Community-oriented primary health care in Brazil – a coming trend

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In Brazil, a National Health Service (SUS) financed through taxes, was implemented during the 1990s and access to health care became formally universal for all Brazilian citizens, regardless of income.

In SUS PHC is a duty of the municipality.

Influenced by the ideas of the democratic movements of the 1980s: health as a social and political issue to be addressed in public (Paim et al. 2011).

Since 1994, the Ministry of Health has fostered, with financial incentives, a new Primary Health Care approach: the Family Health Strategy (ESF).

The Family Health Strategy is based on multi-professional teams, comprising:
- one general practitioner,
- one nurse,
- two nursing auxiliaries and
- 5-6 community health workers (Giovanella et al 2009).
Community-oriented primary health care in Brazil

- The Family Health Team works in a Community Health Center.

- Each team is responsible for up to 1,000 families (3,500 persons), living in a assigned geographical area, with registration and monitoring of the enrolled population (Fausto et al, 2011).

- In 2016, the Family Health Strategy covers 64% of Brazil’s population, with around 41,000 Family Health Teams. (MS/DAB, 2016)

- The local territory is the base for community action for better health and living conditions.

- The ESF teams play a vital role
  - in identifying health and social risk situations in the community,
  - consolidating local social service networks,
  - to promote joint activities with other sectors/organizations to solve community problems,
  - to promote social and individual (user) participation for health issues.
A German research project to explore the family health strategy in theory and practice

Strong commitment to community-oriented primary care as a key feature of the Brazilian family health strategy -

What can other countries learn?

Methods:

• 10 day field visit to explore Family Health Strategy in two Brazilian regions in different stages of programme implementation, March 2016 (project: Primary health centres – concepts and ractices, funded by Robert Bosch Stiftung).

• Carried by the engagement and knowledge transfer of Brazilian hosts.

• Audio records of presentations, semi-structured interviews, talks, and discussions (managers, health professionals), qualitative content analysis of transcripts and summaries.
“He is a link between the community and the health centre.” (B7)

- The CHWs live in the area where they work.
  - Lay workers – with no previous professional training, salaried from municipalities, governmental formal full time job – 40 hours/ week.
  - Each CHW is responsible for 150-250 families.

- CHWs provide community health surveillance, health education at home and connect professional and self care.

- The Community health workers’ role can range:
  - from a more **technical and institutional profile** directed to care for individuals and families through health promotion and preventive actions by monitoring specific population groups,
  - to a more **political role** featuring mainly community action, discussing health and the social determinants of health, and working towards community organization.
“(...) because you need to see that you have a lot of knowledge to get to learn from the people to be able also to share your knowledge.” (B5)

„A lot of trust inside the team, and the team with the population, this is very important.“ (B30)

• All family health team members work in the health centre and have to provide considerable outreach services to the community (health promotion activities, home visits).

• Home visits are not only in favor of the treatment of immobile persons, but moreover the assessment and understanding of complex needs, self care and living situations.

• NASF-Teams (psychologists, physiotherapists etc.) provide additional services and strengthen interdisciplinary competencies of the Family Health Teams by supporting and counselling them, e.g. how to care for persons with mental health problems.

• Community outreach by an interdisciplinary approach is central to the concept, however, high workloads and reluctance of health professionals may hinder the new orientation.
“Change your mentality about the public’s health. This is the change. It is very complicated because you don’t have a materiality about the situation.” (IB2)

“It's to have more conversations, more dialogue, to do the things in a more democratic way, you know?” (B5)

• Professionals have to learn to work collaboratively with communities/families instead of only commanding patients how this or that must be done.

• Change of conventional hierarchies between doctors, nurses and other health professionals towards co-responsibilities and a shared identification with primary health care.

• More than clinical services: competencies in democracy and community participation are needed.
Conclusion

- Beside the technical role of the CHWs, their role as an advocate for the community and an agent of social change should be essential and must be promoted.

- Interdisciplinary competencies of basic primary health care teams should be strengthened instead of fragmentation of care.

- The development of health professionals is not only discussed as a critical factor but pushed on the agenda of curricula, interdisciplinary university programs and continuing education programmes.

