EVALUATION OF THE PERFORMANCE OF THE FAMILY HEALTH SUPPORT CENTER

Avaliação da atuação do Núcleo de Apoio à Saúde da Família

Evaluación de la actuación del Núcleo de Apoyo a la Salud de la Familia

Original Article

ABSTRACT

Objective: To evaluate the performance of the Family Health Support Center (NASF) through the knowledge and evaluation of services by professionals of the Family Health Strategy (FHS). **Methods:** Quantitative descriptive study conducted in 2012 with 10 FHS linked to NASF, District 1, Parnaíba - PI - Brazil, where 76 professionals were interviewed using a questionnaire on the characterization of the professional, their knowledge regarding the NASF activities and the evaluation of services provided by the NASF team. The data were divided into categories, grouped and analyzed using SPSS 19.0. **Results:** In the evaluation of the NASF performance by the members of the FHS, 42% (n=32) considered the service very important, 59.0% (n= 5) of the members were satisfied, 54.0% (n=41) rated the service as accessible to the population, and 90% (n=68) of interviewees recognized which professionals make up the NASF team, highlighting the physiotherapist and the physical educator. **Conclusion:** It is concluded that the FHS have information regarding the structure of the NASF, pointing the service as very important. Additionally, they are satisfied with the activities performed and rate the service as accessible to the population, which is informed by NASF about their rights in public health.

Descriptors: Family Health Strategy; Health Evaluation; Unified Health System.

RESUMO

Objetivo: *Avaliar a atuação do Núcleo de Apoio à Saúde da Família (NASF) através do conhecimento e da avaliação de serviços pelos profissionais da Estratégia de Saúde da Família (ESF).* **Métodos:** *Estudo descritivo quantitativo realizado em 2012 junto às 10 ESF vinculadas ao NASF, distrito 1, de Parnaíba/PI - Brasil, no qual entrevistaram-se 76 profissionais por meio de um questionário composto por caracterização do profissional, investigação do seu conhecimento com relação às atividades do NASF e avaliação dos serviços prestados pela equipe do NASF. Os dados foram divididos em categorias, agrupados e analisados pelo SPSS (versão 19.0).* **Resultados:** *Na avaliação da atuação do NASF pelos membros das ESF, 42% (n=32) apontaram o serviço como muito importante, 59,0% (n=45) dos membros encontravam-se satisfeitos, 54,0% (n=41) classificavam o serviço como acessível para a população e 90% (n=68) dos entrevistados reconheceram quais os profissionais que compõem a equipe do NASF, destacando o fisioterapeuta e o educador físico.* **Conclusão:** *Concluiu-se que as ESF possuem informação com relação à estrutura do NASF, apontando o serviço como muito importante, estando satisfeitos com as atividades realizadas, classificando o serviço como acessível para a população, sendo esta informada pelo NASF acerca de seus direitos na saúde pública.*

Descritores: *Estratégia Saúde da Família; Avaliação em Saúde; Sistema Único de Saúde.*

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RESUMEN

Objetivo: *Evaluar la actuación del Núcleo de Apoyo a la Salud de la Familia (NASF) a través del conocimiento y de la evaluación de servicios por los profesionales de la Estrategia de Salud Familiar (ESF).* **Métodos:** *Estudio descriptivo cuantitativo realizado em 2012 junto a las 10 ESF vinculadas al NASF, distrito 1 de Parnaíba/ PI - Brasil, en el cual se entrevistaron 76 profesionales con um cuestionario constituido de la caracterización del profesional, investigación de su conocimiento respecto las actividades Del NASF y evaluación de los servicios ofrecidos por el equipo Del NASF. Los datos fueron divididos en categorías, agrupados y analizados por el SPSS (versión 19.0).* **Resultados:** *En La evaluación de la actuación del NASF por los miembros de lãs ESF, el 42% (n=32) relataron el servicio como muy importante, el 59,0% (n=45) de los miembros estaban satisfechos, el 54,0% (n=41) clasificaron el servicio accesible para la población y El 90% (n=68) de los entrevistados reconocieron los profesionales que constituyen el equipo del NASF, destacando el fisioterapeuta y el educador físico.* **Conclusión:** *Se concluye que las ESF poseen información respecto la estructura del NASF considerando El servicio muy importante y encontrándose satisfechos con lãs actividades realizadas, clasificando el servicio como accesible para la población siendo la misma informada por el NASF sobre sus derechos de la salud pública.*

Descriptores: *Estrategia de Salud Familiar; Evaluación em Salud; Sistema Único de Salud.*

INTRODUCTION

The Brazilian public health policies were first established during the 19th-20th century transition influenced by economic and political issues. Over time, they were the target of movements known as *Sanitarismo Campanhista* (Sanitation Campaign Movement), national conferences and health promotion charts[1]. The National Constitution defines health as the result of social and economic policies, being a right of the citizen and a duty of the State, participating in social security, and whose actions and services should be provided by the *Sistema Único de Saúde – SUS* (Brazil's Unified Health System) [1].

The *SUS* was implemented in 1990 by the laws 8.080 (effective September 19, 1990) and 8.142 (effective December 28, 1990). Its main guidelines are the universal access to health services in all levels of care; integrality, understood as a continuous and articulated set of individual or collective, preventive and curative actions and services required for each case at all complexity levels of the health care system; health equity, without any kinds of prejudices or privileges; and social participation[2].

Strategies have been developed in order to strengthen *SUS* practices. They include the creation of sanitation districts, local health systems, and the *Programa de Agentes Comunitários de Saúde – PACS* (Community Health Agents Program), which is considered one of the main strategies developed in primary health care[3].

In 1994, the Ministry of Health (MH) implemented the Family Health Program (FHP). However, Ordinance No. 648/06 named it Family Health Strategy (FHS), pointing to a broader concept targeting local-regional specificities, intersectoral work, and the valuation of interdisciplinary knowledge and practices[4].

This strategy aims to reorganize primary health care of *SUS,* substitute the traditional model and expedite the decentralization of services according to the population's needs, which appear as priorities and reflect concrete problems. It ensures principles of territorialization, bonding with the population, care integrality, focus on health promotion through the strengthening of intersectoral actions, and encourages community participation and multidisciplinary teamwork, among others[5].

The FHS comprises doctors, nurses, dentist-surgeons, nursing assistants and community health agents who provide health care in the *Unidade Básica de Saúde – UBS* (Basic Health Care Unit) or at the user's home[6]. This team develops actions based on a multicausality logic, which demands knowledge of different issues from professionals at the expense of fragmented and specialized knowledge as it can be found in the other levels of health care[7]. Each FHS is responsible for providing care to circa three to four thousand people or one thousand families in a certain area. This operationalization needs to be in line with the local reality, as long as it is based on fundamental principles and guidelines[4].

The Ministry of Health implemented the *Núcleos de Apoio à Saúde da Família – NASF* (Family Health Support Centers) through the Minister's Office Ordinance No. 154, effective January 24, 2008 in order to expand the coverage of primary health care actions and offer greater support, integrality, effectiveness and efficacy to *SUS*, corroborating the process of territorialization and regionalization of primary care and giving support to the FHS[8]. The *NASF* is organized into two modalities, *NASF 1* and *NASF 2*, which differ as to the number of teams they are linked to and to the number of professionals they have. The implementation of the two modalities in a single municipality is forbidden. The *NASF* is composed of professionals from different fields of knowledge who collaborate with the FHS professionals in the territories under their responsibility, proving collective learning and training for self-care through meetings and shared services articulated with the FHS they are enrolled to. This service is not a gateway to the health care system[8,9].

Multiprofessional partnerships are important in the search for a more humanized, integral health care approach, and for the joint responsibility of professionals and users, observing the needs of a person within his full context. Therefore, physiotherapists and other healthcare professionals like nutritionists, psychologists, physical educators, social assistants and occupational therapists should be incorporated in a new perspective of action aimed at primary health care [10].

Given this, primary health care is composed of multidisciplinary teams that interact with one another and hence allow the development of a project that must involve everybody in order to provide the population with a comprehensive health care[11].

Therefore, it becomes important to assess the implementation of the *NASF* and its process of adaptation due to the lack of studies on this issue. Thus, this study aimed to assess the work of *NASF* through the FHS professionals' knowledge and evaluation of the services.

METHODS

This is a descriptive quantitative research conducted with the 10 FHS linked to the *NASF – 1* of Paranaíba/PI, which was chosen due to the easy access to its geographical area, the larger number of FHS linked to it, and also because it covers the second largest population. The population of this study comprised 113 healthcare professionals (100% from FHS); however, only 76 (67.25%) were included in the sample for meeting the inclusion criteria: work in the FHS linked to *NASF – 1*; be present in the moment of the questionnaire application, and accept to participate in the research. Workers who were absent from work for any reasons and those who were not present during data collection or refused to participate were excluded from the research.

According to the 2010 census data of the *Instituto Brasileiro de Geografia e Estatística – IBGE*[12] (Brazilian Institute of Geography and Statistics), the city of Parnaíba has a total of 145,705 inhabitants in an area of 435.564 km^2. *NASF – 1* was implemented in August, 2009 and is one of the four *NASF* in the city. They cover an estimated population of 125,287 and have 37 FHS. All *NASF* teams comprise social assistant, psychologist, nutritionist and physiotherapists; three out of the four teams also comprise physical educator and speech and hearing specialist, and two teams count on occupational therapists.

Data were collected from January to May 2012 through interviews using an author-developed instrument, a questionnaire on the characterization of the FHS professional interviewed, FHS members' knowledge of *NASF* activities, and the services provided by *NASF* to the population of the area covered by the FHS. Researchers delivered the questionnaires to the FHS professionals so they could answer it.

The application of the questionnaires took place in the *Unidades de Saúde da Família – USF* (Family Health Care Units). After that, data were divided into categories, grouped and analyzed using the Statistical Package for the Social Sciences 19 (SPSS 19).

The participants were informed about the procedures of the research and then signed the free informed consent form. The study was approved by the Research Ethics Committee of the Federal University of Piauí under Opinion No. 0296/2011.

RESULTS

The questionnaires were applied to the following professionals: 1 (1.3%) Social Assistant, 4 (5.3%) Nursing Technicians, 5 (6.6%) Nurses and 66 (86.8%) Community Health Agents, resulting in a total of 76 people. In all, 62 (82.7%) interviewees were women, and 33 (43.4%) were 30-40 years old. The minimum age of the participants was 18 years, and the maximum was 51 years, with a mean age of 34.5. Doctors did not participate in this research because they said they did not have time to do so and also did not have contact with the *NASF*. Additionally, they were on strike during the period of data collection. The distribution of the demographic characteristics of the sample is presented in Table I.

Table I - Demographic characterization of the members of the Family Health Strategies (FHS). Parnaíba-PI, 2012.

Variable	n	%
Sex		
Male	13	17.3
Female	62	82.7
Age		
18-30 years	6	7.9
31-40 years	33	43.4
41-50 years	22	28.9
Over 51 years	14	18.4
Not informed	1	1.3

Regarding the education level of FHS members, most interviewees, 51.3%, had complete secondary education (n=39), 26.3% had complete higher education (n=20), 10.5% are technicians (n=8), 6.6% have a post-graduation degree (n=5), and only 5.3% have complete primary education (n=4), in this case, the community health agents.

The results of the questionnaire assessing FHS members' knowledge of *NASF* activities are presented in Table II, which shows that 90% (n=68) of the interviewees

know who are the professionals making up the *NASF* team. They have mostly reported the physical educator (93.0%) and the physiotherapist (89.0%).

The main activities reported by the interviewees were: 82.0% collective activities (n=62), 63.0% visits (n=48), and 54.0% home consultations (n=41). Additionally, 87.0 % (n=66) of the interviewees reported that the target population of the service is the people with mental disorders.

The evaluation of *NASF* performance by FHS members (Table III) reveals that 42% of the interviewees classify the service as very important (n=32). A total of 59.0% of the members are satisfied with the service (n=45) and 54.0% classify it as accessible to the population (n=41). It was also observed that 78.0% of the *NASF* team informs the population of their rights regarding public health (n=59) and 84.0% of the interviewees reported the *NASF* clarifies doubts of the population and the FHS members (n=64). Concerning the actions developed by *NASF*, 92.0% of FHS professionals said they were easy to understand (n=70).

Table II - Family Health Strategy (FHS) members' knowledge regarding the *NASF* activities. Parnaíba-PI, 2012.

Variables	n	%
Professionals who make up the *NASF* team		
Social Assistant	65	86.0
Pediatrician	1	1.0
Physical Educator	71	93.0
Nutritionist	19	25.0
Physiotherapist	68	89.0
Psychologist	25	33.0
Hearing and Speech Specialist	1	1.0
Occupational Therapist	36	47.0
Gynecologist	0	0.0
Does not know	2	3.0
Activities performed by *NASF*		
Consultations in the UBS	12	16.0
Educative Activities	57	75.0
In-home Consultations	41	54.0
Waiting Room	3	4.0
Home Visits	48	63.0
Collective Activities	62	82.0
Matrix-based strategies	40	53.0
Others	1	1.0
Does not know	3	4.0
Population assisted by *NASF*		
Children	25	33.0
Elders	51	67.0
Adolescents	33	43.0
Pregnant women	16	21.0
Male Adults	28	37.0
Professionals	33	43.0
Female Adults	36	47.0
Students	14	18.0
People with mental disorders	66	87.0
Alcohol and/or Drug users	28	37.0
Does not know	2	3.0

Table III - Evaluation of *NASF* performance according to the Family Health Strategy (FHS) members. Parnaíba-PI, 2012.

Variable	n	%
Importance of the services provided by *NASF*		
Not important	1	1.0
Little Important	1	1.0
Important	28	37.0
Very Important	32	42.0
Indispensable	11	15.0
Does not know how to answer	3	4.0
Personal experience regarding *NASF*		
Very bad	1	1.0
Bad	4	5.0
Regular	15	20.0
Good	37	49.0
Very good	19	25.0
Satisfaction with *NASF* services		
Dissatisfied	6	8.0
Little Satisfied	17	23.0
Satisfied	45	59.0
Very Satisfied	4	5.0
Does not know how to answer	4	5.0
Does *NASF* prioritize collective activities?		
Yes	68	90.0
No	4	5.0
Does not know	4	5.0
Does *NASF* inform the population about their public health rights?		
Yes	59	78.0
No	8	10.0
Does not know	9	12.0
Does *NASF* take into account the local reality in their actions?		
Yes	60	79.0
No	7	9.0
Does not know	9	12.0
Do *NASF* members clarify your doubts?		
Yes	64	84.0
No	5	7.0
Does not know	7	9.0
Is *NASF* accessible to the population?		
Yes	41	54.0
No	26	34.0
Does not know	9	12.0
Are the actions developed by *NASF* easy to understand?		
Yes	70	92.0
No	4	5.0
Does not know	2	3.0

DISCUSSION

In the present research, the study population is mostly composed of women (82.7%) rather than men (17.3%), which corroborates another study[13] on the utilization of primary health care services. Therefore, it does not appear as a differential aspect of the services provided by the health care facility evaluated in this study.

The results found in the present study show that the health care teams of Parnaíba are composed of social assistant, physical educator, physiotherapist, psychologist, occupational therapist, and nutritionist. The Minister's Office Ordinance 154/08 of the Ministry of Health states that the definition of the professionals who are going to make up the *NASF* is a responsibility of the municipal manager, who must follow criteria as the priority identified

from the local needs, the social and epidemiological profile and also the availability of professionals in each area[8].

Such criteria for the team composition are somewhat positive because they allow the flexibility of actions according to the needs of the teams and the population[14]. On the other hand, they may hinder the development of collective practices and experiences that should be shared and added up to the *NASF*, affecting the development of the program as a whole.

The analysis of the results of the present study revealed that the FHS professionals know who are the professionals who make up the NASF – 1 team. Of all the interviewees, only 3% reported they did not know the members of the *NASF* team (n=2), highlighting the presence of the Physical Educator (93.0%), followed by the Physiotherapist (89.0%), with latter being also highlighted by another study[13]. The professionals who were less reported (the social assistant, the psychologist, the occupational therapist, the hearing and speech specialist and the nutritionist) are also members of the teams evaluated, although FHS members did not remember or did know about it due to the lack of experience or knowledge of their work, revealing a mismatch between the *NASF* and the FHS.

The literature[15,16] shows that FHS professional and also *NASF* professionals are not fully aware of the proposed work methodology presented by *NASF*. This fact reveals the fragility of the interdisciplinary work, which, in addition to structural problems like the lack of specialized services, lead to an arbitrary utilization or underutilization of services. This makes each professional or professional category develop specialized actions, causing a fragmentation of the care[16,17].

There is[18] a need for the clarification of roles concerning the real work of *NASF* within the FHS. The work of *NASF* can only be integrally performed if there are conditions for the development of an Interprofessional approach between *NASF* members and FHS professionals.

The *NASF* work should be divided into strategic areas: physical activity, integrative and complementary practices, rehabilitation, food and nutrition, mental health, social work, child, adolescent and young adult health, women's health and pharmaceutical assistance[8]. According to the results of the present study, the educative and collective activities, and the home visits are the main tools for contacting the population, which is mostly composed of elders, children, adolescents, women, men and drug users, corroborating the information found in the literature[19-21].

People with mental disorders 87.0% (n= 66) are pointed by the interviewees as the main population assisted by the service, meeting the emphasis given to this population by the ordinance that established the *NASF*, which requires the presence of at least one mental health professional due to the prevalence of mental disorders in contemporaneous society[10;14;15]. The *NASF* services were reported by most of the interviewees as important and very important; they also reported being satisfied with the service. Concerning the FHS teams experience regarding *NASF*, it was observed the existence of a good articulation between the teams, which may have influenced their level of satisfaction with the service. There is a good relationship between the FHS and *NASF*, which is a positive point for the implementation of *NASF* in the city of Parnaíba since it can have greater impact on the different factors interfering with health-disease process, promoting the co-responsibility and the integrated and shared management of care.

The teamwork should be guided by a common assistential project in which agents should develop an interaction action to encourage the participation of everyone according to their specificities, contributing to the quality of the provision of health care services. The factors commonly highlighted as drawbacks to healthcare teamwork are: gender, social insertion, length of time spent on the job and employment relationship, professional and life experience, education and qualification, world view, wage gap, and personal interests[11;18]. These differences influence the work process; however, they should not hinder the exercise of collectiveness[20].

In the present study, regarding the level of satisfaction of the 76 FHS interviewees, 59.0% (n=45) are satisfied with the *NASF* service while 31.0% (n=-23) report some points they are dissatisfied with: the difficult access and schedule of home visits, lack of transportation for the teams, the small number of professionals, extensive coverage area, structural and material difficulties, and the distance between the UBS. A research published in 2013, held in the city of Parnaíba – PI, assessing the performance of *NASF* physiotherapists, shows that the complaints reported by the interviewees are similar to the ones presented in our study: controversies regarding the FHS team, lack of materials and transportation, and the impossibility to meet the population demand (on average, there is one physiotherapist for each center, which is responsible for an estimated population of 31,322 people)[21].

In the present study, 92% of the FHS members said that the educative actions are easy to understand, and 84% said that the *NASF* professionals are able to clarify doubts. No complaints about these activities have been reported. In another study conducted in the city of Parnaíba[21], educative activities took place in orientation groups: Diabetes Group, Systemic Hypertension Group, and Equilibrium Group.

The results found in the present study showed that 54.0% of the sample reported *NASF* as an accessible

system, 34.0% said it is a service difficult to access, and 12.0% preferred not to answer. One of the factors that may have interfered with the access to the service is the professional availability, which may be justified by the fact that the number of professionals is sometimes not enough to provide care for the whole population, in addition to the distance and conditions regarding the geographic access[22].

The implementation of *NASF* with an insufficient number of teams to assist the population has already been reported as a drawback to the permanence and development of bonds with *NASF*, which generates conflicts and frustrations because of the incapacity to meet the local demand[22].

The present study identified a scarcity of studies on the process of implementation of *NASF* in Brazil and its relationship with the FHS, an issue that has been showing up as a vast field for further research. This study is expected to help in the planning of actions of *NASF* and contribute to a reflection on the impact of the level of information about the service on the relationship of the health care teams covered by them and its interdisciplinary approach.

CONCLUSION

In conclusion, the FHS teams are informed about the structure of *NASF* and point the service as very important. Additionally, they are satisfied with the activities performed and classify the service as accessible to the population, which is informed by the *NASF* about their public health rights.

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