

Status of Health Promotion Established after the Family Health Strategy

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Abstract

Objective: To summarize the scientific knowledge concerning the promotion of health after establishing the Family Health Strategy. **Method:** This is an integrative review conducted in databases: LILACS, MEDLINE/PubMed, SciELO and Cochrane, using following key words: Family Health Strategy; Health Promotion and Health Personnel. **Results:** After the criteria established 23 articles were selected, identifying strengths, weaknesses and challenges of health promotion after establishing the Family Health Strategy. **Conclusion:** Despite the effectiveness of health promotion practices in many health units of the family still persist the curative care model.

Keywords

Family Health Program, Health Promotion, Health Personnel

1. Introduction

According to the World Organization of Health (WHO), health concerns “the complete physical well-being, mental and social and not merely the absence of diseases or injuries” [1]. This concept has instigated reformulation of the dressing-privatizing clinical model focused on care of hospital central for a model with integral actions in the care of health [2].

The 1st International Conference on Health Promotion took place in November 1986 and it was considered a milestone in the field of health promotion, as well as the Ottawa Charter. In this context, health promotion was defined as the community empowerment process to act on improving the quality of life and health of the assisted population. However, for this, the participation of individuals in control of this process is necessary by: identifying their aspirations, satisfying their needs and modifying favorably

the environment. In this direction it is necessary to earmark approach to social and personal resources as well as to physical capacities because health is more than a healthy lifestyle in an attempt to obtain a global welfare [3] [4].

In this sense, the implementation of Health Promotion has brought changes in the health area, and the absence of disease now has prerequisites. Thus, in the 90s, Law No. 8080, in its Article 3 specifies the determinants and conditioning factors to health: “Food, shelter, basic sanitation environment, labor, income, education, transport, leisure and access to essential goods and services” [4]. With that it has been the goal that people reach their highest health potential, changing habits, lifestyle and better quality of life [3] [5].

Moreover, Art 196 of the Constitution of 1988 states: “Health is a right of all and duty of the State and it is ensured through social and economic policies in order to reducing the risk of disease and other health problems. Added to this it is guaranteed by the State universal and equal access to actions and services for its promotion, protection and recovery” [4].

Thus, the current legislation proclaims that health promotion policies are structured on the basis of territory with the intersectoral participation. In addition it is also important to plan the health surveillance, and primary care, with funding by the three levels of management [6].

The current Family Health Strategy (FHT) was established in 1996 when the Brazilian Ministry of Health began to reformulate the concept of the Family Health Program (FHP). Thus, FHP worked with the idea of “verticality and transience” and the FHT introduced a strategy considering the reorganization of health services provided by Basic Care. The FHT innovates the assistance from the perspective of that people have prevention, promotion, and continuous, humane and good quality care [7].

In this way, the current actions in the FHS are performed by the team of health professionals consisting of at least: a family doctor or a generalist, a nurse, a nursing assistant and Community Health Agents (CHA). All these professionals work from a delimitation of territory where there is a construction of “intra- and extra-family relationships” and improvement of living conditions resulting from a better understanding of the health-disease process [8].

Thus, as the policies established in the FHS are actions focused on health promotion, the guiding question for this study is: what is the situation of health promotion established after the FHT assistance model?

In that way, the theme was thought because of the importance of Health Promotion contained in the FHT and what is established for the health of the family. In this sense, the objective is to synthesize scientific knowledge about the health promotion after fixing the FHS assistance model.

2. Method

This is an integrative review, in which previous studies are selected from the inclusion criteria and analyzed in relation to the objectives, materials and strategies. From this it

is possible to obtain a broad knowledge of the subject studied, which allows the development of future research arising from critical evaluation and synthesis of theme analyzed evidence [9].

Thus, the data collection was conducted in August and September 2015, after had become established: research protocol composing the theme of research, objective, guiding question and use of descriptors. The descriptors used were: Family Health Strategy; Health Promotion and Health Personnel. The search process has consulted the following databases: LILACS, MEDLINE/PubMed, SciELO and Cochrane Library.

The search amounted to 17.446 articles. During this stage of the research was performed the following crossings: Family Health Strategy and Health Promotion and Health Personnel (MEDLINE/PubMed 100; SciELO 2; LILACS 13; Cochrane Library 115); Family Health Strategy and Health Promotion (MEDLINE/PubMed 570; SciELO 92; Lilacs100; CochraneLibrary 940); Health Promotion and Health Personnel (MEDLINE/PubMed 8830; SciELO84; LILACS 118; Cochrane Library 6482), as **Figure 1** below.

After the reading of the titles and abstracts, the following inclusion criteria were applied: articles available in full and free by Capes portal; productions related to the research problem; studies in the languages Portuguese, English and Spanish, no restrictions on the type of study. Moreover, the exclusion criteria used were duplicated productions, of which only one of the reps would be selected; letters to the editor; integrative reviews; dissertations and theses.

From there the articles were pre-selected and saved in the computer. Then complete reading of these studies were conducted, of which 23 articles were selected (SciELO7, LILACS 8; MEDLINE/PubMed 5, Cochrane Library 3) presenting its methodological trajectory clearly.

Finally, data were extracted by the model instrument and validated for data collection [10] and then organized into two frames, where the first of them contained: presentation of studies, references, place of study, objective, method database. The second framework was composed of the item “health promotion” after established the FHT assistance model. This framework was illustrated by counting the number of times each result appeared being grouped by similarity. These groupings emerged the potential, weaknesses and challenges. These results were presented descriptively and analyzed in the literature light.

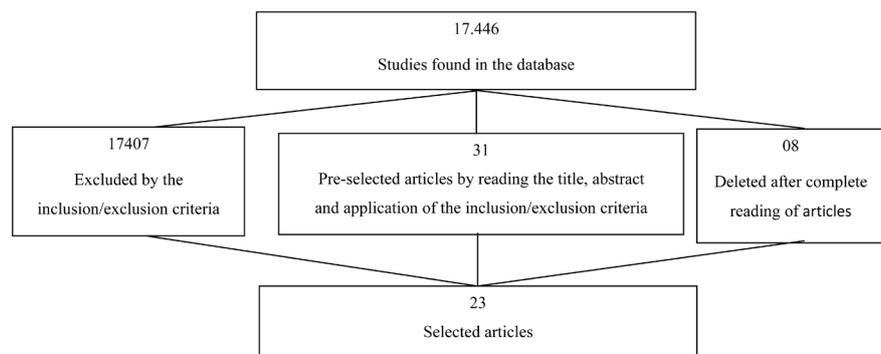


Figure 1. Flowchart of searching process.

3. Results

The **Table 1** presents 23 studies on health promotion established after the FHS assistance model. All the mentioned studies were developed in Brazil, the country where there is this health strategy. In addition, it was observed prevalence of qualitative method with publications beginning in 2004.

It is observed in **Table 2**: potentialities, weaknesses and challenges by the situation of health promotion established after to FHS. Thus, it was appointed high- lighted the health education activities, support groups and home visits as potentialities.

However, other studies also indicate: absence or lack of health promotion activities, absence or lack of medical professional commitment in promotion activities, professional dissatisfaction, wholeness in family care neglected and presence of the curative model. So there is the challenge of professional qualification and the consolidation of the process of building of health promotion in the FHS.

4. Discussion

In search of better health conditions in the community's daily life, the Ministry of Health (MH) implemented in 1991 the Program of Community Health Agents (PCHA). The PCHA had primary focus for the expansion of primary care coverage and introduction of the Community Health Agent (CHA). The program was responsible for interlocution between government and community, enabling actions in the quality improvement of life and community well-being to which they belong [34] [35].

According to chronology proposed by MH, it was established in 1994 the PSF, now called the Family Health Strategy (FHS). The FHS was created to meet needs of the population, using the work of the daily epidemiological approach. In this perspective there must be understanding of the multiple risk factors to health and the possibility of intervention on them. For this are necessary different strategies, such as health promotion [35].

In order to promote better understanding it is noteworthy that the Home Visit (HV) was inserted in the health since the mid-twentieth century when there was still a curative model. However, given the changes to integral model and then FHP, the practice of HV started to work in the intervention of the health-disease process of individuals or planning actions aimed at promoting the health of the community [35].

The development of these shares is attributed to the CHA-the most prominent professional in ESF-because these professionals know the daily routine and community territoriality in which CHA is inserted. For this reason, health promotion and prevention are made possible by the agents in order to provide better health and quality of life. Therefore it is necessary that CHA guide the community and families that are under their responsibility. These actions are based on the family, territoriality and responsibility [36].

Beyond practices of prevention, DV is also responsible for health education activities, where the agent informs families about the FHP program, well-being and quality of life [35].

Table 1. Characterization of the studies (Natal, Brazil, 2015).

Reference*	Place of study	Objective	Method	Database
Medina, <i>et al.</i> 2014 [11]	Brazil	Describe health promotion and prevention of chronic diseases carried out by health teams that joined the National Program for Improving Access and Quality of Primary Care (PIAQ-PC) in Brazil and compare the information given by health professionals with those obtained by interviewers through documentary evidence.	Cross-sectional study	SciELO
Ramos, <i>et al.</i> 2014 [12]	Brazil	Estimate the prevalence of health promotion programs in basic health units in Brazil.	Cross-sectional study	MEDLINE/PubMed
Chagas HMA, Vasconcellos MPC, 2013 [13]	Brazil	Know and understand the reality of some Health Units Family (HUF) of the city of Rio Branco-Acre.	Qualitative study	LILACS
Costa, <i>et al.</i> 2013 [14]	Brazil	Analyze the audiologist's discourse on the practice developed in Support of Family Health Centers (SFHC), followed by core concepts and field in Public Health.	Qualitative study	MEDLINE/PubMed
Lopes, <i>et al.</i> 2013 [15]	Brazil	Know perception of professionals of the Family Health Strategy on health promotion; identify practices adopted to promote the health of the population, facilities and difficulties to carry out such practices.	Qualitative study	Cochrane
Onocko-Campos, <i>et al.</i> 2012 [16]	Brazil	Compare the performance of Basic Health Units according to the implementation of new arrangements and primary care strategies and mental health.	Evaluative research	MEDLINE/PubMed
Kanno NP, Bellodi PL, Tess BH, 2012 [17]	Brazil	Investigate problems and ways of coping referred to by the ESF teams of health professionals facing the medical and social demands presented by users in their daily work.	Qualitative study	LILACS
Melo, MRC, Dantas VLA, 2012 [18]	Brazil	Analyze the conceptions and practices of health professionals on the theme of health promotion at a Family Health Center in Fortaleza, Brazil.	Action research	LILACS
Rocha, <i>et al.</i> 2012 [19]	Brazil	Investigate the conception of the nurses of the Family Health Program (FHP) on Health Promotion.	Qualitative study	LILACS
Galavote, <i>et al.</i> 2011 [20]	Brazil	Evaluate the production of the work processes of Community Health Agents (CHAs) in the Family Health Strategy in the city of Vitória (ES).	Qualitative study	MEDLINE/PubMed
Gurgel, <i>et al.</i> 2011 [21]	Brazil	Know the concepts of health promotion and the interface performance of the nurse in the Family Health.	Qualitative study	Cochrane
Maia MA, Santos JS, 2011 [22]	Brazil	Analyze the perception of Community Health Agents (CHAs) and users of the proposed actions in the Family Health Program (FHP) to improve the quality of life of a population.	Qualitative study	LILACS
Silveira MR, Sena RR, Oliveira S R, 2011 [23]	Brazil	Discuss limits and possibilities of teamwork in the Family Health Strategy (FHS) and its implications for health promotion.	Qualitative study	LILACS
Silva KL, Rodrigues A T, 2010 [24]	Brazil	Analyze intersectoral practices for promoting health in the Family Health Strategy, identifying experiences, facilitating factors and restrictive to the partnership building process.	Qualitative study	SciELO
Gomes, <i>et al.</i> 2009 [25]	Brazil	Assess the impact of the Family Health Program (FHP) in the rural community of Airões, city of Paula Cândido, Minas Gerais.	Cross-sectional study	SciELO

Continued

Shimizui HE, Rosales C, 2009 [26]	Brazil	Identify and analyze the main practices developed in the Family Health Program.	Qualitative study	SciELO
Oliveira SF, Albuquerque FJB, 2008 [27]	Brazil	Evaluate qualitatively the Family Health Program (FHP) from the beliefs of the professionals of the Family Health Strategy (FHS).	Qualitative study	SciELO
Ronzani TM, Silva CM, 2008 [28]	Brazil	Analyze the perception of healthcare professionals, managers and users of the Family Health Program (FHP) in two municipalities of Minas Gerais, Brazil.	Qualitative study	LILACS
Santos ET, Cardoso CL, 2008 [29]	Brazil	Evaluate the FHS user experience in a health promotion group in the community.	Qualitative study	Cochrane
Azeredo, <i>et al.</i> 2007 [30]	Brazil	Evaluate, through home visits, housing conditions and sanitation of the families assisted in Family Health Program of Teixeiras-MG.	Cross-sectional study	SciELO
Caldeira, <i>et al.</i> 2007 [31]	Brazil	Evaluate the knowledge and practices of the Health Strategy teams of the family in relation to breastfeeding.	Cross-sectional study	MEDLINE/PubMed
Guedes, <i>et al.</i> 2007 [32]	Brazil	Compare the results of primary care activities related to two periods: before and after the implementation of the FHS in the Community Macuco, Timóteo-MG.	Documental study	LILACS
Araújo MRN, Assunção RS, 2004 [33]	Brazil	Approach the actions of CHAs in Health Promotion and Disease Prevention.	Qualitative study	SciELO

Font: research data. *The reference column of **Table 1** has superscript numbers on each line to identify of articles on column 2 of **Table 2**.

Table 2. Situation of health promotion established after the implementation of the Family Health Strategy Natal, Brazil, 2015.

Situation of health promotion after established the FHS	
Potencialities	<ul style="list-style-type: none"> • Identification of the situation of population health [17] [30] • Home visits [15] [20] [22] [26] [30] [31] [32] • Health education activities [11] [12] [14] [15] [19] [25] [27] [30] [31] [33] • Support groups [13] [14] [15] [17] [19] [23] [29] • Intervention with families [21] [28] • Health Agent as a category of the most prominent teams [28] • 100% of population coverage [30] • Housing in the same work area [16] [30] • Reorientation of health services [23] • Reinforcement of community action [21] • Job integration in teams and among sectors [16] [17] [23] • Reduction of number of hospital internment [32]
Weaknesses	<ul style="list-style-type: none"> • Integrality in family care neglected [17] [26] • inadequate infrastructure [27] [33] • Dissatisfaction of professionals [27] [28] • Unsuitable materials and equipment for use [27] • Model curative [22] [27] • Assistance focused only on the prevention [28] • Limitation of individual abilities for self-care and community mobilization [33] • The actions are still organized in a normative reference, biomedical and non-dialogical [11] • Number of home visits less than the recommended [13] • Absence or lack of medical professional commitment in the promotion activities [13] [31] • Absence or lack of health promotion activities [12] [19] [24] [28] • Absence of reorientation of health services [19] • Confusion between the concepts of promotion and prevention [18] [22]
Challenges	<ul style="list-style-type: none"> • Professional qualification [25] • Promotion in the FHS is still a construction process [23]

Font: research data.

Conversely, the FHS is one of the guiding principles of the integration of the multi-disciplinary team. This team is often viewed positively among professionals involved, because they can share information, enriching the team. Thus it becomes possible to face, in addition to individual and biological health problems, collective and socio-cultural problems of individuals and the community by which the health team has sanitary responsibility [35].

In addition, the FHS has characteristics for the development of educational activities corroborating for open discussions between user and professional, built on health situations of social groups or specific classes [37] [38].

Thus, developed study reveals that such practices serve as a tool for health promotion by offering knowledge of social, political and economic determinants of the health-disease. In health promotion the dynamics of support groups set up in the interaction between health professionals and users. Through communication and participation, both conduct dialogue on the conditions and determinant factors of health. This allows greater control of the subjects on the social and environmental context in which people are inserted [39].

Such practices are evidenced quantitatively about the impact on the rate of hospitalizations, when a study showed a relation between the gradual increase in the FHS coverage percentage and the consequent reduction in hospitalizations rates [40].

Opposed to this, health faces great problems to cater to its different current models, which propose activities of promotion, protection, recovery and rehabilitation of health. This is because there are still family health teams with curative practice, performing activities only in the presence of disease. Thus home visits targets comes to be lower than recommended by the FHS [41] [42].

The improvement and efficiency of services provided by family health teams are directly linked to infrastructure and good quality equipment. However, it is still common to find units with inadequate physical structures, sometimes even improvised besides maintaining use of obsolete equipment. Given that the FHS should solve about 85% of community health problems, it is necessary to have structural features and compatible devices that allow the action of professionals in relation to that commitment [43].

Health professionals are important stakeholders in the practice of health promotion within the family health. In this sense, the term “work environment salubable” represents a healthy workplace aiming at the welfare of professionals from: physical environment, good personal relationships, good organization and emotional health. These factors are directly related to job satisfaction [44].

However, there are often neglect these factors as their own needs. This causes low involvement of the professional towards the promotion actions and to the assisted population [45].

Health promotion activities are still very confused with preventive character. On this light, there is a common census that health teams work with an educational and preventive profile. Moreover, there is the vision of education as predominantly one-way transmission of knowledge [46]. This type of interpretation interferes with the actions to be developed for health promotion in the FHS.

Thus, it notes that the professionals qualifications and health promotion in the FHS are challenges to be overcome and are in process of construction. Despite this, the qualification and promotion mentioned can be achieved through actions that coordinate communication between the participants through solidarity, interdisciplinary and intersectionality [47].

5. Conclusions

The autonomy of the people on healthy living allows them to be protagonists of their own health. This is because it is considered autonomy as great ally both in health development, and for the policies and actions recommended by the promotion within the scope of the FHS.

Thus, this study synthesizes scientific knowledge on the promotion of health after establishing the FHS assistance model, listing the potentialities, weaknesses and challenges. In this way, the selected articles showed that the multidisciplinary work of the FHS teams is the principal means for interaction of families with health actions, as the promotion practices recommended by the Strategy.

However, despite the potential, it is found that the promotion of health in the FHS process is still under construction, since there is a stagnation by some health workers regarding the act of promoting health. Moreover, many professionals are still conniving to the curative practices, even with the policies of promotion, humanization and assistance.

This situation was explained by the studies when they claim that health professionals are not motivated or do not have the professional qualification in family health area. It is further that there is deprivation and even lack of health promotion activities associated to identified weaknesses. Thus, it identifies curative practice disguised as health promotion.

Therefore, with the development of this study it is expected that the reader understands the importance of knowledge about health promotion actions as main policy within the family health. And the need for adequacy of professionals is identified regarding the current health policies, so there is reaffirmation of what really FHS recommends.

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