Original Article

The promotion health regarding the Family's Health strategy: analysis of health policies in Brazil*

Promoção da saúde na Estratégia Saúde da Família: análise de políticas de saúde brasileiras

Promoción de la salud en la estrategia Salud de la Familia: análisis de políticas de salud brasileñas

Maria de Lourdes de Assis Freitas[1], Edir Nei Teixeira Mandú[2]

ABSTRACT

Objective: To analyze health policies for the program Family's Health (FH), focusing on access to services and goods necessaries to improve the quality of life; also focusing on the population defense of their health. **Methods**: Was assumed that health policies were contradictory when related to welfare models applied to the health scenario. We conducted a research study of the type documentary on four documents of the Ministry of Health (valid from 1994 to 2007), instituting specific policy proposals for the FH program or that contain implications for basic care. Was adopted the thematic content analysis. **Results**: The health promotion is a precept and a strategic FH area, and covers: participation in inter-sector practices, analysis of social, sanitary and family situations, planning actions, encouraging participation and social control, among others. **Conclusions**: Into the promotional activities are not emphasized the mentioned policies, which overall express the predominant health care model patterned in the disease prevention.

Descriptors: Family Health Program; Health policy; Health promotion; Quality of health care, Health services accessibility

RESUMO

Objetivo: Analisar políticas de saúde direcionadas à Saúde da Família (SF), focando o acesso a medidas e bens necessários à qualidade de vida assim como a participação da população na defesa da saúde. **Métodos:** Pressupomos que as políticas de saúde são permeadas por contradições relativas aos modelos assistenciais em confronto no cenário de saúde. Realizamos um estudo do tipo pesquisa documental em quatro documentos do Ministério da Saúde vigentes de 1994-2007, que instituem a política específica de SF ou contém proposições com implicações para a atenção básica. Adotamos a análise temática de conteúdo. **Resultados:** A promoção da saúde é preceito e área estratégica da SF, e abrange: participação em práticas intersetoriais; análise das situações sociais, sanitárias e familiares locais, para o planejamento de ações; estímulo à participação e controle social; dentre outras. **Conclusões:** As ações promocionais não têm destaque nas políticas analisadas, que expressam sobretudo o modelo assistencial predominante pautado na doença-prevenção.

Descritores: Programa Saúde da Família; Política de saúde; Promoção da saúde; Qualidade da assistência à saúde; Acesso aos serviços de saúde

RESUMEN

Objetivo: Analizar políticas de salud dirigidas a la Salud de la Familia (SF), enfocando el acceso a medidas y bienes necesarios a la calidad de vida así como la participación de la población en la defensa de la salud. **Métodos:** Se presupone que las políticas de salud se encuentran muchas contradicciones relativas a los modelos asistenciales confrontados con el escenario de salud. Fue realizado un estudio del tipo investigación documental en cuatro documentos del Ministerio de la Salud vigentes de 1994 a 2007, que instituyen la política específica de SF o contienen proposiciones con implicaciones para la atención básica. Adoptamos el análisis temático de contenido. **Resultados:** La promoción de la salud es precepto y área estratégica de la SF, y abarca: participación en prácticas intersectoriales; análisis de las situaciones sociales, sanitarias y familiares locales, para la planificación de acciones; estímulo a la participación; y, control social; entre otras. **Conclusiones:** Las acciones promocionales no tienen destaque en las políticas analizadas, que expresan sobre todo el modelo asistencial predominante pautado en la enfermedad-prevención.

Descriptores: Programa de Salud Familiar; Política de salud; Promoción de la salud; Calidad de la atención de salud; Accesibilidad a los servicios de salud

** Study extracted from the study "Referenciais de qualidade relativos ao Programa Saúde da Família: um estudo em documentos de política nacional" (Quality references regarding the Family Health Program: a study on national policy documents)*

[1] Master in Nursing. Technician from the Coordination of Primary health care, Health Secretariat from the State of Mato Grosso, Cuiabá, (MT), Brazil

[2] Nursing Ph.D. Associate Professor, Faculdade de Enfermagem da Universidade Federal de Mato Grosso - UFMT, Cuiabá, (MT), Brazil

Corresponding Author: **Edir Nei Teixeira Mandú**
Rua Marcos Pereira da Luz, 111, B. Miguel Sutil - Cuiabá (MT), Brazil
CEP: 78048-590 E-mail: enmandu@terra.com.br

Received article **17/11/2008** and accepted **27/07/2009**

INTRODUCTION

In the present study, we assess the current policies of the Ministry of Health (MS) with implications in the Family Health Strategy (ESF), highlighting the propositions regarding health promotion due to their importance in innovations in the model of basic health care. We want to contribute to critical interpretation of the national government policies directed to the ESF and to the practice of health promotion with the participation of primary health care.

When the healthcare system is divided into territories, health care teams should increase cure and prevention according to the traditional biomedical model also trying to foster quality of life. This is one of the main bases for the change in the health care model.

Considering socio-historical relativity, quality of life has to do with the access to conditions that are considered as standard of comfort and well being of a society, encompassing aspects related to life, family, work, environment, esthetic and social relations, and culture[1].

Health promotion is political and it requires an intersectoral approach, involving the government, the health sector, other social and productive sectors and individuals, families and communities, with actions to develop better conditions of health and life. To make this practice effective the following strategies should be part of the country's policies: establishing health public policies; creating an environment favorable to health; reinforcing community actions; developing personal skills; reorganizing health services[2].

Health policies are interventions from the government on the social organization of health practices. Health problems of the population drive the organization, the management, and care provided by institutions. They guide the routine work in health according to certain historical and social conditions and to individuals' participation. They follow principles, purposes, guidelines and decisions that are general[3]. The routine work in health is guided by certain historical and social conditions and the participation of individuals. Content of the work are part of an idea, incorporated by professionals and the population of what health practices should be, guiding them in a certain way[4]. Health policies are built according certain features that are wanted for the sector, from different purposes, consensus, and dissensions among social groups, reflecting a historical period of the society and its relations, interests, conflicts and projects[4-5].

Thus, we aimed at assessing health policies directed at Family Health, focusing on the access to measures and goods that are necessary to quality of life and the participation of the population in health defense. Health promotion was highlighted, from the understanding that these policies reflect the action of the Brazilian government in primary health care, the history of care models that were built, and the participation of the different people involved. These policies demonstrate potential reproductive and changing contents of the model established for primary health care and allow highlighting analytically the concepts and ways used for health promotion.

METHODS

Documentary, qualitative research carried out in 2007-2008 to assess quality reference regarding the work process in ESF in documents from the national health policy.

First, a survey was carried out on policies published by the MS in its website regarding ESF from 1994, when the Family Health Program (PSF) was introduced to August 2007, with the month and year of inquiry. Then a pre-assessment of the documents found was carried out and six documents were selected, including elements of representativeness, homogeneity, completeness and adequacy[6], considering the following criteria: to build a specific policy for family health; to present propositions with implications for the work in the care environment; to be in force.

The MS established the Family Health Program as a focused policy in 1994 in some regions of the North and Northeast of the country at first. As of the *Norma Operacional Básica de Saúde (*Basic Operational Health Rule) 1996, it became a national strategy, replacing the traditional model in force and being called Family Health Strategy (ESF).

In the present article, we assessed four of the selected documents: the *Política Nacional de Atenção Básica* (The National Primary Health Care Policy -PNAB) from 2006[7], the *Pacto pela Saúde 2006* (Health Agreement - Pacto 2006)[8], the *Política Nacional de Promoção da Saúde* (National Policy on Health Promotion - PNPS)[9], and the document Family Health: a strategy to reorganize the care model from 1997 (herein called Documento 1997)[10] which presents the guidelines and operations of the Family Health as a strategy to remodel primary health care with implications to all the sectors.

In the assessment of these documents, we have adopted the technique of content analysis following its steps[11], highlighting the meanings from the material according to the theoretical objectives and fundamentals of the study.

From the analytical and interpretative process of the theme discussed in the present article, two categories were discussed: access to measures and goods connected with quality of life; and access to autonomy and participation in the defense of policies and actions geared to health promotion.

RESULTS

Access to measures and goods related to quality of life

In Documento 1997, PNAB and in Pacto 2006[7-8,10] the perspective of building a health system was present, starting from primary health care and based on the transversal axis of universality, integrality and equity in a context of decentralization and social control of the management.

Universality concerns the right to broad access to quality health goods and services and accessibility to them, which is related to how easy it is to obtain them. The 1998 Constitution[12] defines health as a right of all and a duty of the State, to be granted by social and economic policies and by universal and equal access to actions and services that foster, protect and recover.

This norm concerns the right to access, both to health services

and to conditions of life that can ensure health. Thus, the ESF and other sectors and institutions are accountable for creating alternatives so that the populations in different territories are entitled to health.

PNPS[9] stresses that health promotion is mentioned by the Unified Health System (SUS) as a possibility to focus on: famine; unemployment and underemployment; violence; lack of adequate sanitation and housing; difficult access to education; disorganized urbanization; poor quality of water and air; among others. Health promotion should present social and political processes that strengthen broad ways to intervene in health.

"Health promotion is a mechanism to strengthen and introduce a transversal, integrated and multi sector policy that enable a dialog among several areas of the sanitation sector, Government sector, the private and non-governmental sector, and the society, forming networks of commitment and co-responsibility for quality of life of the population where all take part in the protection and care of life"[9].

The responsibility of the ESF with actions to foster quality of life is expressed in Documento 1997[10] which establishes as one of its objectives to "make health acknowledged and effective as a right to citizenship and, therefore, an expression of quality of life". This document[10] states that health teams are responsible for "fostering quality of life and contributing to make the environment healthier".

Although this direction is not explicitly stated at PNAB[8], it characterizes care by actions to foster and protect health, in addition to prevention of health harms, diagnoses, treatment, rehabilitation and health maintenance. Additionally, it is established as a strategic area, together with disease care and priority groups.

Health promotion becomes a strategic area in primary health care in the policy of Family Health[7,10], and it is committed to the public duty of providing means, conditions and resources that enable the population to have their needs met with implications to health.

In this sense, the Documento 1997[10] presented the following as one of the objectives of health work: to develop an intersectoral approach through partnership and integration with the several agencies of the public sector that work with social policies.

PNPS[9] considers the intersectoral approach as "an articulation of the possibilities in the different sectors to think about the complex issue of health and to be also responsible for ensuring health as a human right, and to take actions to provide health to all".

PNAB[7] establishes as part of ESF actions the participation in integrated practices from sectors and projects to promote health according to priorities established under the coordination of the municipal management. This search for integration is achieved by getting closer to other government sectors, other institutions, and social organizations especially in the area covered by the ESF to develop partnerships.

In the policies of the Family Health Program[7,10], there is also the concern to promote health through increased home care which is made from the knowledge of the structure and functionality of the families.

Likewise, this perspective is found in the proposition to assess local situation of health to plan local actions, based on social, economic, cultural, demographic, and epidemiological characteristics of the territories (which forms what we call territorialization)[7,10].

In Documento 1997[10] actions on territories are presented as a challenge requiring breaking from the unit walls and embedding in the place where people live. The attributions of the teams are acknowledging problems, risks and local determinants.

We have also identified the articulation to promote surveillance on behavioral, diet/nutritional and environmental/sanitary risks. Documento 1997[10], presents as teams' responsibilities to perform actions for epidemiological and sanitary surveillance geared to risk groups to control tuberculosis, leprosy, chronic-degenerative, and infectious diseases. Epidemiological surveillance is highlighted at PNAB[7] as the active search and mandatory report of diseases, risks and situations of local importance, together with the identification of groups, families and individuals exposed to risks. In this document[7], the performance of actions directed at groups and at behavioral, diet and/or environmental risk factors is established. This is also present at PNPS[9], in the actions assigned to primary health care/ESF, where diet and nutritional surveillance is introduced to prevent and control harms and diseases due to poor diet.

At PNAB[7] and in Documento 1997[10] community health agents (ACS) are made accountable for actions to promote health performed in the micro areas; the participation of other members from the local teams is not mentioned in this task.

The actions/measures highlighted are a broader set of propositions, encompassing clinical and care actions, home care and educational actions, organizational and management aspects of primary health care. In this set, health promotion has a secondary place although it is pointed out as a norm and direction of the ESF work.

Access to autonomy and participation in the defense of policies and actions to promote health

In the documents assessed we have found as ESF's accountability to develop the participation of the population, encouraging community mobilization, social control, and planning, control and assessment of health actions.

When Documento 1997[10] deals with the assignments from community health agents, it makes ESF responsible for mobilizing the community to produce a better quality of life.

PNAB[7], in its presentation, considers participation and social control as a value[7]. That document makes all professionals from the team accountable for promoting and encouraging the participation of the communities in social control. One of the bases for primary health care is to "encourage popular participation in social control".

Documento 1997[10] states that social control is a constitutional principle and community health agents are accountable for encouraging the formation of local councils. The population must take part in formal and informal ways to follow-up, define and supervise the policies in the sector encouraged by health teams. This document[10] considers that the "Family Health Program is deeply committed with defending popular participation in the health area, especially in making health actions

meet the needs of the population".

Encouraging the participation of citizens in the assessment of health services is present in Pacto 2006[8] which also points out the need to strengthen the participation and social control in health actions with the institutional support to councils, health conferences and social movements. More broadly, this policy proposes a movement involving all the society to make health a right and to reinforce participation and social control.

As for the relationship between educational actions, autonomy and social participation, PNAB[7] considers that educational actions should both interfere in the health-disease process of the population, and increase social control of policies, it should also enable the participation in planning, execution, and assessment of health actions.

This proposition is coherent with the norm of health promotion however, at PNAB[7] and Documento 1997[10] we have found a focus in health education that is especially connected with guiding the population for self-care and a proper use of health services.

Documento 1997[10] defines as assignments from health teams to develop educational processes to improve self-care. At PNAB[7], the educational action of community health agents is a mean to guide families on the use of services available and to incorporate practices to contribute to disease prevention. Among health promotion strategies mentioned by PNPS[9] is the insertion of educational actions for body and health care, for healthy diet and smoking prevention and control in all levels of care. Pacto 2006[8] highlights the need to invest in changing the behavior of the population so that they take up regular practice of physical activities, have a proper diet and stop smoking.

In the Family Health policy[7, 10] community health agents, rather than the local team, are especially accountable for educational actions which is an important practice for health promotion.

DISCUSSION

The propositions found on health promotion are, to some extent, important innovations of the policies and of the model of primary health care; however, they do not deal with all important issues for effective health promotion and do not encompass all actions from this level of care.

A critical aspect is that in the policy of the Family Health program, health promotion is not a central axis that guides the actions but rather it is part of the integral care, translated into measures for health promotion, prevention, healing and rehabilitation.

Clinical-epidemiological actions stand out, geared to risk and disease control, demonstrating a certain limitation of a positive concept of health. Despite the important proposition that it presents, proper primary health care must be established based on the analysis of local social and sanitary situations.

The actions of healing and prevention for health production are important, however, the idea of risk presented by them and their categories of factors, behaviors and risk groups is limited because they refer to significant associations between certain characteristics, groups and problems with a thinking that is connected with the idea of prevention and individual reduction of risks[13], instead of a broader idea of health promotion.

To sum up, we may say at first that the policies assessed take on the proposition of health promotion when they value an intersectoral approach and perform their work based on locally acknowledged social, demographic, sanitary and family characteristics. However, due to importance given to individual care actions and to the clinical and epidemiological control of risks, the policies reflect a care model driven by the disease-prevention cycle, which is predominant in the current picture of Brazilian health care.

This is not coherent with the understanding that health promotion places health, rather than the disease, in the agenda of political priorities in all levels and sectors[2], including the health sector.

Another critical aspect regarding the intersectoral approach found has to do with the fact that these strategies require more than identifying partners and the participation from other sectors in practices coordinated by municipal management, as demonstrated by the 2006 version of the Family Health Policy.

Health promotion requires a coordinated action among the involved parts, and to that end, active participation of the management is necessary, together with other institutions and health professionals that should mediate this practice[2].

Thus, ESF may and should act strategically in this task, articulating this practice and keeping close relations with the population, since it is aware (or should be aware) of the local reality, and of the health-disease profile of the population in their area.

The intersectoral approach should be a process of collective and integrated construction of knowledge, language and practices among different institutions and subjects, to locate, interpret and overcome social, sanitary, and family situations that are unfavorable to health. In this process, ESF should be central to mobilize and integrate projects, teams and actions.

To be central, ESF depends on team work and the introduction of integrated and systematic processes for planning and assessment based on broad local information. These three aspects are essential to health promotion.

As it is complex, this introduction demands integrated participation of the whole team, instead of concentrating on one professional category (as suggested by the policy of the Family Health Program when it is connected with the knowledge from community health agents). It also demands a systematic and appropriate investment to be prepared. Health promotion requires integration and application of several knowledge and professional skills with a permanent investment in health education.

Another important aspect among the propositions assessed is some restriction to educational actions proposed because they emphasized self-care and prevention.

Personal development through access to information on self-care and intensification of vital skills is important to make people have greater control on their existence and on disease coping[2]. Health promotion should help people and groups become more independent, leading to self-confidence and a sense of governance. Promotional actions should migrate to several spaces of the community, being responsible for developing personal

skills. Within this perspective, health promotion and education present interfaces[14].

In addition to community reinforcement, ESF must also be committed with health education to make participation an exercise of citizenship. Families and the communities should be given, in a planned and systematic manner, means to work for changes to overcome social inequalities and improve their life conditions. These means should be geared to critically understand social reality, acknowledging rights and responsibilities and the participation of the population in the construction of policies and actions to provide better quality of life and social control. The basic conditions to this practice are: to make questions and to realize that the situation can be changed with organization; to use strategies to face what is established; and to get organized to change unfavorable historical conditions[15].

Health promotion works with the participation of the population to define priorities in decision making, to define strategies for their implementation to improve health conditions. To that end, people and groups must be empowered to intensify self-care, social support and social participation in health issues. This requires access to information and to learning opportunities[2].

The participation of the population in the decisions and social control of public services, especially health services must be guided by autonomy to achieve power so that the individuals and the collective groups can live well, choose and control their lives and health, thinking, feeling and acting with self-determination through the process that make life conditions feasible[16].

This participation should be democratic, involving both the population and workers since public policies result, among other things, from the correlation of forces among different interests and the ability of the actors involved to interfere in decisions[5].

Democratic participation requires the possibility of changing the powers established leading to new contracts and a new hegemony. To that end, the following are important: access to information; horizontal relational exchanges; education for autonomy; giving room for participation in discussions, production of consensus and agreements for decision making; among other things. Health teams should bring to routine practice the concept of participation that goes beyond social supervisory control[4].

Individuals should participate in all the care process in the institutions. Therapeutic process should be shared between users and health professionals in a relationship based on dialog and information so that users can make choices.

Knowledge should be built together, leading to articulation that foster growth of actors that interact and respect the different ways of experiencing and living the health project of each citizen[17].

Therefore, in the technical-political propositions assessed, we have found coherence between SUS principles concerning the relation between health promotion, education and participation. However, these aspects are not highlighted in the documents assessed and come with limited strategies. Workers' responsibility to encourage the participation of the population is based on the understanding that health is a process to be built and that responsibilities in this sense must be shared between the different social actors. There is no emphasis in strategic actions, including education actions directed at team preparation because of the complexity of the task of health promotion.

FINAL CONSIDERATIONS

In the policy assessed, the care model proposed for the ESF is connected with actions for promotion, prevention and cure through the control of diseases and factors and risk groups with emphasis to cure-prevention. Thus, the idea of health promotion present in this policy is not followed by practices to provide access to measures and goods contributing to quality of life and the participation of the population in health defense, in a contradictory manner from that of SUS, based on a positive concept of health.

This occurs in a situation where there is the conflict between establishing an equal universal health system that acknowledges health as a right and is driven by quality of life and democratic access to health, and rationalizing the use of financial resources in health, emphasizing actions directed to certain groups and risk situations.

However, so that Family Health becomes a priority strategy in the reorganization of primary health care, it should be technically and politically guided to make quality of life of users in the territories central, making them take part in it autonomously and democratically. Health promotion must be highlighted by policies and must be restated in the routine of the work from management and health teams, in the strategies for family health, and all over SUS, involving the population as a co-participant to encourage new care and management possibilities for better quality of life.

We must keep in mind the importance of making SUS principles and the concept of health promotion effective in ESF so that care provided focus on health production rather than on disease control.

REFERENCES

1. Minayo MCS, Hartz ZMA. Qualidade de vida e saúde: um debate necessário. Ciênc Saúde Coletiva. 2000;5(1):7-31.

2. Brasil. Ministério da Saúde. Secretaria de Política de Saúde. Projeto promoção de saúde: Carta de Ottawa. Brasília (DF): Ministério da Saúde; 2001.

3. Paim JS. Políticas de saúde no Brasil. In: Rouqueirol MZ, Almeida Filho N. Epidemiologia e saúde. 6a. ed. Rio de Janeiro: Medsi; 2003. p. 587-603.

4. Campos GWS. Um método para análise e co-gestão de coletivos: a constituição do sujeito, a produção de valor de uso e a democracia em instituições: o método da roda. 2a ed. São Paulo: Hucitec; 2005.

5. Franco TB, Merhy EE. Programa de Saúde da Família (PSF): contradições de um programa destinado à mudança no modelo tecnoassistencial. In: Merhy EE, Magalhães Junior HM, Rimoli J, Franco TB, Bueno WS. O trabalho em saúde: olhando e experienciando o SUS

no cotidiano. São Paulo: Hucitec; 2003. p. 55-124.

6. Richardson RJ. Pesquisa social: métodos e técnicas. 3a ed. São Paulo: Atlas; 1999. p. 221-44.
7. Brasil, Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política Nacional de Atenção Básica. Brasília: Ministério da Saúde; 2006.
8. Brasil. Ministério da Saúde. Portaria nº 399/GM, de 22 de fevereiro de 2006. Divulga o Pacto pela Saúde 2006 - Consolidação do SUS e aprova as Diretrizes Operacionais do Referido Pacto.Brasília (DF): Ministério da Saúde; 2006.
9. Brasil. Ministério da Saúde. Portaria nº 687/MS/GM, de 30 de março de 2006. Aprova a Política de Promoção da Saúde. Brasília (DF): Ministério da Saúde 2006.
10. Brasil. Ministério da Saúde. Secretaria de Assistência à Saúde. Coordenação de Saúde da Comunidade. Saúde da Família: uma estratégia para a reorientação do modelo assistencial. Brasília: Ministério da Saúde; 1997.
11. Gomes R. A análise de dados em pesquisa qualitativa. In: Minayo MCS, organizadora. Pesquisa social: teoria, método e criatividade. Petrópolis: Vozes; 1994. p. 67-80.
12. Brasil. Presidência da República. Casa Civil. Subchefia para Assuntos Jurídicos. Constituição da República Federativa do Brasil de 1988. Brasília(DF): Governo Federal; 1988.
13. Ayres JRCM, França Júnior I, Calazans GJ, Saletti Filho HC. O conceito de vulnerabilidade e as práticas de saúde: novas perspectivas e desafios. In: Czeresnia D, Freitas CM. Promoção da saúde: conceitos, reflexões, tendências. Rio de Janeiro: Fiocruz; 2003. p. 117-39.
14. Santos SSC, Barlem ELD, Silva BT, Cestari ME, Lunardi VL. Promoção da saúde da pessoa idosa: compromisso da enfermagem gerontogeriátrica: [revisão]. Acta Paul Enferm. 2008;21(4):649-53.
15. Campos RTO, Campos GWS. Co-construção de autonomia: o sujeito em questão. In: Campos GWS, Minayo MCS, Akerman M, Drumond Júnior M, Carvalho YM. Tratado de saúde coletiva. São Paulo: Hucitec; 2006. p. 669-88.
16. Demo P. Politicidade: razão humana. Campinas (SP): Papirus; 2002.
17. Erdmann AL, Backes MTS, Backes DS, Koerich MS, Baggio MA, Carvalho JN, Meirelles BHS. Gerenciando uma experiência investigativa na promoção do "viver saudável" em um projeto de inclusão social. Texto & Contexto Enferm. 2009;18(2):369-77.