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EVALUATION OF THE FAMILY HEALTH STRATEGY FROM THE PROFESSIONALS' PERSPECTIVE

Avaliação da estratégia saúde da família sob a ótica dos profissionais

Evaluación de la estrategia de salud familiar bajo la óptica de los profesionales

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ABSTRACT

Objective: To check if the essential and derivate attributes of Primary Health Care (PHC) are present in the Family Health Strategy (FHS). **Methods**: This is a quantitative descriptive evaluation research carried out in 21 municipalities in the region of Presidente Prudente (São Paulo, Brazil) from June to September 2015. The Primary Care Assessment Tool (PCATool) was used to collect data as it allows to evaluate the following variables: First Contact Access (access, utilization), Coordination (integrated care, information system) and Comprehensiveness (services available, services provided, family orientation and community orientation). Scores and means of the variables were constructed based on the Manual of the PHC Assessment Tool designed by the Ministry of Health. The statistical analysis calculated the mean, the standard deviation, and the minimum and maximum values of the variables (PHC attributes). **Results**: Participants were 102 professionals (19 health managers, 39 physicians, and 44 nurses). The majority had higher education (98%; n=100), less than half specialized in Family Health (37.3%; n=38) and attended a training course to work in the FHS (48%; n=49). The essential and derivate attributes obtained the following scores: First Contact Access – Accessibility, 5.57; Utilization, 7.71; Coordination – Integrated Care, 7.70; Coordination – Information Systems, 8.74; Comprehensiveness – Services available, 8.29; Comprehensiveness – Services provided, 8.40; Family orientation, 8.53; Community orientation, 8.12. **Conclusion**: From the physicians', nurses' and managers' perspective, the essential and derivate attributes of PHC evaluated in the FHS of the region are present.

Descriptors: Health Evaluation; Primary Health Care; Family Health Strategy.

RESUMO

Objetivo: *Avaliar se os atributos essenciais e derivados da Atenção Primária à Saúde (APS) estão presentes na Estratégia Saúde da Família (ESF).* ***Métodos:*** *Pesquisa avaliativa, quantitativa e descritiva, realizada em 21 municípios da região de Presidente Prudente (São Paulo, Brasil), no período de junho a setembro de 2015. Utilizou-se o instrumento Primary Care Assessment Tool (PCATool) para a coleta de dados, que permite avaliar as variáveis: Acesso de Primeiro Contato (acessibilidade e longitudinalidade), Coordenação (integração de cuidados e sistemas de informações) e Integralidade (serviços disponíveis, serviços prestados, orientação familiar e orientação comunitária). A construção dos escores e médias das variáveis realizou-se com o auxílio do Manual do Instrumento de Avaliação da Atenção Primária à Saúde, elaborado pelo Ministério da Saúde. Na análise estatística, construiu-se a média, o desvio padrão, o mínimo e o máximo das variáveis (atributos da APS).* ***Resultados:*** *Participaram 102 profissionais (19 gestores de saúde, 39 médicos e 44 enfermeiros), entre os quais a maioria possuía ensino superior (98%; n = 100), menos da metade possuía especialização em Saúde da Família (37,3%; n = 38) e curso de capacitação para trabalhar na ESF (48%; n = 49). Os atributos essenciais e derivados receberam os respectivos escores: Acesso de Primeiro Contato - Acessibilidade 5,57, Longitudinalidade: 7,71; Coordenação - Integração de cuidados 7,70, Sistemas de Informações 8,74; Integralidade - Serviços disponíveis 8,29, Serviços prestados 8,40, Orientação familiar 8,53, Orientação comunitária 8,12.* ***Conclusão:*** *Segundo a ótica dos profissionais médicos, enfermeiros e gestores, os atributos essenciais e derivados da APS, avaliados na ESF da região, estão presentes.*

Descritores: *Avaliação em Saúde; Atenção Primária à Saúde; Estratégia Saúde da Família.*

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RESUMEN

Objetivo: *Evaluar si los atributos esenciales y derivados de la Atención Primaria de Salud (APS) se encuentran en la Estrategia de Salud Familiar (ESF).* ***Métodos:*** *Investigación evaluativa, cuantitativa y descriptiva realizada en 21 municipios de la región de Presidente Prudente (São Paulo, Brasil) en el período entre junio y septiembre de 2015. Se utilizó el instrumento Primary Care Assessment Tool (PCATool) para la recogida de datos que permite evaluar las variables: Acceso de Primer Contacto (accesibilidad y longitudinalidad), Coordinación (integración de cuidados y sistemas de informaciones) e Integralidad (servicios disponibles, servicios prestados, orientación familiar y orientación comunitaria). La construcción de las puntuaciones y medias de las variables se dio con el auxilio del Manual del Instrumento de Evaluación de la Atención Primaria de Salud elaborado por el Ministerio de Salud. En el análisis estadístico se construyó la media, la desviación típica, el mínimo y el máximo de las variables (atributos de la APS).* ***Resultados:*** *Participaron 102 profesionales (19 gestores de salud, 39 médicos y 44 enfermeros) entre los cuales la mayoría tenía educación superior (98%; n = 100), menos de la mitad tenía posgrado en Salud Familiar (37,3%; n = 38) y curso de capacitación para trabajar en la ESF (48%; n = 49). Los atributos esenciales y los derivados recibieron las respectivas puntuaciones: Acceso de Primer Contacto - Accesibilidad 5,57, Longitudinalidad: 7,71; Coordinación - Integración de cuidados 7,70, Sistemas de Informaciones 8,74; Integralidad - Servicios disponibles 8,29, Servicios prestados 8,40, Orientación familiar 8,53, Orientación comunitaria 8,12.* ***Conclusión:*** *Los atributos esenciales y los derivados de la APS están presentes en la ESF de la región según la óptica de los profesionales médicos, enfermeros y gestores.*

Descriptores: *Evaluación en Salud; Atención Primaria de Salud; Estrategia de Salud Familiar.*

INTRODUCTION

Primary Health Care (PHC), referred to in Brazil as Primary Care (PC), according to the National Primary Care Policy (*Política Nacional de Atenção Básica – PNAB*), is the users' preferred contact with health systems. It is guided by the principles of universality, accessibility and coordination of care; bonding and continuity; comprehensiveness; accountability; humanization; equity and social participation[1].

PC has Family Health as a priority strategy for its organization according to the precepts of the Unified Health System (*Sistema* Único *de Saúde – SUS*)[1]. In the search for structuring a new model of care, the Ministry of Health (MoH) proposed in 1994 the Family Health Program (*Programa de Saúde da Família – PSF*), which was later renamed the Family Health Strategy (*Estratégia Saúde da Família – ESF*), with the objective of reorganizing the health care model and replacing a doctor-centered care model highly focused on medicalization by a family-centered care model through social inclusion, thus enabling a better understanding of the health-disease process and generating interventions that seek more than curative actions[2].

The ESF represented a significant advance in the Brazilian health policy as it aimed to replace the usual concept of health practices focused on the biomedical model of care by an innovative strategy to integrate and organize activities in a given territory, identifying and solving problems and mapping risks with a view to equity and comprehensiveness through radical changes to the system in an articulated and continuous manner[3].

In recent years, mainly in Brazil, the operational definition of PHC has used as a parameter four essential attributes and three characteristics for the operation of PHC services. The essential attributes are: 1) Individual's first contact access with the health system; 2) Longitudinality; 3) Comprehensiveness and 4) Coordination of care. The three characteristics, called derivative attributes, that qualify the actions of PHC services are: family-centered health care (family orientation), community orientation and cultural competence[4,5].

Thus, a primary care service targeted at the general population can be considered a primary care provider when it presents the four essential attributes, increasing its power of interaction with individuals and the community by presenting the derivative attributes as well[6].

The strict identification of the presence and the extension of the aforementioned attributes is key to defining a service as truly oriented towards PHC[6]. In addition, the empirical identification of the attributes allows to verify the association between them and the effective results of attention to the health of the population[5]. Parallel to the increase in the coverage of primary health care services in Brazil through the ESF, there is a growing association between better health outcomes and greater presence and extension of PHC attributes[5].

In this perspective, the adequate operationalization of ESF within the framework of PHC favors the development of health promotion actions based on the principles of intersectoriality, intrasectorality, comprehensiveness, equity, social

participation, autonomy, empowerment and territoriality, and values of co-responsibility, social justice, humanization and social inclusion[7].

Given the magnitude of the ESF as a structuring strategy of SUS, conducting its evaluation is a task that requires a continuous collective effort. Because of the breadth of PHC itself, a specific proposal for evaluation is usually confined to one of its many perspectives. Thus, identifying within the scenario of heterogeneity that characterizes the ESF the degree of PHC orientation of each health service or team evaluated allows the rigorous production of knowledge about its effectiveness[8].

In this context, the present research aims to evaluate if the essential and derivative attributes of Primary Health Care are present in the Family Health Strategy.

METHODS

This is a quantitative and descriptive evaluation research carried out in twenty one of the twenty four municipalities belonging to the Regional Intermanagement Commissions (*Comissões Intergestores Regionais – CIR*) of Alto Capivari and Alta Sorocabana of the Regional Health Care Network (*Rede Regional de Atenção à Saúde – RRAS 11*) of Presidente Prudente[9], in the countryside of the state of São Paulo, Brazil, from June to September 2015.

In the year 2015, the Alta Sorocabana CIR comprised nineteen municipalities: Alfredo Marcondes (4,064 inhabitants), Álvares Machado (24,482 inhabitants), Anhumas (3,941 inhabitants), Caiabu (4,201 inhabitants), Emilianópolis (3,149 inhabitants), Estrela do Norte (2,752 inhabitants), Indiana (4,951 inhabitants), Martinópolis (25,473 inhabitants), Narandiba (4,564 inhabitants), Presidente Bernardes (13,724 inhabitants), Presidente Prudente (218,960 inhabitants), Pirapozinho (26,146 inhabitants), Regente Feijó (19,468 inhabitants), Ribeirão dos Índios (2,248 inhabitants), Sandovalina (3,974 inhabitants), Santo Anastásio (21,059 inhabitants), Santo Expedito (2,963 inhabitants), Taciba (6,023 inhabitants) and Tarabai (7,028 inhabitants). The Alto Capivari CIR comprised five municipalities: Iepê (7,966 inhabitants), João Ramalho (4,361 inhabitants), Nantes (2,905 inhabitants), Quatá (13,501 inhabitants) and Rancharia (29,732 inhabitants)[9].

Inclusion criteria for the present research were: municipalities should have ESF coverage equal to or greater than 50%, the ESF teams should have been in operation for at least 5 years and be located in the urban area. In addition, the professionals (physicians and nurses) should have worked for at least 1 year in the ESF and health managers should be either Municipal Health Secretaries or Primary Care Coordinators.

The municipality of Presidente Prudente did not meet the criteria for ESF coverage (equal to or above 50%) and the municipal health secretaries of the municipalities of Pirapozinho and Santo Expedito did not authorize the research. Therefore, the sample of the present research considered the universe of health care managers, physicians and nurses who worked in the ESF of the CIR and who met the pre-established criteria.

The Alto Capivari and Alta Sorocabana CIRs had 73 ESF teams in operation in 2015, 62 of which have been in operation for at least 5 years and are located in the urban area. Of the 73 physicians, 50 had been working in the ESF for over a year. Of the 73 nurses, 53 had been working in the ESF for over a year. Thus, 19 health care managers, 39 physicians and 44 nurses participated in the present study. Of the 19 managers, 14 were municipal health secretaries and 5 were PC coordinators.

Data were collected using a questionnaire to characterize the professionals in relation to the variables (profession, education, specialization degree and training course to work in the ESF) and the Primary Care Assessment Tool (PCATool) modified and validated in Brazil to measure the presence and extension of essential attributes and derivative attributes of PHC[10]. The tool is based on the health services quality assessment model, which is based on the measurement of aspects of health structure, process and results[11].

As previously mentioned, there are four essential attributes for the functioning of PHC services: 1) Individuals' first contact access to the health system: it consists of accessibility and use of the health service as a source of care to every new problem or new episode of the same health problem; 2) Longitudinality: existence of a continuous source of care, as well as its use over time; 3) Comprehensiveness: the range of services available and provided by the primary care service; and 4) Coordination of care: it presupposes some form of continuity, either by having the patient be seen by the same professional or by means of medical records or both in addition to the recognition of problems addressed in other services and the integration of this care into the patient's overall care[5].

In addition to the essential attributes, three attributes are defined as derivative attributes, which qualify the actions of PHC services: 1) Family-centered health care (family orientation): assessment of individual needs for comprehensive care, considering the family context; 2) Community orientation: recognition by the health service of the health needs of the community through epidemiological data and direct contact with the community; and 3) Cultural competence: adaptation of the provider (team and health professionals) to the special cultural characteristics of the population to facilitate relationship and communication[5].

The present research used the professional version of PCATool validated in Brazil by researchers from the Federal University of Rio Grande do Sul (*Universidade Federal do Rio Grande do Sul – UFRGS*). The tool consists of 77 items divided into 8 components in the following manner in relation to PHC attributes[12]:

1) First contact access – accessibility, consisting of 9 indicators that seek to know about the possibility of the ESF operating and serving on weekends and at night, providing easy-to-schedule appointments and getting in touch with professionals;

2) Longitudinality consists of 13 indicators that assess the relationship between professionals and users in relation to communication, if the professionals know the life and the real problems of their patients and if there is a bond between the professional and the user;

3) Coordination – integrated care consists of 6 indicators that check whether professionals are aware of their patients' consultations with specialists, describe their clinical history to the specialists when referring patients, and receive feedback from the specialists regarding the assessment and the clinical picture of the patient;

4) Coordination – information system consists of 3 indicators that seek to know whether information on the clinical picture of the patients, treatment and consultations are organized and properly registered and if they can be easily accessed by the user;

5) Comprehensiveness – services available consists of 22 indicators that assess the range of services available, such as: nutritional counseling, immunizations, insertion of families into social programs, oral health, family planning, counseling on or treatment for harmful licit or illicit drug use, counseling on mental health problems, suturing of wounds, counseling on and request for HIV testing, identification of hearing problems, identification of visual problems, splinting, removal of warts, cervical cancer screening test, prenatal care, nail removal, counseling on the changes that occur with aging, home-care guidelines;

6) Comprehensiveness – services provided consists of 15 indicators that check if professionals give advice on healthy eating, home safety, seatbelt use, ways of dealing with family conflicts, practice of physical exercises, and blood tests to check cholesterol levels. In addition, it checks if professionals discuss with the patients the medications they are using and if they teach them how to safely store firearms, prevent burns, prevent falls, prevent osteoporosis in women, common menstruation or menopause problems, behavior problems and changes in children's growth and development;

7) Family orientation consists of 3 indicators that check whether the professionals take into account the patient's opinion, include the family in the construction of the therapeutic plan and ask about the diseases and health problems that the family has;

8) Community Orientation consists of 6 indicators that seek to know if the professionals visit the community and know the health problems of the community, hear opinions and ideas of the community on how to improve health services and if they are aware of the presence of users in the Local Health Council.

The PCATool has the following answers for each of the items: Definitely yes (value=4), Probably yes (value=3), Probably not (value=2), Definitely not (value=1) and Do not know/Cannot remember (value=9)[6]. The score of each attribute is given by calculating the mean of the values of the answers to the items that make up each attribute[6].

The interview technique was chosen for collecting the information from the questionnaire and the tool. Data collection took place after contacting professionals via telephone to schedule appointments and after approval by the municipal health secretaries and PC coordinators so as not to disrupt the work process and the provision of services to the population.

Data were organized using Microsoft Excel for Windows. The scores and means of the essential and derivative attributes of PHC were calculated with the aid of the PHC Evaluation Tool Guidebook developed by the MoH. The Statistical Package for the Social Sciences (SPSS) version 16[6] was used for the statistical analysis. To check whether the essential and derivative attributes of PHC are present in the ESF, the mean of 6.6[6] was used as a parameter. The statistical analysis is described using means, standard deviations, and minimum and maximum values (PHC attributes).

The present research was approved by the Research Ethics Committee (REC) of the Nursing School of the University of São Paulo (*Escola de Enfermagem da Universidade de São Paulo*) under Approval No. 1.024.138.

RESULTS

The characterization of the 102 professionals who participated in the present research showed that 100 (98%) had completed higher education and 2 (2%) had completed secondary education and are health managers. With regard to specialization, 38 (37.3%) are Family Health specialists. As for participation in training to work in the ESF, only 49 (48%) reported having received training.

The assessment of the presence and extension of the essential and derivative attributes of PHC in the ESF of the Alto Capivari and Alta Sorocabana CIRs showed that the attributes Longitudinality, Coordination – Integrated Care, Coordination – Information Systems, Comprehensiveness – Services Available, Comprehensiveness - Services Provided, Family Orientation and Community Orientation obtained a score above the mean of 6.6[6]. The attribute First Contact Access – Accessibility obtained a score of 5.57. The component Coordination – Information System of the attribute Care Coordination was rated the best component by professionals, with a score of 8.74 (Table I).

Table I - Essential and derivative attributes of Primary Health Care (PHC) according to professionals who work in the Family Health Strategy (*Estratégia Saúde da Família – ESF*). Presidente Prudente Region, São Paulo, Brazil, 2015.

Attributes	n	Mean	Standard Deviation	Minimum	Maximum
First Contact Access – Accessibility	102	5.57	1.42	2.22	8.89
Longitudinality	102	7.71	1.26	5.13	10.00
Coordination – Integrated Care	102	7.70	1.23	4.44	10.00
Coordination – Information Systems	102	8.74	1.42	3.33	10.00
Comprehensiveness – Services Available Disponíveis	102	8.29	1.24	2.42	10.00
Comprehensiveness – Services Provided	102	8.40	1.57	3.11	12.44
Family Orientation	102	8.53	1.74	2.22	10.00
Community Orientation	102	8.12	1.41	5.00	10.00
Essential Score	102	7.73	0.85	5.01	9.58
Overall Score	102	7.88	0.90	5.42	9.69

n: number of participants

A detailed evaluation of the component Accessibility is depicted in Table II, which shows that more than 70% of the professionals answered “Definitely not” to the questions “Is your health facility open on Saturdays or Sundays?” and “Is your health facility open, at least on certain days of the week, until 8 pm?”. With regard to the questions “When your health facility is closed on Saturdays and Sundays and your patient gets sick, does anyone in the facility see your patient on the same day?” and “When your health facility is closed at night and some patient is sick, does anyone in your facility see the patient that night?”, it was noted that 48.04% of the interviewees answered “Definitely not”.

As for the questions “When your health facility is open and a patient is sick, does anyone in your facility see the patient on the same day?”, “When your health facility is open, do patients get quick counseling over the phone when they think it is necessary”, “When your health facility is closed, is there a phone number patients can call when they get sick?” and “Is it easy for a patient to schedule a health check-up (routine visit, check-up) in your health facility?”, more than 60% of the professionals answered “Definitely yes” and thus confirmd they to carry out these procedures. Another important information is that 37.25% of the professionals answered “Probably yes” to the question “Do patients usually need to wait more than 30 minutes to be seen by a physician or nurse after triage or user embracement?”, which refers to the time that the patient has to wait to be seen by a physician or nurse.

The attribute Longitudinality was rated as good by the professionals and the more than 64% of them answered “Definitely yes” to the questions “In your health facility, are patients always seen by the same physician/nurse?”, “Can you understand the questions your patients ask you?”, “Do you give patients enough time to talk about their concerns or problems?” and “Do you think your patients feel comfortable talking to you about their concerns or problems?”. This finding indicates that professionals use plain language and give patients enough attention and time to talk about

their problems and health needs because they are always the same physician and nurse who see them. Therefore, there is a concrete possibility of building a relationship between professionals and patients.

In all, 100% of the respondents answered “Definitely yes” and “Probably yes” to the questions “Do your patients understand what you say or ask them?”. More than 85% of the respondents answered “Definitely yes” and “Probably yes” to the questions “If patients have a question, can they call and talk to the physician or nurse who knows them best?”, “Do you know your patients more as a person than just someone with a health problem?”, “Do you understand which problems are most important to the patients you serve?” and “Would you know if your patients could not get the prescribed medication or had difficulty paying for them?”, thus demonstrating that patients are able to access the service via telephone and that professionals are probably using an expanded clinical practice.

With regard to the questions “Do you know who lives with each of your patients?”, “Do you know the complete health history of each patient?”, “Do you know what each patient’s job is?” and “Do you know all the medications that your patients are taking?”, more than 20% of the professionals answered “Probably not”, thus indicating that a significant part of the professionals do not know the clinical history, the job, the members of the family living in the same house and the medications that patients are using (Table III).

Table II - Percentage distribution of professionals who work in the ESF in relation to the items that make up the attribute First Contact Access – Accessibility. Presidente Prudente Region, São Paulo, Brazil, 2015.

Indicators of the attribute First Contact Access – Accessibility	**Definitely yes n (%)**	**Probably yes n (%)**	**Probably not/do not know/ Cannot remember n (%)**	**Definitely not n (%)**
Is your health facility open on Saturday or Sunday?	2 (1.96)	0 (0.00)	9 (8.82)	91 (89.21)
Is your health facility open, at least on some days of the week, until 8 pm?	20 (19.61)	4 (3.92)	4 (3.92)	74 (72.55)
When your health facility is open, and the patient gets sick, does anyone in the facility see the patient on the same day?	79 (77.45)	22 (21.57)	0 (0.00)	1 (0.98)
When your health facility is open, do patients get quick counseling over the phone when they think it is necessary?	74 (72.55)	24 (23.53)	4 (3.92)	0 (0.00)
When your health facility is closed, is there a phone number patients can call when they get sick?	63 (61.76)	18 (17.65)	5 (4.90)	16 (15.68)
When your health facility is closed on Saturdays and Sundays and your patient gets sick, does anyone in the facility see your patient on the same day?	20 (19.61)	11 (10.78)	22 (21.56)	49 (48.04)
When your health facility is closed at night and some patient is sick, does anyone in your facility see the patient that night?	21 (20.59)	8 (7.84)	24 (23.53)	49 (48.04)
Is it easy for a patient to schedule a health check-up (routine visit, check-up) in your health facility?	87 (85.29)	13 (12.74)	1 (0.98)	1 (0.98)
Do patients usually need to wait more than 30 minutes to be seen by a physician or nurse after triage or user embracement?	19 (18.63)	38 (37.25)	36 (35.29)	9 (8.82)

n: number of patients. h: hours

Table III - Percentage distribution of the answers given by professionals who work in the ESF to the items that make up the attribute Longitudinality. Presidente Prudente Region, São Paulo, Brazil, 2015.

Indicators of the attribute Longitudinality	Definitely yes n (%)	Probably yes n (%)	Probably not/ Do not know/Cannot remember n (%)	Definitely not n (%)
In your health facility, are patients always seen by the same physician/ nurse?	68 (66.67)	22 (21.57)	8 (7.84)	4 (3.92)
Can you understand the questions your patients ask you?	80 (78.43)	22 (21.57)	0 (0.00)	0 (0.00)
Do your patients understand what you say or ask them?	60 (58.82)	42 (41.18)	0 (0.00)	0 (0.00)
If patients have a question, can they call and talk to the physician or nurse who knows them best?	45 (44.12)	50 (49.02)	5 (4.90)	2 (1.96)
Do you give patients enough time to talk about their concerns or problems?	84 (82.35)	18 (17.65)	0 (0.00)	0 (0.00)
Do you think your patients feel comfortable talking to you about their concerns or problems?	66 (64.71)	35 (34.31)	1 (0.98)	0 (0.00)
Do you know your patients more as a person than just someone with a health problem?	45 (44.12)	46 (45.10)	9 (8.82)	2 (1.96)
Do you know who lives with each of your patients?	21 (20.59)	49 (48.04)	26 (25.49)	6 (5.88)
Do you understand which problems are most important to the patients you serve?	56 (54.90)	43 (42.16)	3 (2.94)	0 (0.00)
Do you know the complete health history of each patient?	31 (30.39)	44 (43.14)	22 (21.57)	5 (4.90)
Do you know what each patient's job is?	12 (11.76)	45 (44.12)	33 (32.35)	12 (11.76)
Would you know if your patients could not get the prescribed medication or had difficulty paying for them?	37 (36.27)	56 (54.90)	8 (7.84)	1 (0.98)
Do you know all the medications that your patients are taking?	25 (24.51)	45 (44.12)	28 (27.45)	4 (3.92)

n: number of participants.

The attribute Coordination – Integrated Care was rated as good by the interviewees. However, more than 30% of the professionals answered "Probably not" to the questions "Are you aware of all the times your patients have seen specialists or specialized services?" and "Do you get information about the referred patient from the specialist or specialized service?", which indicates that the referral and counter-referral system needs to improve its operationalization in the region.

As for the questions "Does anyone in your health facility help the patients schedule an appointment with the professional they are referred to?" and "When your patients are referred, do you provide them with written information to take to the specialist or specialized service?", more than 80% of the professionals answered "Definitely yes". As for the questions "When your patients need to be referred, do you talk to them about the different services where they could be served?" and "After consulting with the specialist or specialized service, do you talk to your patients about the results of this consultation?", the answers given by the professionals focused on " Definitely yes" and "Probably yes" (Table IV).

The assessment of the mean scores of the PHC attributes according to the professional categories allows to affirm that the health managers assigned lower mean scores than the physicians and nurses as presented in Table V. It should also be noted that the physicians assigned higher mean scores compared with nurses and health managers. Table V also shows that the managers, physicians and nurses who participated in the present study assigned mean scores lower than the reference mean of 6.6 to the attribute First Time Access – Accessibility.

Table IV - Percentage distribution of the answers given by the professionals who work in the ESF to the items that make up the attribute Coordination – Integrated Care. Presidente Prudente Region, São Paulo, Brazil, 2015.

Indicators of the attribute Coordination – Integrated Care	Definitely yes n (%)	Probably yes n (%)	Probably not/ Do not know/Cannot remember n(%)	Definitely not n (%)
Are you aware of all the times your patients have seen specialists or specialized services?	20 (19.61)	47 (46.08)	32 (31.37)	3 (2.94)
When your patients need to be referred, do you talk to them about the different services where they could be served?	52 (50.98)	46 (45.10)	4 (3.92)	0 (0.00)
Does anyone in your health facility help the patients schedule an appointment with the professional they are referred to?	82 (80.39)	19 (18.63)	1 (0.98)	0 (0.00)
When your patients are referred, do you provide them with written information to take to the specialist or specialized service?	86 (84.31)	14 (13.73)	2 (1.96)	0 (0.00)
Do you get information about the referred patient from the specialist or specialized service?	14 (13.73)	51 (50.00)	31 (30.39)	6 (5.88)
After consulting with the specialist or specialized service, do you talk to your patients about the results of this consultation?	35 (34.31)	58 (56.86)	8 (7.84)	1 (0.98)

n: number of participants.

Table V - Description of the mean scores* for the essential and derivative attributes according to professionals (managers, physicians and nurses) who work in the Family Health Strategy (*Estratégia Saúde da Família – ESF*). Presidente Prudente Region, São Paulo, Brazil, 2015.

Attributes of PHC	Managers n = 19	Physicians n = 39	Nurses n = 44	Standard Deviation
First Contact Access – Accessibility	6.07	5.43	5.50	0.29
Longitudinality	6.98	8.11	7.67	0.47
Coordination – Integrated Care	7.37	8.22	7.40	0.39
Coordination – Information Systems	7.84	9.32	8.64	0.60
Comprehensiveness – Services Available Disponíveis	7.92	8.43	8.10	0.21
Comprehensiveness – Services Provided	7.17	8.61	8.75	0.71
Family Orientation	7.37	9.09	8.54	0.72
Community Orientation	7.51	8.30	8.10	0.34
Derivative Score	7.44	8.70	8.32	0.33
Essential Score	7.23	8.02	7.68	0.53
Overall Score	7.28	8.19	7.84	0.37

*Reference mean of 6.6. PHC: Primary Health Care

DISCUSSION

The results of the present study indicate that Accessibility, a component of the attribute First Contact Access, was not rated as satisfactory by the professionals as the scores obtained are below the mean of 6.6, which is considered a parameter in other studies[13-24].

Accessibility refers to things that facilitate and prevents people from being treated in a given health service[24]. Accessibility encompasses four components: a) Geographic component, which refers to physical aspects that impede access (rivers, big avenues) and distance between population and resources; b) Organizational component, which refers to obstacles originated from the way the service is organized (ease of scheduling appointments, opening hours, queues, delay in waiting for medical care); c) Sociocultural component, which refers to the population's perspectives (individual's perception of the severity of the illness, fear of diagnosis and interventions, beliefs, habits); d) Economic component, which refers to the consumption of time, energy and financial resources to obtain health care[24,25].

Changes to improve accessibility in PHC are subjected to political and administrative decision and go beyond changes in the opening hours and provision of the ESF services on the weekends[13]. To increase access, there should be better work conditions for the health team. Such conditions include: duly trained professionals; dimensioning and adequate quantification of professionals; salary commensurate with the working hours and shifts; implementation of protocols to increase access; organization of service scheduling; planning of the actions to be carried out, and adequate and available inputs[13].

The professionals interviewed in the present study rated the attribute Longitudinality satisfactorily. The same was reported in other studie[13-15,21,26]. However, in studies conducted in the municipalities of Chapecó (Santa Catarina), Piracicaba (São Paulo) and Lajeado (Rio Grande do Sul), professionals assigned mean scores below 6.6 to the attribute Longitudinality[16-18].

The evaluation of the items that make up the attribute Longitudinality in the Alto Capivari and Alta Sorocabana CIRs showed that more than 25% of the professionals did not know their patients' job and socioeconomic data. However, what draws most attention is that 27.45% of these professionals said that they probably do not know the medications that patients use. Therefore, although the attribute Longitudinality was rated as good by the professionals who participated in the present research, important indicators that make up the attribute obtained low scores, thus indicating that there are problems in the continuity of care[13].

Difficulties in establishing relationships and ensuring the continuity of care and knowledge of the main individual and collective problems presented by families may be strengthened by the lack of professional training to work in the ESF, which is confirmed by the fact that only 48% of the professionals who participated in the present research took a training course. In addition, the participants reported professional turnover, lack of career planning, low salary and poor working conditions[13].

Integrated care is being delivered in the region according to the professionals interviewed in the present research. This finding is in agreement with the findings of other studies carried out in other Brazilian settings[13-16,19,21,26,27]. However, the professionals interviewed in the present study said that they did not know the path taken by their patients within the health services network. This demonstrates that the referral and counter-referral system used in the CIR is fragile and unknown to ESF professionals; therefore, it needs to be improved. The referral and counter-referral system in the Health Care Networks (*Redes de Atenção à Saúde – RAS*) consists of the flow and counterflow of information, products and people along the points of care in a dynamic and continuous way[28].

With regard to Coordination – Information System, the professionals interviewed in the present research rated it positively. The same was found in other studies carried out in the states of Minas Gerais, Rio Grande do Sul, Santa Catarina, Paraná and Mato Grosso and in the Federal District[13,15,16,19,21, 26]. Despite the positive results of the present research with regard to the components of the attributes Coordination of Care, Integrated Care and Information System, which obtained scores above the mean of 6.6, the detailed analysis of their items showed that that the referral and counter-referral system is flawed.

The Brazilian referral and counter-referral system is known to have many communication barriers, mainly due to the lack of an electronic medical records system to integrate the primary, secondary and tertiary care levels in most of the Brazilian municipalities[28].

The component Services Available, which is part of the attribute Comprehensiveness, obtained a satisfactory mean score in the CIRs analyzed in the present study. The same was found in other studies[13-16,16,19]. However, in

studies conducted in Cuiabá (Mato Grosso) and in the Federal District, Comprehensiveness – Services Available obtained an unsatisfactory score[21,26].

The detailed evaluation of the component Comprehensiveness – Services Available in the present research revealed that procedures such as splinting, wart removal and ingrown nail removal are not carried out by a good part of the ESF professionals of the Alto Capivari and Alta Sorocabana CIRs. In studies carried out in Belo Horizonte (Minas Gerais) and Florianópolis (Santa Catarina), most of the physicians and nurses said that small surgeries are not performed in the ESF, thus corroborating with the results of the present study[29,30].

Changes in traditional health practices, which do not respond to or solve contemporary health problems, will only be built upon profound political, administrative and management changes in the ESF's work process[13]. The logic of the old health care centers, a traditional model of PHC, is rooted in the professionals and the Brazilian population in such a way that the although the ESF has had a positive impact on health indicators, it still features decontextualized practices to address the real problems of the population and generalized protocols, a poorly effective model of PHC[13]. Thus, it is necessary to add innovative practices in the daily life of health professionals in order to respond to the new demands and health needs presented by the families served[13].

The attribute Comprehensiveness – Services Provided was rated as satisfactory by the professionals who participated in the present research and by professionals who participated in studies carried out in Minas Gerais, Rio de Janeiro (Rio de Janeiro), Porto Alegre (Rio Grande do Sul), Chapecó (Santa Catarina), Cuiabá (Mato Grosso), in small municipalities in Northern and Northeastern Rio Grande do Sul and in the Federal District[13-16,21,26]. However, the guidelines on the prevention of firearm accidents are not provided by the professionals working in the ESF of the Alto Capivari and Alta Sorocabana CIRs analyzed in the present study.

Therefore, considering that comprehensiveness assumes the integration of different levels of care and that its operationalization depends on the supply and use of services in different types of care according to the needs of the population, the MoH defines comprehensiveness as the provision of a set of services by the health team to meet the needs of the population related to health promotion, disease prevention, cure, rehabilitation and palliation, being responsible for the provision of services in other points of health care and adequate recognition of the biological, psychological and social problems that cause diseases[31].

In this context, it is necessary to think of ways to improve the operationalization and the availability of services within the scope of the ESF or to organize the system so that services that are not provided by the ESF are available in other levels of care, thus ensuring comprehensive care[28].

The attribute Family Orientation was rated as satisfactory by the professionals who participated in the present research and by the professionals who participated in studies carried out in other states[13,15,16,19,21,26]. The implementation of the ESF aims to reorganize, strengthen and qualify PHC in Brazil by changing traditional practices of curative and individualized nature for practices centered on the family, community and health promotion[1]. In this context, it is imperative that professionals adopt such practices in their work process. Thus, the Family Orientation occurs when the comprehensiveness allows the professionals to see the potentialities and fragilities of the family context in which individuals face the health-disease process[32].

The attribute Community Orientation was rated as satisfactory by the CIR professionals in the present study and in other studies as well[13-16]. The detailed evaluation of the attribute Community Orientation indicates that more than 20% of the professionals working in the ESF in the region of Presidente Prudente do not know the problems and health needs of the population. The operationalization of the community orientation within the scope of the ESF allows the recognition of the needs of the families according to the physical, economic and social context in which they live and facilitates the situational analysis of these needs from a population perspective for their integration into intersectoral programs to confront social determinants of health[33].

For the construction of a PHC that can solve the current public health problems in Brazil and that focuses on non-communicable diseases as a current challenge for the performance of the ESF, it is important to incorporate health practices contextualized with the field of health promotion[7]. In this regard, the incorporation of health promotion actions within the ESF is successful when the essential derivative attributes are present and properly operationalized[13].

In this context, it is necessary to emphasize that the ESF has its own characteristics, such as risk mapping, establishment of relationships with users, knowledge of the population's social and family relations, and proximity to the real problems experienced in the community, which facilitate the design of actions to promote health within the primary health care center and in the households[1]. Although the National Health Promotion Policy is a cross-cutting

policy, it is within the PHC that it has a greater possibility of operationalization, since the characteristics of the work process contribute to its effective implementation[7].

This study is limited by the fact that the interviews carried out with the professionals focused on a specific and delimited geographical area, thus not portraying the evaluation of all the professionals working in the ESF.

CONCLUSION

The essential attributes (the individual's first contact access with the health system, longitudinality, comprehensiveness and coordination of care) and derivative attributes (family-centered health care, community orientation and cultural competence) of Primary Health Care, evaluated in the Family Health Strategy of the region from the perspective of medical professionals, nurses and managers, are present.

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CONTRIBUTIONS

Maria Fernanda Pereira Gomes participated in the design of the study, analysis and interpretation of data and final draft of the manuscript. **Lislaine Aparecida Fracolli** participated in the analysis and interpretation of data and final draft of the manuscript.

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