such postures indicate not only possible understanding of the FHS proposal, but also a lack of commitment that has just reflecting the absence of expansion of services and lack of investment in comprehensive care .[13]

Thus, one might think that the assessment of the operation of the establishment and structuring of the FHS becomes an interesting measure to overcome these gaps and achieve its implementation effectively.

FHS as state policy and strategy prioritized by MOH to organize the BHC in Brazil has been expanding since its inception. By the end of 2012 was present in 98,3% of the

municipalities in the state of SC and 95,2% of Brazilian municipalities. However, the proportion of population coverage estimated by the FHS in the SC State was 69,9% and in Brazil was 54,8% in December 2012.[18] These data demonstrate that the population indices assisted by the FHS in the State and the Country remain below of the CIR West SC coverage ratio.

These data show a different profile, and this strategy has advanced in the deployment process, structure and coverage in the studied region compared to the state and country. However, there are many obstacles to be overcome to achieve an effective health strategy meets all the principles of SUS.

Covering of the community health workers program

Regarding the coverage of the number of CHA, it can be seen that the municipalities of the Regional investigated in its entirety meet these requirements, though there is a sufficient amount of CHA in each municipality, covering the entire enrolled population.

In the state of SC, in December 2012, 98,9% of the municipalities had CHAs, but the rate of population coverage estimated by the CHA strategy was 73,3%. In Brazil, 97.5% of the municipalities had CHAs in this period, however only 65% of the population is accompanied by teams of CHAs.[18]

The CHA has an important role in the community in which operates, playing educational activities in disease prevention and health promotion, seeking to solve the problems through community visits. By integrating the FHS, the CHA becomes a link between the community and the health unit, working with a multidisciplinary team. This should know the problems faced by the community, the demands and unique needs of each resident in the community.[19]

In 2000 the estimated population coverage by the FHS was 9,2%, an increase of its expansion 44,9% by the year 2012. The population coverage estimated by the PACS was 34,4% in 2000, increasing by 30.6% by the year 2012.[18]

The expansion of this proposal as a practical reorganization of primary health care varies from one location to another, making it essential to discuss issues related to qualification and resolution of health teams, as well as the creation of assessment tools that encourage and guide for the scope of the improvement of health services and actions developed by the teams.[20]

It is noteworthy that it is fundamental that all process management and care developed by the multidisciplinary team can be evaluated with the goal of improving FHS.[21] Appropriate evaluative tools are important to understanding the scope and limits of Strategy [20], the gaps, and the goals to be achieved in line with the principles of SUS.

Training programs for health professionals: government initiatives

In order to evaluate and qualify the BHC, the Ministry of Health launched in 2011 PMAQ[22]. With its creation was established that, for membership in 2011 the ceiling of Primary Care Teams (EAB) by municipality would be 50% of the number of FHS teams. [5]

In this sense, it can be seen in this study that the data go beyond the minimum requirements of MOH, with the accession of 95,4% of Health teams of CIR West Family at PMAQ by the end of 2012. This reality can point a commitment of the municipalities with its population in access and improving the quality of primary care.

PMAQ aims at continuous improvement of results in the context of the Family Health Strategy, which promotes better access to health services, higher resolution and humanized care, since these purposes should be targeted by managers, health professionals and other actors involved in this process.[23]

It is noteworthy that the teams that have not joined the PMAQ belong to the municipality with the largest population index unassisted by the FHS, which shows gaps and weaknesses regarding compliance with the guidelines of SUS.

Some challenges for PMAQ can be perceived as the short term to accession; difficulty thorough understanding of the entire program; lack of clarity on how the application of financial resource PMAQ; and lack of contracting for management culture, impact assessment, user satisfaction, performance, and negotiation.[24]

However, this assessment is important as it opens the possibilities of building solutions based on identifying problems, as a reflective and problem-solving character tool. Enables to checking the reality of local health, identifying the weaknesses and the potential of the primary care network, leading to intervention plans for improving access and quality of services.[25]

Among the weaknesses of the BA it can be considered the scarcity of many professionals and little qualification for acting in these health services. According to Ministry of Health, Brazil has an average of 1,8 doctors per thousand inhabitants, a relatively low average when compared to developed countries like Spain that has an average of 4,0 and Portugal with 3,9 doctors every thousand inhabitants. Besides the lack of professionals, the country suffers from an uneven distribution, and 22 states have number of doctors below the national average and five of them with less than 1 doctor per thousand inhabitants.[26]

In order to qualify the primary care professionals and address the lack thereof, which has a close relationship with the quality of service, the MS establishing PROVAB, the same year the PMAQ, which aims to qualify and secure health professionals in primary care in difficult regions thereof in order to increase the population coverage.[27]

According to the first swing PROVAB presented by MS in 201328, the program presented difficulties in its first year of implementation, in which the goal of MOH, was to hire about seven thousand doctors in 2012, but only 381 doctors have joined the program. This also reflects the reality found in this study, where in 2012 48% of the municipalities of CIR SC West did not join the PROVAB.

The year 2013, in turn, has better numbers; of the 2.867 municipalities registered by health secretaries, managed 1.291 physicians interested. The southern region received 312 physicians in 152 cities that were divided into three states. The state of Rio Grande do Sul has 123 participants in 66 municipalities in SC are 110 doctors in 52 cities, and Paraná, 79 people in 34 cities. The country's Northeast region is the one that had greater adherence to PROVAB: 2.241 physicians in 645 cities. [28]

Among the incentives presented by MOH include the remuneration in the form of a monthly stipend of R$ 8000 for participating physicians. Professionals must meet 32 hours per week of practical activities in the Basic Health Units (BHU) hours per week course graduate in Family Health, lasting 12 months. The graduates who meet the established activities and receive a minimum score of seven on the evaluation will be additional score of 10% in residency tests.[28]

In addition to advances in adhesion of medical professionals to PROVAB, the Ministry of Health launched the edict nº 58 on the date of November 7th, 2013, calling nurses and dentists to apply to the program for the second phase, starting in 2014.[29] However there is a lack of studies on the evaluation of this program and its effectiveness for care services Primary Health.

Coverage of psychosocial care service and of the Network Stork

Qualifying and extending the BHC cover means provide health services with quality to each and every individual of the same needs, this logic arises Law 10.216 of 2011 that instituting the rights and users of mental health care services, and enhanced by ordinance 3.088 of 2011 that instituted the Psychosocial care network for people with mental distress or disorder and needs arising from the use of crack, alcohol and other drugs, in the SUS.[7]

In 2010, Brazil had a 63% coverage of psychosocial care services, and the indicator used provided for a CAPS for every 100 thousand inhabitants. Santa Catarina has an 82% coverage overcoming national coverage. The findings in this study indicate that the CIR West 64% of the municipalities are discovered by CAPS, with a coverage of only 36% of the municipalities, corresponding to 71,1% of the population below the state coverage.

Public policies for mental health in effect in the country have on individual rights and redirecting the care model in mental health. States and municipalities should propose an equitable mental health policy, included, extra-hospital community based. Responsible managers will enable technical and political conditions that guarantee the right to treatment, the organization of a network of care health through health and sociocultural devices incorporating various dimensions of functioning. Following this logic it must ensure that the CAPS are strategic devices, able to function as articulators centers of the instances of basic health care, including family health strategy, Basic Attention, network clinics, tertiary care and support social activities.[30]

In addition to the BC programs to the need to improve the health services in 2011 was created by the Ministry of Health the Stork Network program, which is a strategy based on the principles of humanization and assistance for women, infants and children. This strategy aims to implement a network of care that can guarantee women the right to reproductive planning, humanized attention to pregnancy, childbirth and the postpartum period and children the right to safe birth, growth and healthy development.[8]

According to Ordinance **nº** 1.459 of June 24th, 2011, are objectives of Stork Network[8] (Art. 3):

> I -promoting the implementation of new model of attention to women's health and children's health with a focus on attention to the

> labor, the birth, growth and development of the child from zero to twenty-four months;
> II - organize the Network of Maternal and Child Health Care in order to ensure access, reception and resolution; and
> III - reduce maternal and child mortality with an emphasis on neonatal component.

The Stork Network should be implemented throughout the country by the year 2014. The implementation in the State of SC, initially started by the regions of Northern Plateau, Northeast and Florianopolis [31], can consider that in the region under study there were great advances in relation to its implementation in these municipalities, and by the end of 2012, 68% of these had already joined the program.

The program is fairly recent, but has already generated controversy, especially with the feminist paradigm because it implies a thirty year setback in the fight for women's health and women's emancipation, claiming that the initiative reiterates the notion that women's health and the very Woman person would be targeted for maternity only .[32] However, the authors argue that this is not a moral or biological imposition of motherhood, but a health policy that has become a priority of government, especially since pregnancy happens so oblivious to the State, leaving him, however, provide access to health and quality care.[33]

Has recognized the value of the program for a country with: urgency of resolving the lack of infrastructure in hospitals, the high rates of cesarean sections, the high rates of maternal and infant mortality, and quality of assistance provided by the medical staff and the State's own.[32]

Currently, SC has a maternal and infant mortality rate lower than the national average. In 2011, 11 children died per thousand live births in the state and in the country the proportion of dead children was 13,5 per thousand. The reduction in infant mortality was possible due to the adoption of measures such as increased vaccination coverage, increased prenatal coverage, promoting breastfeeding and expansion of health services with the Family Health Strategy (FHS). However, the deaths of these children are still linked to problems at birth or in the first days of life, so the importance of implementation of the Stork Network.[31]

CONCLUSION

The results obtained in this research can be seen an expansion of FHS that has occurred in different intensity in the Country, State and Western Health Region. Regarding the CHA strategy, it is recognized that their coverage is satisfactory, which can be explained by its appearance since the 90s, the first attempt to reorganize the current health care

model at the time. Both deserve investments for deployment and operation because it is historical programs.

We found a good adhesion of the region SF teams studied the PMAQ, which can bring positive results as improving the quality of access and care of primary care. The accession of municipalities to PROVAB, CAPS and the Stork Network is significant, but must achieve higher percentages, which can be explained by recent programs are still in consolidation phase. Investments are needed for the qualification of services offered and people's access to them.

Existing gaps in the coverage of strategies for strengthening primary care may be related to lack of training of health professionals of Primary Care, still associated with little commitment and lack of awareness of municipal managers about the importance of its implementation.

There is a need to raising awareness of professionals in the health teams the Family and managers for the new recommended health care model, aimed at family health and community, occurs in an effective, comprehensive and equitable.

It was observed during this study the lack of studies to assess the coverage and effectiveness of these programs. It will be important to evaluate the results and management for planning actions and reach the agreed targets. There are suggested studies aimed at assessing the impact and resolution of implementation of the programs established by the MOH.

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