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Reviewing health needs assessment approaches in the Family Health Strategy*

INSTRUMENTOS DE AVALIAÇÃO DE NECESSIDADES EM SAÚDE APLICÁVEIS NA ESTRATÉGIA DE SAÚDE DA FAMÍLIA

INSTRUMENTOS DE EVALUACIÓN DE NECESIDADES EN SALUD UTILIZADOS EN LA ESTRATEGIA DE SALUD DE LA FAMILIA

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ABSTRACT

The main objective of this exploratory and descriptive study was to acknowledge the instruments used to assess health needs of the population in the Family Health Strategy. Two districts of Sao Paulo Municipality, Brazil, were taken as the scenario. The theoretical and methodological basis was the Theory of Praxical Intervention in Collective Health. Data were collected in Heath Care Units, with Family Health teams' members. The results showed the inexistence of specific instruments to assess health needs. The discussion addresses the three contractions identified: the structural polarity in the conceptualization of health needs in the Brazilian Unified Health Care System, the principle of integrality postulated by this System and the possibility of its implementation by the health care teams, and also the theory-practice antinomy in their labor process. The conclusion is that these contradictions must be overcome in order to redirect policies and practices towards health needs assessment.

KEY WORDS

Health services needs and demand.
Public health.
Family health.
Community health nursing.

RESUMO

Este estudo, descritivo e exploratório, teve como objetivo geral conhecer os instrumentos utilizados para o reconhecimento das necessidades de saúde da população no âmbito da Estratégia de Saúde da Família. Abrangeu dois Distritos do Município de São Paulo. A base teórico-metodológica consistiu da Teoria de Intervenção Práxica de Enfermagem em Saúde Coletiva. Os dados foram coletados junto a unidades de saúde e equipes de saúde da família. Os resultados mostraram a inexistência de instrumentos específicos para o reconhecimento das necessidades em saúde da população. Discutem-se três contradições presentes no fenômeno estudado: a polaridade estrutural na conceituação de necessidade contida no SUS; o princípio da integralidade postulado pelo SUS e a possibilidade operacional das unidades de saúde e a antinomia teoria-prática no processo de trabalho das equipes da ESF. Conclui-se que é imperativo superar as contradições para redirecionar as políticas e as práticas rumo ao enfrentamento das necessidades em saúde.

DESCRITORES

Necessidades e demandas de serviços de saúde.
Saúde pública.
Saúde da família.
Enfermagem em saúde comunitária.

RESUMEN

Estudio, descriptivo y exploratorio, cuyo objetivo general fue conocer los instrumentos utilizados para el reconocimiento de las necesidades de salud de la población en el ámbito de la ESF. Comprendió dos Distritos del Municipio de Sao Paulo. La base teórico-metodológica fue la Teoría de Intervención Práctica de Enfermería en Salud Colectiva. La recolección fue junto a las unidades y equipos de salud de la familia. Es evidente la inexistencia de instrumentos específicos para el reconocimiento de las necesidades en salud. Fueron discutidas tres contradicciones: la polaridad estructural al conceptuar las necesidades contenidas en el SUS; el principio de la integralidad postulado por el SUS, la posibilidad operacional de las unidades de salud y la antinomia teoría-práctica en el proceso de trabajo de los equipos de la ESF. Se concluye ser prioritario superar las contradicciones para redireccionar las políticas y las prácticas rumbo al enfrentamiento de las necesidades en salud.

DESCRIPTORES

Necesidades y demandas de servicios de salud.
Salud publica.
Salud de la familia.
Enfermería en salud comunitaria.

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INTRODUCTION

Health studies, debates and policies have looked at the population's health needs. Brazilian and foreign authors have produced research whose main goal is to answer the question on how to recognize and respond to these needs. First, however, they need to be situated in the theoretical-philosophical context, so as to define the conceptual framework that will make it possible to distinguish among different needs and determine what needs will be attended to[1].

Health needs are defined, distinguished and objectified and, thus, recognized in the spaces for articulation between health services and the population in the territories where these services are located. It is also primarily in these spaces, integrated with other levels of the health care network, that efforts are made to respond to health needs. In fact, the theoretical pole of collective health is tensioned by the reality in which health care is constructed[1].

Understanding the organization and functioning of systems and local practices, in terms of the potential to recognize and cope with health needs, is fundamental to understanding how health work processes articulate with the reality in a given territory. Therefore, knowledge is needed about the different realities in which health teams work, so as to understand the contexts in which health work processes occur[2].

From a Marxist viewpoint, the most fertile conception of needs can be found in the work by Agnes Heller, who defines need as a

> conscious desire, aspiration, intention directed at any time towards a certain object that motivates the action as such. The object in question is a social product, independently of whether this refers to goods, a way of life or another man[3].

The author distinguishes between two types of needs: *natural needs*, related to the conservation and perpetuation of life, and *necessary needs*, which are radical or truly human; both are socially determined. The former include needs for food, shelter, sexual needs, social contact and cooperation, hence related to self-conservation and preservation of the species, although that is not why they can be considered *natural*, as they are produced in social contexts. The volume of these natural needs and the way they are attended to are historical products as well. Necessary needs, on the other hand, include freedom, autonomy, self-accomplishment, self-determination, moral activity, and reflection, among others. In this sense, not all needs are deficits because, as these are necessary needs, their continuous improvement makes us progressively humane[3].

One author[4] discussed health needs in a Hellerian viewpoint, considering that all human work aims to satisfy needs. The intentionality present in work processes is not individual but social, so that work is oriented towards the social needs that justify it. Like other human needs, health needs are social and historically determined and are situated between nature and culture, that is, they do not only refer to the conservation of life, but to the realization of a project in which the individual, as a bridge between the particular and the generic, becomes progressively humane[5].

A more recent conception of health needs within the Unified Health System (SUS) considers these needs as estimates of the demand for health actions and services, determined by pressures and temporary social consensuses, according to the current stage of technological development in the sector, the level of materials available for its accomplishment, legitimized by the population that uses the system and by relevant actors in its definition and practice. This way, the goal is to overcome the utilitarian foci marked by a subjective and individual bias, pointing towards the creation of normative consensuses on adequate supply levels of goods and services through health sector actions, in care as well as health promotion, as an essential condition to raise autonomy levels and expand individual and group capacities in the search for health[6].

At the heart of the meaning of health needs lies the conception of the health-disease process, historically determined by the way human beings are inserted in society, that is, in the last instance, by the way they relate with nature and with other human beings. Health-disease processes are the synthesis of the set of determinants that end up resulting in distinguished vulnerabilities or potentials[7].

Finally, a key concept to discuss health needs and the ways in which they are recognized is vulnerability. Originally, the term vulnerability designates legal or politically weakened individuals or groups in the promotion, protection or guarantee of their civil rights, linked up with situations of inequity and social inequality, expressed through coping or disease potentials (strengthening and exhaustion) related to individuals, groups and collectivities[8].

In this conception, vulnerability is not restricted to individual susceptibilities, but refers to the collective level, demanding health practices characterized by the development of actions that involve a *social response*, resulting from the participation of different social subjects in the supportive search for possible strategies to respond to health needs[9].

In health work processes, knowledge about the instruments that articulate and, at the same time, intervene in Objects to achieve Goals is fundamental. In the work of the Family Health Strategy (FHS), health units and teams use different instruments, however, without knowing whether these manage to recognize health needs and permit coping with these needs. Among collective health practices that are being constructed in Brazil, FHS has showed to be the most fertile milestone. This research is part of a larger project whose general goal is to get to know the

instruments used to recognize the population's health needs and their vulnerabilities in the context of the FHS.

OBJECTIVE

This study aimed to get to know the instruments used to recognize the population's health needs in the context of the FHS.

METHOD

This exploratory research was developed in São Paulo City, more specifically in the Administrative Health Districts of Butantã and Capão Redondo. The criterion for choosing these Districts was the network of partnerships between the Collective Health Nursing Department of the University of São Paulo School of Nursing and the Nursing Course at Universidade Adventista de São Paulo - UNASP, at undergraduate as well as graduate level.

The choice of the Health Units and family health teams was based on the range of epidemiological profiles in the coverage areas and their different micro-areas, in the attempt to study units and teams that dealt with the best and worst health-disease profiles. The selected teams were invited to participate and all members accepted.

Data were collected between October 2007 and November 2008 at 13 Health Units, involving 42 FHS or Community Health Agent Program (CHAP) teams from Capão Redondo and Butantã, located in the South and West of São Paulo City, respectively.

The empirical database consists of documents and reports from Health Units within the Districts. Primary data were obtained through interviews. Authorization for the research was obtained from the Research Ethics Committees at EEUSP and the Municipal Health Secretariat (process Nos. 563/2006 and 86/2007).

The theoretical base used in this research was the Praxis Intervention Theory in Collective Health Nursing – TIPESC. TIPESC is a nursing theory that rests on a materialist, historical and dialectic worldview. It originated in collective health and the framework of the social determination of health-disease processes. TIPESC attempts to perform the Nursing intervention through a dynamic and participatory method. It is a dynamic systemization of capturing and interpreting a phenomenon articulated with social production and reproduction processes, related to the health-disease of a given collectivity, in the framework of its conjuncture and structure, within a historically determined social context; of intervening in this reality and continuing by reinterpreting the objective reality so as to again start an intervention instrument. Three dimensions of the objective reality need to be taken into account to put TIPESC in practice: the structural dimension, the particular dimension and the singular dimension[10].

To get to know how health services recognize and cope with the health needs of the population within its territory, an instrument was used to capture the objective reality which allowed the researchers to describe the situation of the health institution according to the three dimensions of the objective reality. Moreover, the work reality of the family health teams was captured.

RESULTS AND DISCUSSION

The results show the diverse range of health practices for recognizing and coping with the population's health needs. None of the health units uses appropriate instruments to recognize the health needs, although many teams mention these needs when questioned about them. The interviewees do not directly relate the data produced through the unit's actions with information related to health needs.

From the institutional viewpoint (particular dimension), for the workers, information coming from different sources they access, ranging from the most general databases to information surveyed in care delivery to families at home or during consultations does not represent possibilities to recognize needs, although actions are performed as established in health protocols or programs.

At the Health Units of Capão Redondo, managed by UNASP, a dynamic information panel exists on the territory, which is exposed to the public, turning it into an excellent management instrument. Each family health team, in turn, maintains a dynamic panel with data from its micro-area, with possibilities for rapid analysis and verification of improvement or worsening in some indicators, such as number of pregnant women without prenatal care, increase of tuberculosis cases, pregnant adolescents, among others.

As to the instruments used to recognize health needs, 19 teams from Capão Redondo affirm that they use *home visits*, 11 mentioned the Basic Care information System (SIAB), five mentioned the use of *epidemiological data*, and yet another five, *care records*. Other instruments mentioned were *health card*; *consultations*; *family card* and *Pap smear control*.

It is remarkable that 17 teams indicated that the Community Health Agent (CHA) was the main person responsible for surveying health needs, through *home visits* and also by following the *health care* and *family card*. Among other team members, the nurse is mentioned as responsible for recognizing health needs during *home visits*, when assessing *epidemiological data* or in *care records*. In only one team, the physician was appointed as responsible for surveying health needs through *consultations*.

In Butantã, differently from teams in the Capão Redondo District, health needs are mainly recognized through the SIAB, *care records* and, to a lesser extent, during *home visits*. Other health need recognition instruments mentioned were: *health card*; *consultations*; *family card* and *prenatal*

SIS. In those teams, the CHA is also appointed as the main responsible for recognizing the health needs, through the *SIAB*, *care records*, *home visits* and, also, *prenatal SIS*. A smaller number of teams mention the nurse as responsible for recognizing health needs, using the *SIAB*, *care records*, *consultations* and *prenatal SIS*.

The main result of this research highlights the inexistence of specific instruments the units and interviewed teams use to recognize both the population's needs and vulnerabilities. Even those instruments they mention, such as the SIAB database, epidemiological data and care forms (attendances, consultations, home visits), do not permit identifying how the needs and vulnerabilities are recognized, which parameters are used and, mainly, how the obtained data can contribute to the organization of the team's work process with a view to coping with those needs and vulnerabilities.

It is also remarkable that team professionals identify the CHA as the main responsible for acknowledging health needs, with little or no reference to other team members, except for the nurse, who is appointed as responsible for interpreting some of the instruments mentioned (care records, consultations, SIAB or epidemiological data).

Hence, data analysis revealed the lack of systemized work to recognize the population's health needs and vulnerabilities in the team's work process. Even when information on health issues within the territory is systemized, like in Capão Redondo, this systemization is not recognized as a needs assessment instrument. This can be observed, for example, in the restricted relation or almost lack of bond between the programs and actions that are proposed or performed and the population's health-disease profiles.

The main result of this research highlights the inexistence of specific instruments the units and interviewed teams use to recognize both the population's needs and vulnerabilities.

Different contradictions are found in the interpretation of the objective reality and this article addresses the three most remarkable ones. The first refers to the contradiction in the structural dimension, as the structural framework of the SUS itself contains different conceptions of health needs, which will lead to conflicts or new contradictions when putting it in practice. According to some authors[11], the Brazilian Federal Constitution, which established the SUS, recognized that health is not improved by care delivery to diseases only. By mentioning the determinants of the health-disease process, however, a multicausal perspective is adopted, which refers to the causes and not the interpretation of how society is organized to produce life to determine the ways in which social groups produce and reproduce themselves socially, giving rise to enormous distinctions in terms of quality of life and health potential, including service accessibility.

Thus, answering health needs should mean putting actions in practice that affect the determinants, and not only the disease, which results from processes of exhaustion expressed in the individual biopsychic body[11].

By discussing the correspondence between health needs and the legal-political and institutional framework created to comply with these needs, the proposal is to use a normative concept that can be put in practice so as to *convey the dialectics between the individual and the social*[12].

The second contradiction refers to the poles situated in the structural and particular dimensions: the integration put forward by the SUS and the operational possibility of health units. One author refers to the funding mechanisms of the *Programação Pactuada Integrada* (Integrated and Negotiated Programming). Established in NOAS-SUS 1/2001, by defining the integration of actions and equity in resources allocation in the three government spheres, the Decree affirms: *a parameter is adopted that is exclusively based on care actions, that is the clinical outpatient pathology, due to the weight of this spending*[12].

The practice of integration through specific programs, based on care delivery to diseases, as verified in the scenarios that were studied, is considered a dialectical contradiction[12].

By using care records, SIAB and the biologistic excerpt through which they focus on the health-disease process of families or, better, of individuals inside families, the family dynamics does not even appear as a need or vulnerability. This way, they feed back the contradiction, which is perpetuated in its circularity. The extent of the demand to solve disease-related issues is so great that health workers see no possibilities to overcome this. Overcoming the contradiction demands instrumental changes to recognize and cope with the needs, interpreted in the perspective of social determination of health-disease and in the understanding of the health work process as a response to the need that created it. It can be overcome through the critical emancipation of work processes, so as to break with the existing circularity.

The final contradiction discussed here is located in the singular dimension and refers to internal contradictions in the work of family health teams, in the antinomy established between theoretical conceptions and health practices. The responsibility for recognizing the health needs these teams will face is almost unanimously attributed to the CHA. When questioned, the CHA cannot tell what health need is it, like other team members. Despite different conceptions of needs, the professionals do not hesitate to ptomote CHA as important for their ability to recognize health needs. This confirms the findings of a bibliographic review that found a higher frequency of studies reducing the object of care to exclusively biological needs[13].

With respect to conceptions on the health-disease process, the teams do not show a consensus interpretation, which is necessary for collective work. As opposed to what one study mentions[14], for these teams, responding to

health needs does not mean assuming the needs of individuals from different social classes in a given territory as the object of the work process, and taking the public health policy forward towards a universal right.

It is fundamental to recognize family resources and how these change over time, constituting a stronger potential towards the disease, so that different forms of coping with health needs can be offered[15]. By attributing the role of interpreting certain needs-related data to the nurse, the FHS teams give this professional the potential to overcome the theoretical-practical contradictions related to health needs and, thus, put in practice the critical and emancipatory transformation of FHS work processes, so as to allow the health work processes established by the SUS to respond to needs instead of only fill out some part of the gaps.

CONCLUSIONS

TIPESC made it possible to get to know how health needs are recognized in the context of the FHS and to express existing contradictions. One of the routes to overcome those contradictions is a greater presence of the State, responsible for guaranteeing the supply of services, which in turn provide access to the consumption of goods produced in public services. It is always possible to create and put in practice health needs recognition instruments that permit interventions from the perspective of social determination of the health-disease process. It is even more important for health workers to assume the contradictions found in this research with a view to critical and emancipatory overcoming, by reassuming the work process they act in, in a reverse alienation process.

REFERENCES

1. Egry EY. Apresentação. In: Egry EY, organizadora. As necessidades em saúde na perspectiva da atenção básica: guia para pesquisadores. São Paulo: Dedone; 2008. p. 9-10.

2. Oliveira MAC, Egry EY. Marcos teóricos e conceituais de necessidades. In: Egry EY, organizadora. As necessidades em saúde na perspectiva da atenção básica: guia para pesquisadores. São Paulo: Dedone; 2008. p. 31-8.

3. Heller A . Teoría de las necessidades em Marx. Barcelona: Península; 1986.

4. Mendes-Gonçalves RB. Práticas de saúde: processos de trabalho e necessidades. São Paulo: CEFOR; 1992.

5. Melo-Filho DA. Repensando os desafios de Ulisses e Fausto: a saúde, o indivíduo e a história. Cad Saúde Pública. 1995;11(1):5-33.

6. Brasil. Ministério da Saúde. Secretaria Executiva. Departamento de Apoio à Descentralização. Diretrizes Operacionais dos Pactos pela Vida, em Defesa do SUS e de Gestão. Brasília, 2006.

7. Nakamura E, Egry EY, Campos CS, Nichiata LYI, Chiesa AM, Takahashi RF. The potential of an instrument to identify social vulnerabilities and health needs: collective health knowledge and practices. Rev Latino Am Enferm. 2009;17 (2):253-8.

8. Ayres JRCM, Paiva V, França Junior I, Gravato N, Lacerda R, Negra MD, et al. Vulnerability, human rights and comprehensive health care needs of Young people living with Hiv/Aids. Am J Public Health. 2006;96(6):1001-6.

9. Sanches AIM, Bertolozzi MR. Pode o conceito de vulnerabilidade apoiar a construção do conhecimento em Saúde Coletiva? Ciênc Saúde Coletiva. 2007;12(2):319-24.

10. Egry EY. Metodologias para captação da realidade objetiva. In: Egry EY, organizadora. As necessidades em saúde na perspectiva da atenção básica: guia para pesquisadores. São Paulo: Dedone; 2008. p.79-90.

11. Campos CMS, Bataiero MO. Necessidades de saúde: uma análise da produção científica brasileira de 1990 a 2004. Interface Comum Saúde Educ. 2007;11(23):605-18.

12. Stotz EN. Os desafios para o SUS e a educação popular: uma análise baseada na dialética da satisfação das necessidades. In: Brasil. Ministério da Saúde. Secretaria de Gestão do Trabalho e da Educação na Saúde. Departamento de Gestão da Educação na Saúde. Ver – SUS Brasil: cadernos de textos. Brasília; 2004.

13. Barros DG, Chiesa AM. Autonomia e necessidades de saúde na Sistematização da Assistência de Enfermagem no olhar da saúde coletiva. Rev Esc Enferm USP. 2007;41(n.esp):793-8.

14. Campos CMS, Mishima S. Necessidades de saúde pela voz da sociedade civil e do Estado. Cad Saúde Pública. 2005;21(4):1260-8.

15. Cowley S. Principles of British health visiting. Rev Esc Enferm USP. 2007;41(n.esp)756-61.

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