Ministério da Saúde

DOCUMENTO TÉCNICO

Avaliação para Melhoria da Qualidade da Estratégia Saúde da Família

Evaluation for Quality Improvement of the Family Health Strategy

TECHNICAL DOCUMENT

Evaluation for Quality Improvement of the Family Health Strategy

MINISTRY OF HEALTH OF BRAZIL

EVALUATION FOR QUALITY IMPROVEMENT OF THE FAMILY HEALTH STRATEGY

Technical Document

Brasília – DF
2006

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MINISTRY OF HEALTH
Secretariat of Health Care
Department of Primary Care

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Series B. Basic Texts of Health

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Series B. Basic Texts of Health

First published in 2005

Formulation, distribution and information:
Secretariat of Health Care
Department of Primary Care
Coordination of Monitoring and Evaluation
Esplanada dos Ministérios, Bloco "G", Edifício Sederters
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Department of Management and Regulation of the Work in Health

Secretariat of Monitoring in Health
Department of Epidemiologist Monitoring
Department of Health Situation Analysis

Printed in Brazil

Catalogue Record

Brazil. Ministry of Health. Secretariat of Health Care. Department of Primary Care.
Evaluation for Quality Improvement of the Family Health Strategy / Ministry of Health, Secretariat of Health Care. Department of Primary Care. – Brasília : Ministry of Health, 2005.
6v.- (series B. Basic Texts of Health)

Content: Technical Document – Notebook of self evaluation n.1: Health Municipal Management – Notebook of self evaluation n.2 : Municipal Coordination of Family Health Strategy – Notebook of self evaluation n.3 : Family Health Unit – Notebook of self evaluation n.4 : Family Health Team : part 1 – Notebook of self evaluation n.5 : Family Health Team : part 2.
ISBN 85-334-1034-4 (complete work)
ISBN 85-334-1035-2 (technical document)

1. Health care quality. 2. Evaluation of processes and results (health cares) 3. Family Health. I. Title. II. Series.

NLM W 84

Cataloguing in the source – MS Press – 2005/1197

Titles for indexation:
In English : Evaluation for Quality Improvement of the Family Health Strategy : technical document
In Spanish : Evaluación para mejora de la Calidad de la Estrategia Salud de la Familia : documento técnico

PRESENTATION

The guarantee of the quality of care is, nowadays, one of the challenges to the Unified Health System (SUS), considering the necessity of its comprehension in light of the principles of comprehensiveness, universality, equity and social participation. Over the last 10 years the Primary Care, in Brazil, has undergone an intense transformation from the definition of the Family Health Strategy in the reorganization of its practices aiming a real standard change. This initiative intended also to expand the access and coverage of the basic health services and to organize the demand to other care groups, reaching social groups that have been excluded from comprehensive health care.

During this period the investment in network and human resources expansion linked to the first level of care of the system, led to a continuous growth of population access to health services and actions. However, it is still imperative that the organizational development improve intensifying the efforts destined to the improvement of the quality of health services and practices, to consolidate the strategy as the axis of the Primary Care reorganization, with repercussion in the reordering in the health system as a whole.

The proposal Evaluation for Quality Improvement of the Family Health Strategy represents the institutional commitment to contribute to the consolidation of the Monitoring and Evaluation of Primary Care. According to this, the usage of the quality evaluation becomes an important step to in order to offer better health care to individuals, families and community.

Ministry of Health of Brazil

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I. Introduction

The Evaluation for Quality Improvement of the Family Health Strategy makes closer the connection between evaluation and the field of Health's Quality, enabling the agents who work in the municipalities the acquisition of methods and tools to make this process by themselves.

To evaluate means to form an opinion, to judge, to decide about something or someone after thinking carefully. Evaluation is frequently associated with negative aspects such as punishment, ranking and elimination of the ones who haven't reached a certain result. However, we many times, find the concept or pre concept, that evaluation is a very complex knowledge that can only be understood by specialists from the services or the academy.

When it comes to quality, it is usual the idea that it is a very subjective field, so much so that there is no definite way to evaluate it. The idea that it is not possible to offer good quality services within the Brazilian Unified Health System (SUS) is also falsely spread.

In order to overcame these limited conceptions which are based on historic and cultural precedents, the actual proposal sees the evaluation as a permanent tool to decision making, and the quality as a fundamental attribute to be reached by the SUS – and both of them should be appropriated by any professional working within Family Health Strategy.

This document unites the methodological, conceptual and operational references of an evaluation model to improve the quality of the Family Health Strategy. Technicians; experts; health services managers, schools and research professionals, as well as professionals from the three governmental levels participated and contributed to its production.

The Evaluation for Quality Improvement of the Family Health Strategy is a proposal that municipal secretaries of health shall take in a participative and voluntary way, motivated by the will to offer a better quality in Health Care.

- It proposes, as a nuclear methodology, a self evaluation oriented by tools designated to specific agents and areas: municipal health management, coordination, health units and teams. This way, it places the inner perspective, of self administration, led by the ones who develop the strategy actions.

- It guides the formulation of a diagnosis about the organization and the functioning of the services and its practices, starting from the Family Health Strategy current struture (principles, lines of direction and acting fields). It enables the identification of the development levels, the critical aspects, as well as its potentials and consolidated matters. In the same way, it leads the formulation of intervention plans to solve the identified problems, in a strategic way.

- It can be used as a reference to the Family Health Strategy organization in the municipalities, due to its strong guiding, pedagogic and inductive aspect of good practices in health.

The content of this document does not intend to exhaust the evaluation field and quality in health. It does not intended to be a singular path that lead to an ideal situation about quality in health services. However, it shows some ways and possibilities to be studied by different agents within the different fields of strategic acting.

II. Justification

Offer the population accessible, resolutive and humanized health actions is a responsibility to be shared by the three administrative levels of the Unified Health System (SUS). Investing in the quality improvement of the services, considering all care levels, means to promote health and to reduce risks and morbid-mortality[1], assuring better effectivness[3] and effectivity.

The accelerated growth of the Family Health Strategy and the recent investments in its expansion 10 years after its implementation calls for reflection about its conception, execution and sustainability[2]. It also demands the creation of strategies destined to ensure the quality of its development and the quality of the Health Care offered by the teams. In order achieve this, it is essential to have the participation of all agents involved in the organization, searching for new methodologies and tools to implement the actions of monitoring, evaluation and improvement of the available services[4], including the organizational and operational aspects.

The use of evaluation processes, known as continuous critical-reflexive action that can subsidize the decision making and influence the development of the system concerning its functioning, working processes and practices of management and service, helps managers and professionals to get the necessary knowledge to identify health needs and assistance demands, in order to reach the system resolubility and the users' satisfaction.

This way, the Evaluation for Quality Improvement of the Family Health Strategy offers specific tools to this care model, enabling the agents who work with the strategy within its different fields to evaluate it in a systemic and integrated way, in order to reach management, technical and scientific improvement.

This proposal integrates a conjunct of actions, activities and experiences developed within the policy for Monitoring and Evaluation of Primary Care, which is embedded in a wider process of institutionalization and evaluation strengthening in the three governmental levels of the health system. It brings evidence of the Ministry of Health's commitment to investing, besides services expansion, in the continuous improvement of actions, services and health practices and in the strengthening of the monitoring and evaluation systems, which are essential tools in the SUS administration.

III. Goals

General:

Promote the monitoring and the evaluation of the quality levels of the Family Health Strategy.

Specific:

- To make available the tools that help in the diagnosis of the health situation and the intervention planning and to boost the continuous improvement of quality in administration, services and practices in Family Health Strategy;
- To verify the development levels reached by the municipalities considering all the components of a municipal administration, coordination and team work;
- To identify critical areas and to support the health services managers in the development of action plans aiming at the improvement of strategy quality; concerning its organization and practices;
- To support, to follow-up and to evaluate the development of the improvement initiatives of the strategy quality;
- To contribute to streghten the evaluating capacity within the quality field in the municipal and state health secretaries.

IV. Guidelines for the Evaluation for Quality Improvement of the Family Health Strategy

GUIDELINES

- Self evaluating process;
- Free adhesion by municipal health secretaries, who should sensitize and motivate coordinators and teams to participate;
- Lack of rewarding or punishment like financial sanctions or others related to results;
- Use of a digital system to feed the data bases and make available several kinds of reports;
- Integration to the developed activities within the State Plans for Monitoring and Evaluation of Primary Care.

USERS OF THE PROPOSAL FOR THE EVALUATION FOR QUALITY IMPROVEMENT

The development of a proposal for quality improvement stems from the idea that the management, the structure and the current processes of action implementation, services functioning and practices may be improved in order to reach the desired quality[5]. However, users of this process may come from different places and with different interests. This way there should be a definition of the target public of the actual proposal.

Considering the goals of the proposal for quality evaluation as part of a qualification initiative that allows pushing the development of the Family Health Strategy, it is understood that its implementation is of immediate interest to the municipal secretary of health, for this initiative may provide information about various aspects concerning management improvement and the services of Primary Care. Being a voluntary initiative, its achievement depends on the interest of those involved with the

local services in getting to know the difficulties and the accomplishments experienced by the strategy, as well as to the politic decision and the commitment of acting to solve the identified problems. So, it is intended that the qualification for Family Health Strategy occurs through formal and voluntary adhesion.

It is understood, as well, that health professionals must be involved with the proposal development, for they are the responsible agents for the consolidation of the health's actions in its daily practices in the services. Their attitudes within the working process are related to the available knowledge, to their previous expectations and the context in which they are inserted. Some of these aspects will be discussed in the quality evaluation of the health teams and will allow the recognition of difficulties and obstacles for the formulation and development of action plans, pointing to the necessary investments, its nature and direction, aiming at reorganization of the Primary Care, having the Family Health Strategy as an axis.

State and Federal levels of the coordination of the Family Health Program also stand as users of this same process. To these the identification of the main problems and the follow-up of the results in quality improvement got by the health teams, will allow a better comprehension about the way the strategy is being developed within the country's different realities. This project will show the priority areas for investing as well as the innovative and resolutive work experiences. It will also help to identify new lines of action and different approaches to the problems and needs of the health system users, as well as changes in the population's health situation.

BENEFICIARIES OF THE EVALUATION PROPOSAL FOR QUALITY IMPROVEMENT

The main **beneficiaries** of this initiative are the users of the health system themselves, identified as the focus of this proposal. The reach of more advanced quality levels in the development of the Family Health Strategy will represent an improvement of services, better resolubility and humanized care, once these goals are pursued by health managers, professionals and others agents involved in the continuous quality improvement.

V. Family Health Strategy: principles, guidelines and actions

The Department of Primary Care (DAB) of the Ministry of Health has established the basis for the implementation and functioning of the Family Health Strategy since 1994. The organization of the Strategy in the municipalities guides itself according to pre defined operational guidelines that will lead the way of functioning of the units and the teams practice, including the regulation according intervention areas and strategic lines of action. It has to be highlighted that the municipalities have searched, beyond the fulfillment of the operational guidelines, to explore all strategy potentialities in order to reach equity and comprehensiveness within health assistance.

The effort for the reorganization of the Health Care System (SUS) in Brazil presented new perspectives since the proposition of the Family Health Strategy as the structuring axis of Primary Care. Pioneer experiences as the Health Care Communitarian Agents Program (PACS) adopted by the Ministry of Health in 1991, have served as inspiration for the Family Health Program. Ever since, the model is being improved and extended to the whole country as a strategy for this care level. In July 2005 there were 22.410 Family Health teams implemented in 4.791 Brazilian municipalities, representing 86,2% municipality and offering coverage to 40,9% of Brazilian population.

Nowadays Family Health Strategy has been implemented replacing the traditional model for the Primary Care, making possible, in a defined territory, complete and continuous care to individual and community health, with actions of health promotion, protection and recovering[6,7]. The health actions are developed having the family as the center, understood in its socio-cultural environment. In the Family Health Unity (USF) is settled the multi professional team responsible for a pre determined population. This organization favors the establishment of bonds of responsibility and trust between professionals and families and enables an better comprehension of the health/disease process and the necessary interventions considering the identified problems and demands[1,8].

Having the SUS principles as conditions for its development, the Family Health Strategy faces as a great challenge: reach universal coverage and equity. The quality improvement and humanization are other goals to be achieved. The development of its practices requires the integration of highly complex technology in the knowledge area, with the establishment of new abilities and attitude changes[1]. Besides that, and according to the principles of Primary Care which point to the importance of coordination of the actions considering professionals and care levels, a greater efficiency in the use of the available resources is expected. In order to reach such goals there were financial, educational and political incentives aiming at a redefinition of the health actions objective, the reorganization of the local health system and the reorientation of the work processes and health practices.

PRINCIPLES OF THE FAMILY HEALTH STRATEGY

Embodying and reassuring SUS basic principles – universality, comprehensiveness, equity and social participation – the work in the Family Health Strategy is developed according the following leading principles[9]:

1. ***Substitutive perspective:*** the FH Strategy does not propose the creation of new structures, except in areas that lack any kind of service. Replacing the traditional assistance practices, that focused on the diseases, by a new work process committed with prevention, with quality promotion in the population's life and with assistance resolubility.

2. ***Comprehensiveness:*** the FHU is a synonym for Primary Care, becoming the first contact between the population and the municipality health system. It is expected that Family Health Team, with its knowledge and practices, be able to identify and answer to the health needs, considering both individual and collective expression. Furthermore, the units must be linked to the services network, in a way that both references and counter references for any other level of the system be assured. Understanding comprehensiveness in its broader meaning, far beyond assistance assurance in other care levels, both municipal coordination and teams must search in other social segments the necessary complementariness to its actions and practices, aiming to accomplish the essential requirements of health promotion and disease prevention.

3. ***Territorialization:*** the local work should be organized based on the population's epidemiologic and social conditions. The team working according to this logic deals with a definition of the coverage area and enrolled population (which may vary between 2.400 to 4.000 people), doing family registration, follow-up of health situation, harm exposure and environmental conditions, besides developing programmatic actions. Within the teams' acting territory, there is the definition of micro areas. This allows a better follow-up of life and health conditions of the families and enables the identification of inequalities and the offering of specialized care to the more vulnerable groups.

4. ***Multiprofessional Team:*** the Family Health teams are composed of at least one doctor, one nurse, one or two nurse assistants and four or five Health Care Communitarian Agents. Since December 2000, with the creation of a financial incentive for the insertion of one Buccal Health Team for each two Family Health teams, a progressive growth of these professionals working within the strategy has been observed. The ministerial norm nº 673/GM/MS, June 2003, predicts the incorporation of one Buccal Health team for each Family Health team according the following conditions: one dentist and one dental clinic assistant (DCA), and possibly, besides those two, a dental hygiene technician (DHT). The actions for Buccal Health promotion are inserted in a broad health concept which transcends the technical dimension of dental assistance, incorporating itself into others public practices.

Other professionals – such as psychologists, nutritionists, social assistants and physical therapists – may be incorporated composing support teams, according to the local needs and possibilities. The FHU may act with one or more teams, depending on the population concentration in the territory under its responsibility. The approach to the problems and health needs, as well as the organization and functioning strategy method, within the comprehensiveness perspective, requires that the teams are able to articulate technical requirements to a practice that considers individual, familiar and collective contexts, and the relationship among professionals, developing abilities and attitude changes.

5. ***Responsibility and bond:*** the teams take on as their own responsibility to contribute to the improvement of families' health and life quality, considering the ones living within their comprised area or territory. In order to do so they shall make efforts to offer humanized care, considering the subjective and social dimension of its practices, favoring the formation of cooperative networks and promoting the people and social groups autonomy.

6. ***Community participation and social control:*** The health management must favor and strength the social participation in all fields of the strategy. The team, for its turn, must promote the participation of social organizations and its members in the planning, administration and local health evaluation, and develop coupled projects for the improvement of the population's life quality.

ACTING FIELDS OF THE FAMILY HEALTH STRATEGY

Health practices within Primary Care must comprehend all levels concerning the health-disease process and intervention areas, such as:

Health Promotion was defined by WHO (1986) as "the process of enabling people to increase control over, and to improve their health". The health pre-requisites go beyond the simple illness or lifestyle prevention, including aspects[1] such as "peace, protection, education, nourishment, income, stable ecosystem, fairness and social equity". The goal is to reach the capacity of analyzing and acting over the social determinants of the health-disease process, as well as acting on the problems that affect life and life conditions[10].

Disease and health problems prevention works with the reduction of risk factors to individuals and social groups, counting on collective health knowledge and methodologies in its various areas and programmatic actions to do so. Primary prevention areas are emphasized through health promotion (to prevent the disease in the population, intervening in the risk factors), and specific protection (to prevent the disease in sub clinical groups or risk groups). These actions include the ones predicted in epidemiologic, sanitary and environmental monitoring area.

Treatment and Assistance (secondary prevention) are directed to early disease recognition, the adoption of comprehensive individual, familiar and community treatment measures according to the care level and health technology development. In order to achieve this, health teams must have access to work conditions that assure assistance quality to the patients, the families and the communities, as well as a guarantee of reference to the other levels of care of the system.

Health **Rehabilitation** (tertiary prevention) aims at the reestablishment of the functioning capacity of people who had deteriorated due to the illness process. According to the Family Health Strategy context, rehabilitation actions require family closeness to the process and proper housing conditions to achieve better results, as well as access to specialized rehabilitation services whenever it is necessary.

STRATEGIC LINES OF ACTION

It is expected that the health practices developed by the teams cover all levels of the human life cycle (health of children, adolescents, youths, adult men and women, elderly), the priority health problems, health needs, transmissible and non transmissible chronic diseases (hypertension, diabetes mellitus, tuberculosis, leprosy, STD/AIDS, malaria, dengue and alcoholism) and programmatic actions (mental health, worker health, community rehabilitation program).

It has been considered, in the formulation of the proposal and the tools for the Evaluation for Quality Improvement, this extended view of the organization, functioning and health practices within the strategy.

GUIDELINES FOR THE FAMILY HEALTH TEAMS' (FHT) WORK

The FHT must know what happens within its coverage area and, with this information (health diagnosis), work on action planning and follow-up, monitoring of risk and disease situations and evaluation. It is expected that services and practices be organized in permanent interaction with the community. Having that in mind, the main guidelines for this work are:

1. Get to know families' reality within the acting area, considering socio economic, cultural, demographic and epidemiologic aspects, identifying the most common health problems and the exposure risk for the population.

2. Register the defined population in a cadastre.

3. Formulate a local health plan based on the health diagnosis of the population, program activities and restructure the work process together with the community.

4. Perform health monitoring and act in the control of diseases such as tuberculosis, leprosy, sexually transmissible diseases and AIDS, other infectious-transmissible diseases in general, non transmissible chronic diseases, besides the work and environment related illnesses.

5. Offer resolutive assistance, according to the demand and the main health problems detected in the population, trying to articulate other care levels in order to assure comprehensiveness in care.

6. Organize the health service emphasizing the family as the center of the attention. In this way, implement health promotion actions and strengthen the bonds with the community.

7. Develop educational projects within the population through community groups, focusing on health improvement and life quality aspects.

8. Promote inter-institutional actions and actions with formal and informal community organizations to act together in the solution of health problems, bringing up the themes of citizenship, right to health and its legal basis.

9. Boost the participation of Health Municipal and Local Councils, strengthening the social control.

PROESF: A PROJECT FOR THE EXPANSION AND CONSOLIDATION OF FAMILY HEALTH STRATEGY

The adhesion of the municipalities to the Family Health Strategy has varied according their size, having the smaller cities been able to perform its establishment faster and in an easier way than the larger ones. This is related to multiple variables, like: socio-sanitary complexity, the existence of already established Health Care models and aspects of urban organization (buildings, condominiums, invaded areas), profile and formation of professionals, among others.

In order to overcome the limitations related to the strategy expansion in the big cities and urban centers, a project was developed which main goals are to boost and extend the number of teams, to form professionals to work in the strategy and to strengthen the monitoring and evaluation processes in these locations.

The Project for the Expansion and Consolidation of Family Health – PROESF is an initiative of the Ministry of Health, supported by the World Bank – BIRD, aiming the strengthening of Primary Care in the country[12]. The Project is structured in three acting components:

I. Support the conversion and expansion of the Family Health Strategy – directed to the municipalities with over 100.00 inhabitants.

II. Development of human resources within Family Health Strategy – directed to the states and municipalities, regardless of its size.

III. Monitoring and evaluation – directed to states and municipalities, regardless of its size.

The Evaluation for Quality Improvement of the Family Health Strategy integrates component III of the PROESF, together with the Base Line Studies and the State Plans of Monitoring and Evaluation of Primary Care, among other actions.

VI. Quality of health care according to the Family Health Strategy perspective

Conceptually, quality will always be a social formulation, constituted by references of the involved parties – who attribute meanings to their experiences, giving privileges or excluding certain aspects according a hierarchy of preferences.

Thus, it will always be a great challenge to search for a quality concept approach concerning the Family Health Strategy, considering the plurality of its dimensions (politic, economic, social, technologic) and the agents involved in its development (individuals, families, communities and professionals) [13,14].

Concerning this proposal, quality in health will be defined as the obtainment of established quality standards according the norms and protocols which organize actions and practices, as well as the actual technical and scientific knowledge, respecting culturally accepted values[15,16]. The assistance to the health needs and the users and their families' expectations, as well as the answer to the technically defined necessities will also be considered.

VII. Evaluation methodologies for health quality

There are different alternatives to evaluate health quality considering actions services and practices. They can vary according to the perspective, purposes, methodology or mechanisms.

The evaluation perspective may be of **external**[17] or **internal** nature, depending on the agent that requires, conducts or validates the evaluation. Among the ones of external nature there are Accreditation, Certification and Licensing, when external agents formulate the final result, this being a score, a certificate or a license. The Evaluation for Quality Improvement is based on the internal evaluation perspective, considered more appropriate for the Family Health Strategy because it is conducted, in all levels, by its own involved parties.

EXTERNAL EVALUATION

ACCREDITATION: It is a process of evaluation and measure of the formal quality of the work developed by a health organization, which uses standards defined by an Accreditation Commission (generally a non-governmental organization) that is not related to the institution to be accredited. The commission recognizes as excellent a service or health organization that, having developed a process of quality improvement, surpasses the pre-established measurement standards. The accreditation process is voluntary (required by the organization to be accredited), periodic and systematic, and is applied in a national, regional or local context.

CERTIFICATION: Through this process an organizational station (governmental or not), evaluates and recognizes a person[18] or organization that accomplishes the requirements or pre-established criteria (example: ISO-9000).

LICENSING: Through this process a governmental authority gives permission to an individual health professional or a health organization to perform health services. It is sustained by the compliance of certain minimum requirements of services offering. The license has a validation period that requires its continuous renewal, according the International Organization for Standardization (ISO)[19].

INTERNAL EVALUATION:

CONTINUOUS QUALITY IMPROVEMENT (CQI): processes oriented to quality promotion in Health Care in a systematic and continuous way, designed to reach the quality levels oriented by the care model according the social demands and the scientific and technological advancements in health.

The Evaluation for Quality Improvement in the Family Health Strategy uses the evaluation internal perspective, articulating elements of the normative evaluation and the continuous quality improvement (CQI), presenting itself as a methodology of services internal administration. Starting from the pre-established criteria and standards, it aims to boost processes of quality improvement, offering the health manager a work tool that makes the strategy proposals easier to reach.

EVALUATION FOR QUALITY IMPROVEMENT

→ Evaluation perspective: internal

→ Participative process that includes health managers, professionals and other parties involved with intervention

→ Articulated initiative of the three administration levels of the Family Health Strategy (municipal, state and federal)

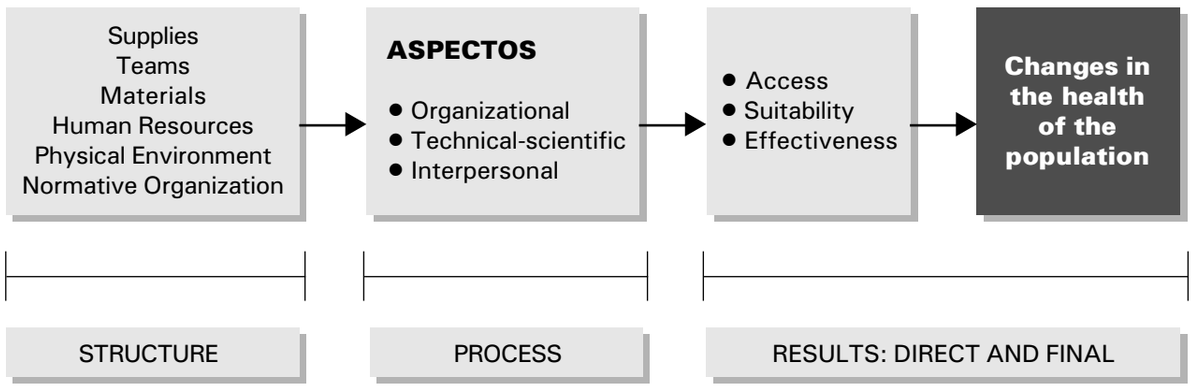
→ Promotion of the evaluative culture and of the management of the quality improvement in Primary Care

→ Process inserted in a program of continuous quality improvement

VIII. Approach of the Evaluation for Quality Improvement of the Family Health Strategy

The Evaluation for Quality Improvement of the Family Health Strategy adopts, as a conceptual reference in the evaluation field, the model proposed by Donabedian based in the systemic theory which considers the elements of **structure, process and result**[21], having as an analysis focus the health services and assistance practices.

Figure 1: Evaluation elements of the Family Health teams



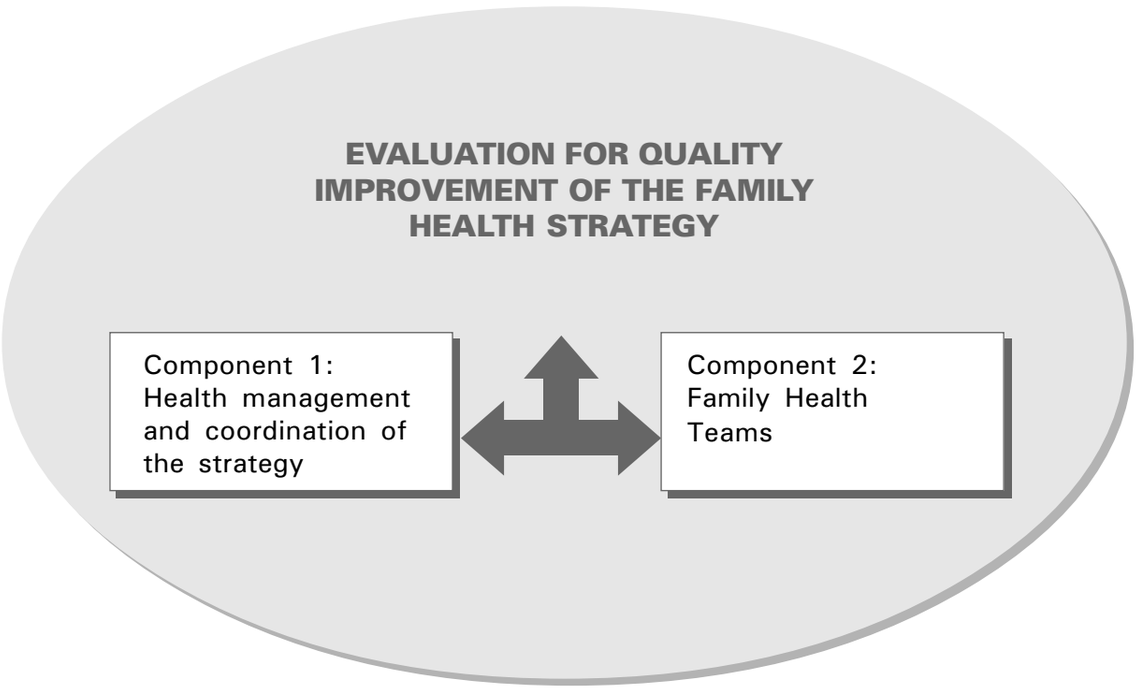
Considering this, the proposal was defined:

1. The self evaluation tools emphasize the elements of the **process**, especially the work processes, because these offer wider and more accessible intervention possibilities once the problems are identified. Even though the emphasis is smaller, the aspects of structure and result are also taken as parameters to quality evaluation, from a dynamic view of inter related quality levels[25].

2. Two nuclear components or analysis units for evaluation were defined: Management and Teams. Afterwards, the activities developed in each one of them were listed, determining the thematic sub dimensions of the elements. For each sub dimension quality standards were proposed and validated. Even though two components are organized in an equivalent manner, as parallel elements, there should not be neglected the fact that the management component determines the conditions and opportunities for the team component to happen, basing itself in the understanding that adhesion, coordination and creation of favorable conditions for the implantation and implementation of strategies depend mainly on the politic will of the municipal secretaries of health. It must be highlighted that the structure elements, although they may and should be evaluated within teams' work, are the managers' responsibility.

In many evaluation standards, proposed to both components, a great deal of importance is given to the development of new abilities and attitudes by the managers, coordinators and professionals, as well as initiatives concerning changes in work processes and team practices, aiming at the effective development of inter-institutional actions and health promotion.

Figure 2: Components or Analysis Units for the Evaluation for Quality Improvement of the Family Health Strategy



The aspects of the **municipal management of the Family Health Strategy** to be evaluated include the priority given by the health manager to the strategy, its capacity of conducting inter-institutional actions, besides the organization, the planning, the work administration and management of the actions and services, monitoring and evaluation, as well as social participation in the formulation, execution and control of the actions. These elements must show the strategy principles taken as references to its implantation and development in the municipality.

The aspects that refer to the **structure** for the proper functioning of services and practices of the Family Health Teams are:

- Infrastructure: professionals and health agents of the FHU, physical environment (units, offices availability, appropriate places to attend the patients, work meetings, educational activities) and equipment. Although the infrastructure provisions are verified in the FHU, this is understood as a responsibility of the municipal health manager.

- Normative aspects: the existence and the use of guidelines, manuals, protocols, among other documents.

The evaluation of the **Family Health Teams** will focus on the aspects of process and result related to the acting fields, established goals and guidelines.

Comprehensive Care	• Health promotion
	• Health problems and disease prevention
	• Early diagnosis and treatment
	• Rehabilitation
Goals and guidelines of the FH Strategy	• Diagnosis
	• Action planning
	• Usage of norms and protocols
	• Evaluation of the coverage, performance and results
	• Promotion of inter-institutional actions
	• Attention focus on the family and community

The **Processes** refer to predicted actions for the FHS and FHU functioning, as well as the intervention and interaction among users and professionals. The processes, will be evaluated according to the organizational, technical and scientific aspects, besides the interpersonal relationship[22].

ORGANIZATIONAL ASPECTS

It is considered the team actuation in the organization of services and practices, internally and in its interaction with other social participants, institutions and local organizations, observing:

- Planning: appointment making, assistance to spontaneous demand, access, making a cadastre of the population, availability of services, programmatic actions, coordination of other system levels, mechanisms of monitoring and evaluation, ombudsman, information systems of good quality.

- Scope: mobilization of resources and efforts of the various participants and social segments for the obtainment of adequate health conditions.

- Community participation: aspects such as planning, implantation, monitoring and evaluation of the actions in health are fundamental axes of united actuation between the community and the health services.

TECHNICAL SCIENTIFIC ASPECTS

- Technical scientific competence: includes the activities designed to enhance health awareness, abilities and practices. The activities of the continuing education must remain in line with the goals of the strategy and stay tuned with its operational principles. In these aspects, quality refers to comprehensive health practices including health promotion, risk and diseases prevention, early diagnosis, initial treatment, guiding and temporal rehabilitation.

- Protocols: development and use of manuals and guidelines for assistance, prevention and health promotion according the advances in science and health technology and the SUS principles.

INTERPERSONAL RELATIONSHIP

- Commitment: is directly related to adequate and humanized care that the service offers its users, besides the operational dimension, complaint hearing and health needs, searching for resolute attention through the articulation of the services network[23]. This aspect is fundamental because it influences aspects such as the trust levels between provider and user, adherence to indications, assistance continuity, individual respect and users' satisfaction, among others.

- Interpersonal communication: health results depend, mostly, on the information level and communication that may exist during the execution of practices. Relevant aspects include information about the health-disease process, health risks, treatment, prognostic, prevention, collateral effects of medication, risk minimization, health care.

The **results** consider the effects of the processes in the concretization of the actions and practices performed by the teams according the principles and goals pre-established. We can observe two kinds of results: direct and final.

- The direct results relate to the effects of the actions and practices developed in the HFU concerning access (coverage enlargement, if the population got the necessary care and if it got the care when it was required), suitability (adequate offer of services in quantity and quality, according the available knowledge and technology, and the capacity to anticipate problems and risks) and effectiveness (sufficient effort put forth to satisfy needs and demands of the population's health, that is, positive impact on the epidemiologic indicators when it comes to internment caused by avoidable disease, morbidity and mortality).

- The health final results depend on many factors non-related to the rendering of care in the first level of the health system, but also to the other levels of care of the system, and especially of the participation of the other sectors of the society and the social conditions.

Table 1 shows the general structure of the Units of Analysis (Components) defined by the Evaluation of Quality Improvement and the respective sub dimensions or thematic areas.

Table 1: Components or Units of Analysis, Dimensions and Sub dimensions proposed by the Evaluation for Quality Improvement of the Family Health Strategy.

Components or Units of Analysis	Dimension	Subdimensions
Management	Development of the FH Strategy	Implantation/ Implementation of FH in the municipality Integration of the Service Network Work Management Streghthening of the FH Coordination
	Technical Coordination of Teams	Planning and Integration Assistance of the Family Health Team Permanent Education Evaluation Management Normative Actions
	FH Unit	FHU Infrastructure and Equipments Supplies, Immune-biologic and Medicines
Teams	Consolidation of the Family Health Care model	Organization of the Work in Family Health Strategy Commitment, Humanization and Responsibility Health Promotion Community Participation and Social Control Health Surveillance I: General Actions
	Health Care	Children's Health Adolescent's Health Adult women and men's Health Elderly's health Health Surveillance II: Transmissible Diseases Health Surveillance III: Regional Health Problems Loco-regional standards

IX. Quality standards: definitions and formulation methodology

Definition and standards characteristics:

A standard is defined as a level of quality reference that must be reached by the organization aiming to demonstrate a certain degree of quality and excellence. The standard is the declaration of expected quality[24]. Its direction is affirmative or positive and expresses expectations and desires to be achieved. In the formulation of health standards it must be considered that they are appropriate at the moment, acceptable to the users and applicable.

Quality standards are used, frequently, in both mechanisms of quality evaluation, internal or external. Facing the growing interest in quality improvement programs, mainly by accreditation in hospitals, The International Society for Quality in Health Care (ISQua) defined principles to the formulation of standards based in key concepts, independently of their content and application area[25]. In order for the standards to become legitimate, get professional adhesion and have applicability to a daily use inside the health system/service, some basic characteristics are required:

1. Scope: It refers to a complete view of the system, having as reference the traditional focus of structure, process and result. In this proposal the concept has been enlarged to the utilization in the entire national territory, or pre determined groups, considering the different levels of care of the health system and the actions of promotion and prevention[26,27].

2. Sensitivity to evidence changes: The standards shall have the capacity to evidence the process of quality improvement and evolution, the advances and, also, the retrocession in the quality levels reached when it comes to the aspects of management, organization and rendering of services.

3. Simplicity in the application: they must be comprehensible and easy to apply during the evaluation moments.

Table 2: PRINCIPLES TO STANDARD FORMULATION

1. *Identification and definition of concepts*. The standard content must be wide and clearly structured, reflecting the type it belongs to, its scope and the activities or groups it is designed for.

2. *Identification and definition of the standard type.* The standards are classified in three types – structure, process and results. As no type is superior to the other, all of them may be appropriated in any moment of the development of the quality program in the country.

- Structure standards: are used to analyze the structure capacity of an organization to provide health care, in the physical aspect (material, equipment, buildings and personnel) or in the organizational aspect (norms, routines, protocols, planning).
- Process standards: describe how an activity happens (actions, practices, health procedures).
- Result standards: measure the degree or level of quality reached and its effects according the requirements previously established.

3. *Precise definition of the standard extent*. The standards must be oriented in order to facilitate the quality improvement within the work process of a health organization, being an establishment, a service network or an entire health system. It must be defined if they cover the totality of actions, just a part, or if they focus on specific activities or groups of patients.

4. *Clear definition of the process of standard formulation*. In standard formulation we can employ a six-part process:

a) participation of the users in its formulation;
b) consultation with the key sectors, for which it is designed, assuring that these have the opportunity to contribute in its formulation;
c) developed according the national/regional laws and regulations;
d) proper investigation that assures that the standards are based in legitimate, practical and updated information;
e) guarantee that the standard has been validated by Pilot studies before its definitive implantation;
f) definition of the evaluation process and periodic revision of the standards.

5. *The standards allow performance evaluation*. The measure of the performance against the standards use may aid in the creation of sophisticated numeric scales and mathematic formulas, as well as simple verbal descriptions. And it can be verified by valuators externals to the organization or by self-evaluation.

6. *Continuous standard revision*. The standards have a lasting period depending on the quality level wanted and achieved by the organization. This temporality characteristic is fundamental in the perspective of pushing the actions continuity in aid of quality.

Reference axes to standard formulation

The reference axes were defined from aspects considered fundamental and guiding to the formulation of quality standards: principles, guidelines, norms and consensus. The diverse responsibilities, acting fields and parties involved in each of the components of the Family Health Strategy require equal diversity in the reference axes.

Reference axes to the management component: The municipal health managers have a conjunct of responsibilities and duties such as: planning, organization, action management, monitoring and evaluation. In keeping with the goals of reorganization of the local health system having as a structural axis the Family Health Strategy, the manager and the local coordinator must promote and/ or support political and organizational capacity for the effective and efficient conduction of the health system in a way that responds to the populations' expectations. In what concerns Family Health Strategy these responsibilities must be achieved according its guiding principles.

Reference axes to the Teams component: Being a strategy concerned with health promotion and risk management, diseases and health problems prevention, securing the access, assistance quality and its resolubility, it is necessary to define the reference axes that reflect that goal. They must, also, be tuned with the norms of the country, in order to push program accomplishment, which describes the responsibilities of the professionals and the Family Health team.

Formulation and validation of the quality standards

The standards defined by this proposal were formulated and validated with the contribution of key parties, in a wide participative and shared process, according the achievement of the following steps:

- Formulation of a preliminary proposal for the standards: from the proposal methodological design, technicians and consultants of the Coordination of Monitoring and Evaluation of the Primary Care Department (CAA/DAB) defined a preliminary relation of quality standards.

- Internal Validation (validation of the standards with experts): it was held through the presentation and discussion of the preliminary standards with a wider work group composed by technicians from the Ministry of Health (representing the areas within the proposal), external consultants of the MH and representatives from the states and municipalities, as well as potential users. This step enabled a first adjustment of the proposed standards considering their goals (the standards are suitable to evaluate what is intended – validity), object (the aspects to be evaluated are the ones that most need evaluation), reach (users and beneficiaries) e evaluation purposes (suitable to the establishment of the development level and quality improvement in the Family Health Strategy)

- Formulation of the tools to quality evaluation: after the realization of many workshops to come to a consensus on the selection of standards (emphasizing the following characteristics: universality, sensitivity, applicability), tools were developed to evaluate the quality of the strategy management and the actions of the Family Health teams.

Validation of the measure tools:

The tools and their standards were submitted to analysis according the validity (to measure what is intended), reliability (to be reputable) and applicability (to be of easily understood and used), with the following methodology:

- Pre validation with potential users: a detailed discussion of the standards was conducted, initially formulated in pre test, carried out in two municipalities, including health managers, coordinators and professionals of four FH teams. The main goal was to make clear the applicability degree and the pertinence of the selected standards and the tools designed in municipalities of different regions, in diverse conditions of economic development, population size, management condition and population coverage of the strategy.

- Validation: after the analysis of the level described above, standards and tools to quanti-qualitative pilot test carried out in 24 Brazilian municipalities were re-formulated, with the participation of over 500 teams distributed throughout the 5 regions. The debates and opinions of these collaborators about the self evaluation tools were decisive in the result obtained and the formulation of the definitive material.

- Final adjustments: after the pilot test there was a re-organization of the tools and standards by technician and consultants of the MH directly responsible for the proposal and representatives of the various technical areas involved.

X. Quality Levels in the proposal Evaluation for Quality Improvement of the Family Health Strategy

Although there are many considerations in literature about the non linearity quality of the structure, process and result elements, for the present proposal the quality improvement is approached in a continuous way, beginning with the structure and infrastructure conditions, going through the services and practices organization and forward to the more complex actions, in the work processes and in the impact over the health conditions of the assisted population. This option reflects the educational, pedagogic directionality that is intended with the proposal.

In the self evaluation tools, the concept of quality levels is associated to each of the standards, which are presented below:

Level E Standards
Elementary Quality (addresses fundamental elements of structure and the most basic actions of the FH strategy);

Level D Standards
Development Quality (addresses initial organizational elements and the improvement of some work processes);

Level C Standards
Consolidated Quality (addresses consolidated organizational processes and initial considerations of coverage and actions results);

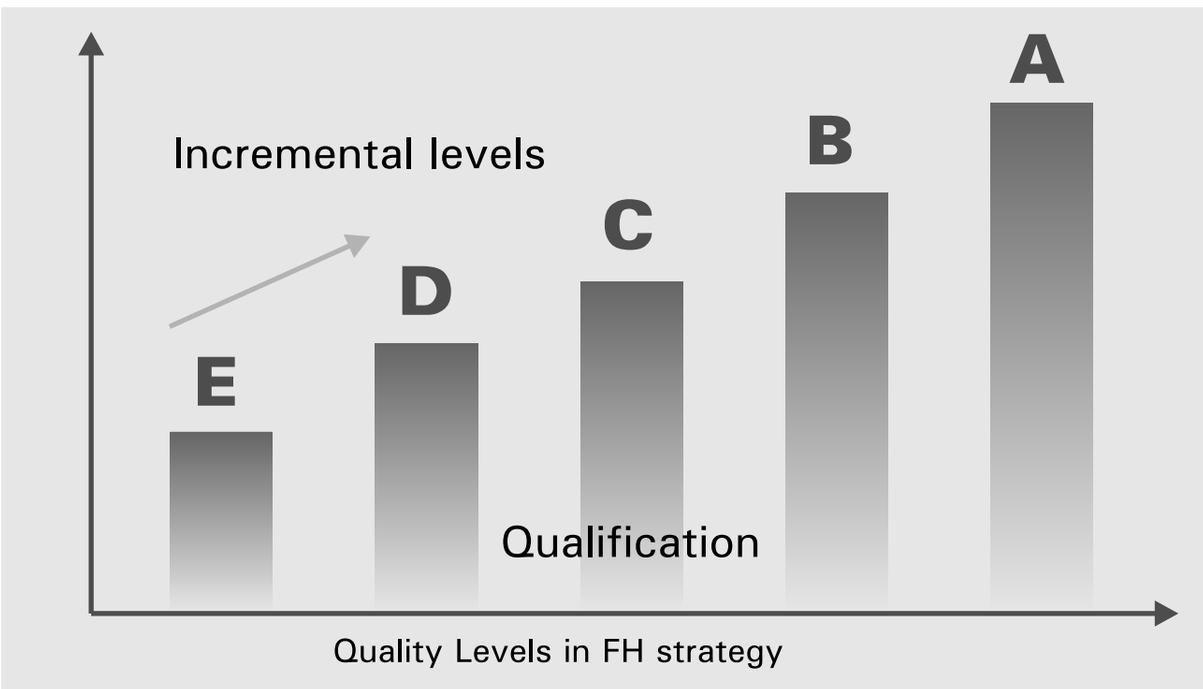
Level B Standards
Better Quality (addresses actions of greatest complexity in care and more lasting and sustained results);

Level A Standards
Advanced Quality (is the goal to be reached, concerning structure, processes and, primarily, in results).

It is expected that these levels do not represent stagnant situations of unaltered quality but that they reflect moments of the process of the group involved in the strategy and the successes in the reach of a pool of standards. In this sense, the analysis result is not a level classification of a municipality in relation to another, but a possibility of evaluating the quality of the strategy in all aspects (management and team) and/or in pre defined aspects (child health, women health, for instance). The standards will be continuous and opportunely revised so that they are updated and compatible with the expected quality improvement.

The quality evaluation interacts with the natural process of quality evolution in services, making it possible to objectively view the advances and gains in the process as a whole. There is, this way, a process of quality gradients, where each one corresponds to "moments" of the process of quality maturation (Graph 3).

The present proposal, as a technical and methodological decision,



formulated standards exclusively of the categorical type, like "yes and no", disposed in incremental and ascendant levels. This decision was based in the need to establish well defined quality principles and criteria considering the great territorial extension and the diversity of initiatives in FH strategy in Brazilian municipalities. It also considered the various aspects and progressive degrees of quality of the approached matters in each standard, as well as the incremental classification of them, enabled by the levels of quality development, from elementary to advanced.

The standards disposition in the tools was conceived according a temporal and incremental evolution, searching to absorb, as an evaluation tool, situations related to the implanting process of the Family Health strategy, levels E, D, C, evolving to situations related to the guarantee of quality of the actions developed, levels B and A.

The transient quality of the standards emphasizes the concept of "standard life cycle", that is, the standards will be of use during the period in which quality improvement allows for their attainment. Once that moment is passed, the standards may lose relevance and must be replaced by others that reflect new quality levels.

Measures and Classification

There are many possibilities in the creation of grading scales in quality[28], of different levels of complexity, some of which use descriptive and simple analyses, based on the fulfillment, or lack answer of the quality standards. Other models are based on complex statistic proofs of analytical nature (multivariate models)[29] that make a selection of the most relevant standards (through the technique of analysis of the main components) or other models that propose balance (grades) having as reference statistic procedures as the factorial analysis[30].

There are, still, methods based in numeric scales applied, for example, in evaluation of health interventions[31], where the definition of measures and the establishment of grades for the measurement of quality levels are accomplished through consensus techniques with people of noted knowledge on the issue.

To this proposal, considering the great diversity of the Brazilian health system, as well as the fact that this is a pioneer experience, qualification scales that are simple, consensual, of easy applicability and acceptability, with an understanding at a local level were developed in order to assure adherence, internalization and continuity of the model by the various parties involved. The attribution to each standard of its corresponding quality level consisted of the methodological option chosen by the technical team. This way, each standard represents a structure, process or result element, inside a certain dimension, allowing a wide and process based diagnosis of the strategy situation in the municipality, in its different aspects: management, coordination and teams.

The levels initially achieved by the municipalities must continually evolve, as a result of the improvement actions of management, organization and rendering of services. In order to do so, the health managers must institute a strategy of continuous sequential and horizontal communication with the coordination and professionals in order to strengthen the successful projects and overcame the operational weaknesses identified, assuring proper working conditions[32]. The coordinators and the teams must also identify the problems that should be solved first, their causes and alternative solutions that can be applied in an adequate and effective way.

Considering the constant evolution of the functioning of the Family Health Strategy in the country, as well as the transient quality of the standards, the interval between the self-evaluations must be of six months to one year, enabling the evidencing of the changes promoted by the local initiatives to quality improvement.

XI. Predicted aspects for the implantation of the proposal Evaluation for Quality Improvement of the Family Health Strategy

The Evaluation for Quality Improvement of the Family Health strategy intends to evince situations susceptible of being modified, stimulating organizational changes directed to achievement of a better quality level of the Health System.

Recognizing the different contexts of the proposal implantation, the specifics of each reality and the importance of including, in its execution, the various groups involved, the following aspects are predicted:

- Knowledge of the proposal by the municipalities.

- Health Managers interested in instituting a process of quality improvement will adhere through inscription on the site of the project (www.saude.gov.br/amq), and they will search to sensitize and motivate the teams to participate.

- The self evaluation tools will be distributed among the professionals. The answers can be registered in a computing system, accessible through the internet. The data base will enable the consolidation of an evaluation record and, latter on, feed reports for evaluation and analysis.

- Considering the result of the self evaluation held, the municipalities will be able to identify problematic situations that may be revised/ modified using proper work methods and making the feasible interventions considering the local conditions.

- As a work process to interfere on the identified situations, the next step will be the formulation of action plans for the improvement of situations. In order to do so the proposal counts on tools that help in the formulation and implementation of plans, which, for quality improvement programs, follow the following steps:

Planning	Processes analysis; definition of which changes may improve them and the formulation of an action plan contemplating the objective of this change (that will always be related to the goals of the FH strategy and focusing on the users), the activities to be achieved (or the processes to be improved), the responsible agents and the deadline for its execution.
Execution	Plan development in a small scale, as a pilot.
Evaluation	Checking whether the changes predicted by the plan are taking place.
Implantation	If the evaluation is positive, it is implanted in a large scale; if not, the plan is revised and the cycle starts all over again.

Some of the aspects considered problematic may be complex and difficult to solve in the local and present conditions. Many, however, may be approached according the local conditions and possibilities. It is suggested to initiate the action plans in these cases (the easy cases and situations), as they make it possible for the team to see the result of their efforts before being able to work over more complex processes.

- Initially, the evaluations should be performed each semester. In this occasion the procedure will be the same of the first evaluation, making possible the continuance or the change in the quality levels (response to the standards) in relation to the previous classification.

- Development of supporting and assistance nets through university nucleus focusing on the quality area is predicted. These will be stimulated to give support and assistance to the municipalities that are engaged in the process of quality improvement of the Family Health Strategy.

- The possibility of external validation through later evaluation performed by team, assigned specially to this finality, is being studied. This step will enable the corroboration of the achieved advances in quality within the evaluated work processes. These evaluations will be performed with the agreement of the parties involved in the implantation of the proposal.

XII. Attributions of the governamental levels

The implantation and the positive development of the proposal require the definition of the assignments and implantation goals to the different levels of the government and involved parties, as well as commitment to its achievement. The participation and co-responsibility of the managements in the federal, state and municipal scope are extremely necessary to the initiative achievement.

The priority of the proposal is to contribute to strength the process of institutionalization of monitoring and evaluation of Primary Care in the three government levels. In this way, the implantation process as an opportunity to reach that goal.

It is defined the following attributions and goals implantation to the different management levels:

1. Federal Level: The Ministry of Health, through the Coordination of Monitoring and Evaluation of the Primary Care Department, will be responsible to accomplish the activities of planning, monitoring, evaluation, promotion and negotiation of the proposal together with the involved organizations.

Attributions:

- Formulation of the Proposal of Evaluation for Quality Improvement, including its standards and tools enabling a participative evaluation to be made with an accord.
- Proposition of steps and deadlines for the implantation.
- Presentation and negotiation of the proposal with public and social organizations.
- Presentation of the proposal through seminaries, national workshops and events.
- Financial cooperation for the states to the implantation of the proposal: through the State Plans of Monitoring and Evaluation of Primary Care.
- Technical support to the states for the presentation and implantation of the proposal in the municipalities.
- Monitoring and evaluation of the implantation process and proposal development in the national scope.

2. State Level: It is proposed to the states to support the process in all its steps, working together with the municipalities for its implantation and implementation.

Attributions:

- Integration of the Proposal to the State Plans of Monitoring and Evaluation of the Primary Care.
- Presentation of the proposal to the municipalities through seminars, regional and municipal workshops.
- Planning the steps of implantation of the proposal in the state.
- Follow-up and technical support to the municipalities in the process of proposal implantation and development.
- Monitoring and Evaluation of the process of implantation and development of the proposal in the state level.

3. Municipal Level: The municipal secretariats of health are the focus of the proposal development, along with the accomplishment of the actions for quality improvement.

Attributions:

- Organization and coordination together with the state technical team for the implantation of the proposal in the municipality,
- Planning implantation and development of the proposal.
- Presentation of the proposal to the parties and social segments involved: managers and professionals of the Municipal Secretariat of Health, professionals of the Family Health teams, Health Council (Municipal, District, Local Council).
- Involvement of the social parties responsible for the implantation and achievement of the actions for quality improvement.
- Viability of the necessary conditions for the execution of the programmed actions for the self evaluation of the quality and for the development of the actions for quality improvement.
- Monitoring and Evaluation of the process of implantation and its development within the municipality.

XIII. International experiences of quality evaluation of Primary Care

The field of quality evaluation of the primary health care, until the present moment, may still be considered incipient in the country. It is interesting to notice that the studies about health quality in the European continent had their origins in the area of Primary Care, with special importance of the United Kingdom[34], which developed pioneer initiatives in this area. These have always been conjugated actions among the medical corporation, the government and the academy in order to reach quality improvement.

The actions in the area of Quality of the Primary Health Care have been expanded, mainly, among the European countries and Australia. Since the formation of the *Leeuwenhorst* Group, during the II Conference in the Teaching of General Practice, in Noordwijkerhout, Holland, in the year of 1974, the matter of Primary Care structure has been the object of attention of professional corporations, educational institutions and health assistance. The group mentioned above, composed by 15 members of 11 European countries produced three important documents or Declarations.

The first one, in 1975, revised in 1981, defined the work of the physician and described the objectives of the training and formation of specialists. In 1977, a Second Declaration had contributions for the general practice in graduation. The third Declaration approached the team of continuing education. The process of European unification reinforced the need of gauging the graduation and post graduation formation. The discussions about the matter of quality of the Primary Care gained more importance with the debates promoted in the European Section of the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians – **WONCA** and culminated with the creation of the EQuiP[34], (European Working Party on Quality in Family Practice), approved in the **WONCA** European Council, in 1990, in Barcelona. It has begun its activities in 1991, in Utrech, Holland, and nowadays has 23 delegates in European countries, nominated by the National associations.

A subsection of the **WONCA** – Europe aims to achieve its goals by promoting collaboration between organizations, associations and colleges of general practitioners/family doctors in Europe on the topic of Quality Development. Besides the European group there is also a World Group in **WONCA**, for quality, composed by Australia, Mexico, South Africa, Norway, Finland, USA and Philippines.

According the EQuiP their work on Quality Development must:

- be an internal and continuous process and an integral part of learning and improvement of the professionals;
- cover all aspects of patient care; taking into account structure, process and outcome;
- be a routine part of daily practice, and therefore, must be valid but also simple in their implementation,
- be patient-oriented, including the evaluation of accessibility and satisfaction;
- enhances appropriate use of services in health care, and validate strategies of the Primary Care, such as: continuity and comprehensiveness;
- make decisions explicit;
- be used as a professional and educational activity and not in a punitive manner or for control purposes

Among the contributions of EQuiP it is the expertise and experience exchange on Quality Development. In this way, we can mention many initiatives of tools for quality evaluation developed in the last ten years in many countries or in countries partnerships, such as: Moniquor (Portugal), Primary Care Group Standards – United Kingdom; EPA – Germany, Switzerland, Holland; VIC – Holland; EUROPEP – EU; Standards for General Practice – Australia. Many others initiatives have been implemented in the development of protocols, manuals, analysis of clinic and organizational evidence[35,36].

We can mention two tools that propose standards for the continuous improvement of primary health care. The first one, named Standards for General Practice[37], produced by The Royal Australian College of General Practitioners, has as goals: to search for better levels of practice quality, achievable in a gradual way; to purvey a public and recognized tool of quality measure of general practice; to be voluntary; to be available and to offer tangible benefits to the professionals; to be established in a determined period of time; to be an educational and gradual process, no punitive; to be of an equitable basis for the entire country; to work as an evaluation among pairs; to be of control of the own professionals; to have non lucrative purposes, to be known by the governments and communities. With two already developed versions, respectively in 1991 and 19996, this last one composed by 212 standards of the categorical type for self-evaluation.

The MoniQuOr.CS[38] - Assessing and Monitoring Organizational Quality in the Health Centers – developed by the National Institute for Quality in Health of the Portuguese Health Service is the second tool to be mentioned. It fits in a global strategy of Continuous Improvement of the Health Care Quality and it is mainly concerned with the Organization of the Services and with the continuous and systematic revision of the processes that lead to the delivery of effective and efficient health care services. Among its goals are: monitoring and evaluation of the performance levels; responsibility; the validation of documents and procedures; continuous and systematic revisions of the processes of continuous improvement; formulation of programs for continuous improvement; the improvement of internal communications; the organization of patient centered services; the formulation of an action plan; the external recognition; the strategic planning of quality. Created in 1997, it is now undergoing a process of revision.

This tool proposes as methodology the self-evaluation, the evaluation among pairs and the external evaluation. It is composed by 163 quality criteria, 73 of the categorical type ("yes" or "no") and 90 with answers according the scale: not implemented/in progress/ almost implemented/ totally implemented. The criteria should receive values according to the following definition: not implemented (0), in progress (0,33), almost implemented (0,67) and totally implemented (1). Both tools mentioned above are mainly concerned about the structure and process evaluation, search to promote the participation of its own professionals in the dynamic of assessment and development of diagnostic process, situation analysis and election of priority areas.

In Brazil, there are some initiatives of some State Secretariats of Health aiming to search standards to quality monitoring in order to create a politic of financial incentives, support and strengthening of the Family Health Strategy in the municipalities. Recently, the Ministry of Health, in technical cooperation with the Pan American Health Organization initiated the formulation of this proposal aiming to fulfill the need of tools and projects in this field. This initiative corroborates the importance for the public health management to view the quality matter as one of its priorities for the development of the Primary Care in the country, together with the efforts to the consolidation and expansion of the FH strategy.

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Appendix

Predicted Tools to Self-evaluation

In the perspective of continuous Quality improvement, five self-evaluation tools were developed, aiming different users, gathering a total of 300 quality standards.

The **Evaluation for Quality Improvement of the Family Health Strategy** considers two great integrated **Analysis Units**, also known as Components: Management and Team. To each of these units, analysis axes, called **Dimensions**, were defined. Each Dimension has sub-axes, or **Sub dimensions**.

This way, each tool represents an **Analysis dimension**, adding up to five possibilities. In its internal structure, according to the subject, each tool is organized in **sub dimensions**, covering certain groups of corresponding standards.

The components, or Analysis Units (**Management** and **Team**) are like two big boxes that comprise smaller boxes (**Dimensions**), which, for its turn, organize the quality standards according to its theme and attribution or responsibility. See the general structure of the tools in the table bellow.

Understanding and Identifying Quality Standards

The quality standards are organized within the Tools (Dimensions) in Sub dimensions according to its theme and responsibility for the corresponding action.

Enumeration

In the first column there is the numeration. The standards are numerated according the tool they belong to, from 1 to 5, followed by its sequential numeration within the same tool, For example:

1.1 – Tool 1, standard 1

1.20 – Tool 1, standard 20

3.1 – Tool 3, standard 1

3.35 – Tool 3, standard 35

5.14 – Tool 5, standard 14

Standard variability according to the population size

During the Pilot testing of the tools it was possible to verify that some standards from the Management component were more appropriate to some municipalities according to its size (population). Due to this, the second column indicates the classification for the tool numbers 1, 2 and 3 according to the size:

BS – Basic Standard: universal applicability, to all Brazilian municipalities.

>20 – Means that the standard is applicable to the municipalities with more than 20.000 inhabitants

>100 – Means that the standard is applicable to the municipalities with more than 100.000 inhabitants

>500 - Means that the standard is applicable to the municipalities with more than 500.000 inhabitants

General Structure of the Tools

Components or Analysis Unit	Tool (Dimension)	Sub dimension	User (who responds)
Management	Development of the FH Strategy	Implantation/Implementation Integration of the Service Network Work Management Strengthening of the FH Coordination	Municipal secretary of health
	Technical Coordination of the Teams	Planning and Integration Assistance of the FHT Permanent Education Evaluation Management Normative Actions	FH Strategy coordination
	FH Unit	FHU Infrastructure and equipments Supplies, Immune Biologic and Medicines	Decision makers for the FHU or its coordination
Team	Consolidation of the Family Health Care Model	Organization of the work in Family Health Strategy Commitment, Humanization, Responsibility Health Promotion Community Participation Health Surveillance I: General Actions	All participants of the FH team
	Health Care	Children's Health Adolescent's Health Adult Women and Men's Health Elderly's Health Health Surveillance II: Transmissible Diseases Health Surveillance II: Regional Health Problems Loco-regional standards	Professionals: Physician, Nurse and Dental - Surgeon

Notes

Evaluation for Quality Improvement of the Family Health Strategy

Tools, dimensions and sub dimensions

Tool 1: Development of the FH Strategy

Sub dimensions:

I. Implantation and Implementation of the FH in the municipality
II. Integration of the Service Network
III. Work Management
IV. Strengthening of the FH Coordination

Tool 2: Technical Coordination of the Teams

Sub dimensions:

I. Planning and Integration
II. Assistance of the Family Health Team
III. Permanent Education
IV. Evaluation Management
V. Normative Actions

Tool 3: Family Health Unit

Sub dimensions:

I. FHU Infrastructure and Equipments
II. Supplies, Immune biologic and Medicine

Tool 4: Consolidation of the Family Health Care Model

Sub dimensions:

I. Organization of the Work in Family Health Strategy
II. Commitment, Humanization and Responsibility
III. Health Promotion
IV. Community Participation and Social Control
V. Health Surveillance I: General Actions

Tool 5: Health Care

Sub dimensions:

I. Children's Health
II. Adolescent's Health
III. Adult Women and Men's Health
IV. Elderly's Health
V. Health Surveillance II: Transmissible Diseases
VI. Health Surveillance III: Health Problems with Regional Prevalence

Loco-regional standards

Glossary of abbreviations used in the description of the standards

ARI: Acute Respiratory Infection
BHT: Buccal Health Team
BMI: Body Mass Index
Ceo-d: average number of deciduous teeth with cavities, extraction
CLT: Labor Laws
CPO-D: average number of permanent teeth with cavities, lost and with dental restoration
DCA: Dental Clinic Assistant
DH: Dental Hygienist
DV: Domiciliary Visit
FH: Family Health (strategy)
FHT: Family Health Team
FHU: Family Health Unit
G & D: Growth and Development
HCA: Health Care Communitarian Agent
MD: Ministry of Health
HPC: Health Primary Care
IBGE: Brazilian Institute of Geography and Statistics
MHC: Municipal Health Council
MSH: Municipal Secretariat of Health
NA: Nurse Assistant
NB: Newborn
NCHS: National Cadastre of Health Establishments
NGO: non-governmental organizations
ORT: Oral Re hydration Therapy
PC: Primary Care
PC/ FH Coordination: Primary Care/ Family Health Coordination
PE: Permanent Education
PEC: Permanent Education Centers
PSA: Prostate-Specific Antigen
SIAB: Information System of the Primary Care
SSH: State Secretariat of Health
STD/AIDS: Sexually transmitted disease and Acquired Immune Deficiency syndrome
TB: Abbreviation of tuberculosis

Evaluation for Quality Improvement of the Family Health Strategy

Tool nº1

Development of the Family Health Strategy

Implantation and Implementation of the Family Health in the Municipality

Q Elementary

1.1	BS	**E**	The Municipal Plan of Health defines the FH as the strategy to the reorganization of the Primary Care.	**(Y) (N)**

The standard refers to the definition of the FH as the model for the Primary Care, described in the Municipal Plan of Health. Being the Plan, simultaneously, a technical and politic instrument, this definition indicates the priority of the political strategy.

1.2	BS	**E**	The implantation of the FHS has as a priority the areas with socio economic conditions less favorable and or socially excluded.	**(Y) (N)**

The FHS must be implanted focusing the areas and the populations of greater risk and vulnerability within the municipality, considering the social and sanitary aspect. This standard is related to the search for greater equity and accessibility for the municipal health system.

1.3	BS	**E**	All teams are responsible for an enrolled population up to 4.000 people.	**(Y) (N)**

The maximum of people linked to each team must be respected considering that the quality of the actions is affected by the amount of work. The answer must be affirmative only when all municipal teams are respecting that limit.

1.4	BS	**E**	Municipal health management feeds the Information Systems regularly and respects the deadlines.	**(Y) (N)**

This standard evaluates whether the municipal health management is mobilized to the careful treatment of the feeding of the information systems. Information Systems considered: SIM: Mortality Information System, SINASC: Information System on Live Births, SISVAN: Food and Nutrition Surveillance System, SINAN: Reportable Health Events Information System, SIPNI: Information System of the National Immunization Program, SIAB: Information System on Primary Care, SIA-SUS: SUS Hospital Information System and CNES: National Cadastre of Health Establishments.

1.5	BS	**E**	Municipal Health Management establishes BH teams	**(Y) (N)**

Buccal Health is one of the Ministry of Health for Primary Care priority areas and its integration to the FH strategy can happen in two ways: integrating the dentist and the DOA to the team, or yet the Dentist, the DOA and the DH. Both ways are financially supported. To an affirmative answer, consider any number of the BH teams implanted, no matter the modality.

Q Development

1.6	BS	**D**	Municipal Health Plan details the guidelines and the planning for the implantation, implementation and consolidation of the FH.	**(Y) (N)**
It is a higher level comparing to 1.1, meaning that the Municipal Health Plan presents a strategic plan to the reformulation of the assistance model through implantation, implementation and consolidation of the FH strategy.				

1.7	BS	**D**	Municipal Health Management makes an analysis of the municipality health situation to subsidize the FH implantation.	**(Y) (N)**
It is a higher level comparing to 1.2, meaning a study to evaluate the health situation in the municipal population segments, discriminating the epidemiologic profile, the social, environmental and social risks of its regions. Consider the answer affirmative when the implantation of the FHT is supported by these studies and analyses, being defined a smaller number of users to the teams responsible for the more critical areas.				

1.8	BS	**D**	The Municipal Secretariat of Health keeps the strategies of sensitization and presentation of the FH concerning the population.	**(Y) (N)**
Considering the principles of social participation and social control, the guidelines' sensitization and the presentation, goals and characteristics of this health care model to the population and social and organizational networks is important. Another goal is to win support and legitimacy for the strategy.				

Q Consolidated

1.9	BS	**C**	Guidelines and planning for the implantation, implementation and consolidation of the FH are agreed upon and approved with the MHC.	**(Y) (N)**
The Municipal Health Council is the main center of SUS social control. The participative discussion of planning and implementation of the FH strategy must be agreed at the MHC to assure its politic, social and community sustainability. The standard refers to the guidelines and goals' agreement, beyond the initial proposal of adhesion at the MH.				

1.10	BS	**C**	Municipal health management keeps analysis and evaluation of the health situation to subsidize the FH implementation.	**(Y) (N)**
It is a higher level comparing to 1.7. It means that municipal management, besides having achieved the implantation basing itself in studies and analysis, keep this performance during the implementation of the strategy.				

1.11	BS	**C**	The Municipal Secretariat of Health keeps the strategies of sensitization and presentation of the FH principles to the health professionals of the municipal network.	**(Y) (N)**
It is a higher level comparing to 1.8. It is necessary that the FH strategy is comprehended by all health professionals of the services network in order to assure better integration, access and solvability of the health care in the municipality.				

1.12	BS	**C**	Municipal health management develops actions in a way articulated to other government sectors.	**(Y) (N)**

Considering the necessity to articulate and integrate the intervention agendas to the modification of the health determinants, improving the population's life quality, the proposision of the actions/strategies/projects which involve the many sectors of the government (intersectional approach) is important.

1.13	BS	**C**	Municipal health management develops the FH strategy through the implantation of the BH in the proportion of one team for two FHS, at least.	**(Y) (N)**

It is a higher level comparing to the 1.5. Consider the answer affirmative when there is, at least, one Buccal Health Team to two FHS, no matter the modality (Dentist and DOA or Dentist, DH and DOA).

1.14	BS	**C**	Municipal management monitors the stock and lack of supplies in the FHU.	**(Y) (N)**

The purchase planning, the stocking regularity, the sensitization of the professionals for the rational usage and control of the stock aiming error elimination, are considered actions that assure the consolidation of the service quality. Consider an affirmative answer the existence of spreadsheets or tools for the referred monitoring.

Q Better

1.15	BS	**B**	Municipal Health management supports and legitimates popular participation and social control of the FH.	**(Y) (N)**

It is a higher standard comparing to the 1.9. The community leaderships, representatives of the social movements and MHC itself take part on the strategy's planning and implementation through local health councils, users' representation, among others.

1.16	BS	**B**	The FH Strategy is institutionalized in the municipality through a legal instrument.	**(Y) (N)**

The definition of the FH as a care model through a municipal law, decree or other legal instruments assures its legal and institutional continuity in the politic transitions. It also enables a later proposition of a municipal plan of jobs and salaries for the FH.

1.17	BS	**B**	The organization of the FHU teams equilibrates criteria of regionalization, comfort and sanitary safety for the development of activities.	**(Y) (N)**

In the municipalities up to 100.000 inhabitants, the FHU must have the maximum of three teams, and in the municipalities with a bigger number of inhabitants, the FHU must have five teams, at the most. The existence of a technical responsibility (doctor and nurse) is predicted in a legal norm. This guidance aims to assure quality, according the criteria of regionalization, access, optimization of the FHU spaces, comfort and sanitary safety for the teams to develop their work in a proper way. Consider the answer affirmative when all FHU evaluated are according these parameters.

Q Advanced

1.18	BS	**A**	The municipal health management has covenants or partnerships with organizations of the civil society and/or social movements.	**(Y) (N)**

Inter-institutional work in its broader definition concerns to articulate actions between public sector and the work developed by organizations of the civil society aiming to broaden and potentialize initiatives and interventions that enable life quality improvement.

1.19	BS	**A**	Municipal Health develops FH strategy implanting Buccal Health in the proportion of one team to each FHS.	**(Y)** **(N)**
It is a higher level comparing to the 1.13. Consider the answer affirmative when there is one Buccal Health Team to each FHS, no matter the modality (Dentist or DOA or Dentist, DH and DOA).				

Integration of the Service Network

Q Elementary

1.20	BS	**E**	Municipal health management enlarges or makes adjustments in the services network due to the implantation of the FH in the municipality.	**(Y)** **(N)**
It is understood by reorganization of the municipal network actions like the enlargement of diagnostic and therapeutic support's offer of exams, specialized appointments and hospital beds. Other actions include to reform or build units to work as a support and reference to the FHU. The answer must be affirmative when any of these actions is happening.				

Q Development

1.21	S > 100	**D**	Municipal health management enlarges or makes adjustments in the reference network basing itself on studies about verified and/or estimated demand in the FHS.	**(Y)** **(N)**
It is a higher level comparing to 1.7, meaning that studies and analyses about the FH demand are performed by services to subsidize the reorganization of the municipal network. The standard does not refer to the effective assistance of this demand.				

1.22	BS	**D**	There is a programmed offer of basic complementary exams for the FHS.	**(Y)** **(N)**
The standard considers as basic exams: blood counts, blood type, urea, creatinine, blood glucose, urine, urine culture, serology for human immunodeficiency (HIV), serology for syphilis, research of acid-fast bacilli, gynecological pathology of uterine cervix, immunologic test for pregnancy, feces parasitological exam. It must be considered: electrocardiography, chest x-ray, ultrasonography when it is required. Consider that there is programmed offer in relation to the demand of the FHS for all the exams listed.				

1.23	BS	**D**	Municipal health management assures the collection and sending of all serology solicitations for dengue diagnostic.	**(Y)** **(N)**
Dengue was chosen for this standard as a condition of quality for the epidemiologic surveillance due to its prevalence and relevance in Brazil. In epidemic situations, consider the sampling for an affirmative answer.				

Q Consolidated

1.24	BS	**C**	Municipal health management develops strategies to assure to the FH teams' enrolled population reference for hospitalizations in basic clinics.	**(Y)** **(N)**
The hospitalization guarantee for the FH enrolled population is fundamental to reinforce the bond, the responsibility, the trust and the satisfaction. To this tool are considered as basic clinics: Pediatric, Medical Clinic, Gynecology/ Obstetrics and General Surgery.				

1.25	BS	**C**	Municipal health management assures the high-risk prenatal care to all pregnant women who need so.	**(Y) (N)**
This standard considers that the assistance occurs, for all the high-risk pregnant women indicated by the FHS, within the municipality or its network.				

1.26	BS	**C**	There is a programmed offer of cardiology assistance for the FHS based on demand studies.	**(Y) (N)**
The standard understands that assistance must be based on studies of verified and estimated demand. To the municipalities that work as regional centers, consider only the assistance of the municipality itself.				

1.27	BS	**C**	There is a programmed offer of orthopedics assistance for the FHS based on demand studies.	**(Y) (N)**
According the standard the assistance is based on studies of verified and estimated demand. To the municipalities that work as regional centers, consider only the assistance of the municipality itself.				

1.28	S>100	**C**	The proceedings of exams, proceedings and hospitalizations scheduling occur through a scheduling center.	**(Y) (N)**
The existence of a scheduling center represents an important step in control, regulation and integration of the services network. To the small size municipalities, the center may be organized in a fragmented way.				

Q Better

1.29	BS	**B**	The municipal health manager monitors the specialized exams required by the FHS not included in the reference.	**(Y) (N)**
The standard refers to the monitoring of the non included specialized exams, according their relevance, aiming to improve the offer.				

1.30	BS	**B**	There is a programmed offer in rehabilitation for the FHS based in demand studies.	**(Y) (N)**
The standard understands that assistance in physical therapy and speech therapy is based in studies of verified and estimated demand. To the municipalities that function as regional centers, consider only the assistance of the municipality itself.				

1.31	BS	**B**	There is a programmed offer in ophthalmology for the FHS based in demand studies.	**(Y) (N)**
The standard understands that assistance is based on studies of verified and estimated demand. To the municipalities that function as regional centers, consider only the assistance of the municipality itself				

1.32	BS	**B**	There is a programmed offer in otolaryngology for the FHS based in demand studies.	**(Y) (N)**
The standard understands that assistance is based on studies of verified and estimated demand. To the municipalities that function as regional centers, consider only the assistance of the municipality itself.				

1.33	BS	**B**	There is a programmed offer in neurology for the FHS based in demand studies.	**(Y) (N)**

The standard understands that assistance is based on studies of verified and estimated demand. To the municipalities that function as regional centers, consider only the assistance of the municipality itself

1.34	BS	**B**	Municipal health management develops strategies to assure to the FH enrolled population references to specialized dental areas.	**(Y) (N)**

The standard refers to the offer of specialized dental service, at least, in endodontics, minor oral surgery, periodontics, assistance to people with special needs and buccal diagnosis emphasizing buccal cancer detection. The current model to reference services in BH is the Center of Specialized Dental Areas- CEO. The implantation of these units is a priority for the National Politic of Buccal Health.

Q Advanced

1.35	BS	**A**	The health services network assures to the FH enrolled population access to laboratory services of dental prosthesis.	**(Y) (N)**

This service includes its own units, from other municipalities or contracted services. The implantation of Regional Laboratories of Dental Prosthesis – RLDP is an action planned in the national Politics of Buccal Health.

1.36	> 20	**A**	Municipal health management develops integration strategies between the Mental Health service and the FHS.	**(Y) (N)**

The municipal management promotes the integration of the Mental Health (MH) to the FH strategy through actions of health promotion, prevention and assistance. The current model of care to the MH is the constitution of a service network replacing the psychiatric hospital (Centers for Psycho-Social Care - CAPS, Residential Therapy Service – SRT, Relocating Program, hospital beds in hospitals and actions in Basic Care) – http://pvc.datasus.gov.br

1.37	S>20	**A**	Municipal health management monitors the usage of urgency, emergency and instant attendance public services by the population under FH.	**(Y) (N)**

This standard enables the evaluation of the solvability, the users' satisfaction and the effectiveness of the FH work. It refers to the monitoring of the urgency usage, emergency and instant attendance services as an entrance way to SUS.

1.38	S>100	**A**	The support given by other professionals to the FH teams occurs in a systematic way, considering an established model.	**(Y) (N)**

The standard refers to the support organization for professionals such as pediatrician, gynecologist, clinician, physical therapist, psychologist, nutritionist, social assistant and for Services like sanitary and epidemiologic surveillance integrated to the FH, performing health care actions as well as actions of continued education and technical support. This organization has been called "matrix support". The answer must be affirmative when at least 50% of the teams are under this initiative.

Work Management

Q Development

1.39	BS	**D**	Municipal health management develops strategies for the stability of working rights in FH.	**(Y)** **(N)**
The municipal management has a work plan planning the regularization of the working rights to all FH professionals, according to the legal instruments.				

1.40	BS	**D**	The MSH criteria for the selection and hiring of FH professionals are described in an official document.	**(Y)** **(N)**
There are rules and technical criteria that enable the selection of professionals with the best profile and competence for FH work. Legal norms such as the demand of the medical register are respected. The answer must be affirmative if theses criteria comprise the elementary, medium and superior levels.				

Q Consolidated

1.41	BS	**C**	The criteria for the selection of FH professionals with college degree valorize the medical residence or post graduation in Family Health.	**(Y)** **(N)**
The rules and criteria for the selection of professionals with college degree privilege the post graduation within this area (Public Health, Family and Community Medicine and Family Health).				

Q Better

1.42	BS	**B**	The entrance of professionals with a college degree of the FH occurs through a public competition for a permanent position or public job.	**(Y)** **(N)**
The Public competition is the main way to incorporate FH professionals. For an affirmative answer consider that 80% or more of the professionals with a college degree of the FH have a permanent position or public job.				

1.43	BS	**B**	The entrance of professionals with a technical degree of the FH occurs through a public competition for a permanent position or public job.	**(Y)** **(N)**
The Public competition is the main way of incorporating professionals of the FH. For an affirmative answer consider that 80% or more of the professionals with a technical degree of the FH have a permanent position or public job.				

Q Advanced

1.44	BS	**A**	The FH professionals with a college degree have been working in the municipality for over two years.	**(Y)** **(N)**
The stability of the professionals in the FH strategy broadens the possibilities of continuity, bond and responsibility. To an affirmative answer consider 80% or more of the professionals in this situation.				

1.45	BS	**A**	The HCA have been working in the municipality for over two years.	**(Y)** **(N)**
The stability of the professionals in the FH strategy broadens the possibilities of continuity, bond and responsibility. To an affirmative answer consider 80% or more of the professionals in this situation.				

1.46	BS	**A**	Municipal management has a program of incentives for the FHS related to performance, goal achievement and results obtained.	**(Y) (N)**
The successful initiatives of professionals, teams or units are recognized and awarded annually by the coordination, considered some defined criteria.				

1.47	BS	**A**	Municipal health management has career plans, positions and institutionalized salaries, concerning the FH.	**(Y) (N)**
There are legal instruments, instituted by the municipal government, for the professional career and progression of the health workers, concerning the FH professionals. Only if the three levels (superior, medium and elemental) are achieved, the answer to the standard must be affirmative.				

1.48	BS	**A**	80% of the professionals with a college degree have a specific formation within this area.	**(Y) (N)**
Consider as professionals with a college degree of the FH teams: physicians, nurses and dental surgeons. Consider as a specific formation within this area: specialization in Family Health, Public Health, Preventive and Social Medicine, Residence in Family and Community Medicine, Specialization in Preventive and Social Dentistry, Public Buccal Health. The standard points to the efforts developed by the management for the qualification of its professionals.				

Strengthening of the FH Coordination

Q Elementary

1.49	BS	**E**	The MSH has a specific coordination for the PC/FH.	**(Y) (N)**
The municipal management designates a professional or team to perform the coordination of the PC and or FH strategy in the municipality. The standard considers exclusive dedication to this activity, the professional not being involved in the assistance.				

Q Development

1.50	BS	**D**	The PC/FH coordination is inserted in the organizational structure of the Municipal Secretariat of Health.	**(Y) (N)**
The standard refers to the position of FH coordination being legally established. Consider the answer affirmative when the sector of PC and/or FH is represented in the MSH organizational chart. These aspects indicate the institutional legitimacy of the coordination.				

Q Consolidated

1.51	BS	**C**	Municipal health management concerns PC/FH coordination in the process of settlement of the indicators of the Primary Care settlement.	**(Y) (N)**
Considering the relevance and the impact of this action, the PC/FH coordination must take part on the settlement, with no delegation or transfer of responsibility.				

Q Better

1.52	BS	**B**	Municipal management enables the participation of the PC/FH coordination in professional congresses and encounters.	**(Y) (N)**
The standard refers to municipal management enabling and encouraging the participation of the PC/ FH coordination members, at least once a year, in technical and scientific events concerning the FH area, such as: sampling, encounters, Public Health congresses, Family and Community Medicine and Family Health.				

1.53	>100	**B**	The technician(s) responsible for the PC/FH coordination have a specific formation within this area.	**(Y) (N)**
The standard refers to the universe of technicians with a college degree involved in the coordination of the PC/FH in different areas of the system (central, regional, districts and FHU) have a post graduation in Public Health, Family and Community Medicine, Family Health or Administration and Management. To an affirmative answer consider 50% or more of the professionals in this situation.				

1.54	>100	**B**	The coordination of the PC/FH is composed of a multi professional team for the support, supervision and technical supervision of the FHS.	**(Y) (N)**
This standard refers to the existence of a group composed by various health professionals, including professionals of health surveillance, responsible for the technical supervision of the FHS.				

1.55	>100	**B**	There is a decentralized coordination responsible by the assistance of, at most, 8 FH teams.	**(Y) (N)**
In municipalities of a greater size the assistance to the teams has to be decentralized, assuring a closer technical and management support to groups up to 8 teams. The coordination actions may be performed by a technician of the FHU, of the districts or shared by a regional coordination team.				

1.56	>100	**B**	The MSH has a professional responsible for the BH area in the PC/FH coordination.	**(Y) (N)**
The coordination must, ideally, be integrated by professionals with a college degree of the BH aiming to assure the specificities and relevance of the actions.				

Q Advanced

1.57	BS	**A**	Municipal health management and/or coordination establish or use mechanism for the monitoring of the level of the FH users' satisfaction.	**(Y) (N)**
The standard refers to municipal health management or the coordination establishing or using methods and tools to monitor the level of users' satisfaction. Consider the answer affirmative when this action is achieved in a systematic way, to all FHU (or sampling for the municipality), every two years (or less).				

1.58	>100	**A**	Technical areas work in an integrated way with the PC/FH coordination.	**(Y) (N)**
The professionals of the technical areas, such as: Children Health, Women Health, Mental Health, Epidemiologic Surveillance, Sanitary and Environment Surveillance work together with the PC/ FH coordination in the development of technical materials, politics and actions of assessment and supervision of the FHS.				

1.59	BS	**A**	The PC/ FH coordination support and promote the formation of Local Health Councils in the basic units.	**(Y) (N)**
The Local Health Councils or Unit Councils (FHU or Family Basic Unit), when active and well formed, are a scaffolding for the ascendant development of the decisions related to the municipal health. It is the main role of the manager to promote, support and assure its constitution in all health units.				

1.60	BS	**A**	Municipal health management develops, together with PC/ FH coordination and other technical areas of the MSH, a Humanization politics for the municipal net, including the FH.	**(Y) (N)**
In order that the teams are able to develop effective and systematic actions of Humanization, Commitment and Responsibility, it is fundamental that the guidelines and the mechanisms of the implementation are established from the MSH as politics for the municipal network.				

Notes

Evaluation for Quality Improvement of the Family Health Strategy

Tool nº2

Technical Coordination of the Teams

Planning and Integration

Q Elementary

2.1	BS	**E**	The PC/ FH coordination has a schedule of visits to the FHU and meetings with the FHT.	**(Y) (N)**
The schedule is a basic tool in the organization of the coordination work where the systematic and regular follow up of the FHS is planned.				

Q Development

2.2	BS	**D**	The PC/ FH coordination has a working plan guiding the activities to be developed.	**(Y) (N)**
The standard refers to a working plan establishing the competences of the coordination, the actions to be developed, priorities, goals, deadlines and the decision makers. Consider for the affirmative answer the existence of a document penned every two years.				

2.3	BS	**D**	The PC/ FH coordination registers the follow up of the FH situation in the municipality: number of teams, coverage, professionals and results.	**(Y) (N)**
The work of the FHT is monitored about its coverage, production, goals achievement and indicators contained in the ISPC. This must be updated at least every three months.				

Q Consolidated

2.4	BS	**C**	The PC/ FH coordination regularly takes part in the meetings of the Municipal Health Council.	**(Y) (N)**
The standard considers the participation of the Coordination members in most Council meetings as possible, preferably, in 50% of the meetings. In the big size municipalities it is considered for an affirmative answer the participation in District or Local Councils.				

2.5	BS	**C**	The PC/ FH coordination get together with the public and social sectors of the municipality.	**(Y) (N)**
The standard points to the development of the intersectional approach and strengthening of the FH. Consider the meetings with the government sectors related to health, education, social assistance, environment and sanitation, as well as local organizations and social movements. The meetings must involve planning, execution and/ or evaluation of the actions. The answer must be affirmative when the meetings with one or more of the refereed sectors happen every three months.				

2.6	BS	**C**	The PC/ FH coordination has and makes available for the FHT an updated register of the municipality social resources.	**(Y)** **(N)**
The standard refers to the research, systematization and presentation for the FHS of the main services of social assistance, public utility, citizen assistance, consumer law and NGO of the municipality.				

Q Better

2.7	BS	**B**	The municipal experiences with the FH are presented in related congresses and encounters.	**(Y)** **(N)**
The standard considers, for an affirmative answer, one or more presentations per year. In municipalities over 500.000 inhabitants, it must be considered one annual presentation per health region/district.				

2.8	>100	**B**	The PC/ FH coordination develops initiatives of integration and partnership with academic institutions, enabling the realization of scientific production within Primary Care.	**(Y)** **(N)**
The standard points to the technical body with the capacity to formulate, reflect and interact with the academic institutions, promoting a knowledge/practices exchange and enabling the production of knowledge within this field.				

Assistence of the FHT

Q Development

2.9	BS	**D**	The PC/ FH coordination get together every month with the FHT.	**(Y)** **(N)**
A higher level comparing to 2.1, where there are guaranteed mensal meetings of the members of the team with the coordination, with established subjects and agenda.				

Q Consolidated

2.10	BS	**C**	The PC/ FH coordination assures to the FHT a weekly shift destined to team meeting.	**(Y)** **(N)**
It is understood as the dedication of 4 hours per week to the team meeting to aim the planning, evaluation, integration and knowledge exchange. The coordination is sensitized to the importance of this activity and gives the necessary support.				

2.11	BS	**C**	The PC/ FH coordination uses tools to the follow up of the actions and practices of the FH.	**(Y)** **(N)**
It means that the coordination develops or uses tools, such as: spreadsheets, graphs and indicators to follow up the performance of the FHT, enabling some comparative and temporal analyses, among others.				

2.12	BS	**C**	The PC/ FH coordination develops strategies to administrate conflicts between FH professionals.	**(Y) (N)**
It means that eventual conflicts and relationship problems in the work environment constitute a care focus for the coordination, which tries to solve them in a positive way, enabling the opening of communicative channels and the improvement of the FHT work environment.				

2.13	BS	**C**	The PC/ FH coordination evaluates the level of satisfaction of the professionals with the work and takes into account criticisms and suggestions in action planning.	**(Y) (N)**
The coordination performs a formal process of evaluation of the level of satisfaction of the professionals, dedicating special care to participative and ascendant management, enabling the opinions of the FHT to be internalized in the daily work routine.				

Q Better

2.14	BS	**B**	The PC/ FH coordination develops together with the teams strategies for facing the problems found in the care of the population.	**(Y) (N)**
The problems faced by the FHT are followed up by the coordination, which takes the necessary measures to solve them, specially the ones which hinder the quality of the client care.				

Q Advanced

2.15	BS	**A**	The PC/ FH coordination develops, together with the teams, tools for the organization and monitoring of the actions and practices of the FHT.	**(Y) (N)**
A more advanced level compared to 2.11. It means that the evaluations of the FH works happen in a participative way, enabling the sharing of the management decisions and the exchange in the formulation or proposal of the tools used in the monitoring.				

Permanent Education

Q Development

2.16	BS	**D**	The PC/ FH coordination offers preparatory courses to the FH workers.	**(Y) (N)**
The coordination prepares and executes (or joins other areas to do so) courses or encounters to discuss principles, guidelines and the work dynamic of the FH with the strategy workers.				

2.17	BS	**D**	The PC/ FH coordination regularly takes part in forums or encounters to the development of the Permanent Education.	**(Y) (N)**
The standard refers to the direct participation of the coordination members in local or regional activities related to the development of permanent education actions. Consider the maximum regularity possible, according the proposed schedule of encounters.				

Q Consolidated

2.18	BS	**C**	The PC/FH coordination decides together with the FHT the themes and activities to be developed in the Permanent Education.	**(Y) (N)**
There is an active participation of the professionals in the proposal of themes considered priority or necessities concerning permanent education.				

Q Better

2.19	BS	**B**	It is offered theoretical and practice formation in the basic areas to the FH professionals with a college degree who need so.	**(Y) (N)**
The coordination organizes theoretical and practice formation in the health basic areas (children, women, hypertension and diabetes, buccal, mental, sanitary surveillance, epidemiologic and environmental etc) to physicians, nurses and dentists who require or demonstrate lacks in its formation concerning the theme.				

2.20	>100	**B**	The technical areas and the FH develop, in an integrated way, Permanent Education activities.	**(Y) (N)**
The standard evaluates the effective and systematic participation of the technical areas of the MSH in the actions of permanent education developed by the PC/ FH coordination, supporting and making viable activities like the ones described at the standard 2.19.				

Q Advanced

2.21	BS	**A**	The PC/FH coordination enables the specialization within the area for the FHT professionals.	**(Y) (N)**
A more advanced level comparing to 2.19. There is a guarantee of specialization for the FHT professionals, obeying the technical criteria for priority such as time in service, interest, worthiness etc.				

Evaluation Management

Q Elementary

2.22	BS	**E**	The coordination evaluates the production of the FHT every month.	**(Y) (N)**
Although the FH develops actions in a way different from the logic by proceedings, based in the population and the territory, the evaluation of the team production is the most elementary action for the follow up of the developed actions results.				

Q Development

2.23	BS	**D**	The PC/ FH use the information of the ISPC as a management tool: evaluation, planning and monitoring.	**(Y) (N)**
The SIAB analysis works as a decision maker and is used for action improvement, in a systematic and regular way, by the coordination.				

2.24	BS	**D**	The PC/ FH coordination analyses every month the SIAB reports together with the FHT.	**(Y) (N)**
The SIAB analysis and its utilization as a planning and management tool occur with the teams' participation.				

Q Consolidated

2.25	BS	**C**	The PC/ FH coordination analyses data and reports of the SUS information systems or in health.	**(Y) (N)**
Every six months, analyses of the health situation and of the FH/ PC development are made using the data available at the Information Systems: SIM: Mortality Information System, SINASC: Information System on Live Births, SISVAN: Food and Nutrition Surveillance System, SINAN: Reportable Health Events Information System, SIPNI: Information System of the National Immunization Program, SIAB: Information System on Primary Care, SIA-SUS: SUS Hospital Information System and CNES: National Cadastre of Health Establishments.				

2.26	BS	**C**	The PC/ FH coordination elects criteria and indicators to evaluate the teams and the impact in the population's health condition.	**(Y) (N)**
The teams are involved in the analysis of the actions impact, using different indicators, or more specific ones, comparing to the ones that exist at the SIAB. The answer must be affirmative if this process is performed, at least, once a year.				

2.27	BS	**C**	The coordination analyses the demand of exams and guidance from FH observing if it fits the estimated necessity.	**(Y) (N)**
This is about the existence of a management mechanism to evaluate whether the amount of exams and guidance required by the FHT fits the client profile according the technically defined necessities.				

Q Better

2.28	BS	**B**	The PC/ FH coordination debates the results and plans the FH goals with the teams.	**(Y) (N)**
The PC/ FH planning is preceded by an evaluation with all the FH professionals, as well as a settlement of the performance and coverage goals, among others. This process must occur, at least, every six months.				

2.29	BS	**B**	The PC/ FH coordination gets together with the others MSH areas to debate the results obtained within the PC.	**(Y) (N)**
The results of the teams' work are presented and debated with the other sectors of Municipal Health, evaluating the actions' impact and the health profile. This standard is different from 2.5 where the focus is the development of the intersectional approach, legitimacy and support. Consider, to an affirmative answer, that there are formal meetings in order to achieve this goal, at least, every six months.				

Q Advanced

2.30	BS	**A**	The PC/FH evaluates the goals established for the Settlement of Indicators of the Primary Care with the FHT.	**(Y) (N)**
The coordination debates with the teams the proposed goals for the Settlement of Indicators of the Primary Care and monitors their goals, at least, every six months.				

2.31	> 20	**A**	Buccal Health Epidemiologic epidemiologics inqueries are gathered in the municipality.	**(Y) (N)**
The standard considers the minimum periodicity of four years to the realization of this kind of epidemiologic study.				

Normative Actions

Q Elementary

2.32	BS	**E**	The PC/ FH coordination makes available to all FHT a document with the principles and guidelines of the FH strategy.	**(Y) (N)**
The coordination has a written document with the principles and guidelines of the FH, and this document is available and accessible to all FHU professionals.				

2.33	BS	**E**	The PC/ FH use the written norm about facilities and equipment.	**(Y) (N)**
It refers to the use of updated technical documents, regulations of sanitary surveillance (formulated by the federal, state or municipal areas) concerning the establishment of a norm for the facilities and equipments of the FHU.				

Q Development

2.34	BS	**D**	The PC/ FH coordination makes available to all FHT updated information from the municipal reference and counter reference system.	**(Y) (N)**
There is information in all FHU, such as: documents, instructions, flowcharts, services list, guiding criteria or standardized behaviors, written, updated at least every six months, about the municipal reference and counter reference system.				

2.35	BS	**D**	The PC/ FH coordination makes available a manual of basic pharmacy medicine.	**(Y) (N)**
There is a manual, formulated by MSH itself or by other management area (state or federal), about the medicine used in the basic pharmacy. Consider, for an affirmative answer, that all teams have this material.				

Q Consolidated

2.36	BS	**C**	The PC/ FH coordination makes technical scientific support material about frequent situations in Primary Care available to the teams.	
Textbooks, manuals, technical reports or memorandum about sanitary risks, illnesses or monitoring situations frequent in PC are provided by the coordination to the FH professionals. This material does not refer to the informative material destined to the users.				

2.37	BS	**C**	The PC/ FH coordination makes technical scientific support material about the infectious and parasitic diseases of greater incidence in the country available to the team.	**(Y)** **(N)**
There are textbooks, manuals, technical reports or memorandum provided by the coordination to the FHU professionals. It is not being considered the informative material destined to the users.				

Q Better

2.38	BS	**B**	The PC/ FH coordination has a document establishing the conduct of each FH professional.	**(Y)** **(N)**
It refers to the existence, in the units, of a document or instruction paper, formulated by the MSH itself or another related area, establishing the conduct of each FH professional category concerning actions, behavior, procedures and activities (DOA, HCA, nurse assistants, dental surgeons, nurses, physicians and DH).				

2.39	BS	**B**	The PC/ FH coordination makes available to the FHT/ BH protocols and technical information about the approach in urgent situations.	**(Y)** **(N)**
There are manuals, routines, documents and protocols which guide and establish, in a technical perspective, the urgency assistance.				

Q Advanced

2.40	BS	**A**	The PC/ FH coordination makes available to the FHT/ BH protocols and technical information about the approach in Mental Health urgency situations.	**(Y)** **(N)**
There are manuals, routines, documents and protocols which guide and establish, in a technical perspective, the urgency assistance in Mental Health, specifically.				

Notes

Evaluation for Quality Improvement of the Family Health Strategy

Tool nº 3

Family Health Unit

FHU Infrastructure and Equipment

Q Elementary

3.1	BS	**E**	Each FHT has an consulting room with basic equipments to population assistance.	**(Y)** **(N)**

Basic Equipment to FH consulting room: gynecologic table, stethoscope, tensiometer, thermometer, standard view-box, lantern, rules for measuring children, tape measure, Pinard stethoscope, gynecologic swab of different sizes, focus, otoscope, as well as conditions for frequent hygiene of the hands and infantile and adult scales (these last items may serve for more than one clinic).

3.2	BS	**E**	The FHU consulting room enable visual and auditive privacy of the medical consultations.	**(Y)** **(N)**

The standard refers to the medical consultations not being able to be heard or viewed by people who are in a room adjacent to the location of the consultation, assuring ethics, privacy and secrecy. This can occur in many ways, according to the local conditions.

3.3	BS	**E**	The consulting room where gynecologic exams are performed must have, at least, a private dressing place.	**(Y)** **(N)**

This privacy may be assured according the existing conditions. It is fundamental that the gynecologic consultations occur in a humanized environment, respecting the principles of privacy and inviolability, besides the cultural references of the users.

3.4	BS	**E**	The HCA have basic equipments for external work.	**(Y)** **(N)**

Basic equipment for HCA: it is recommended that they have, at least, a vest or t–shirt, a clipboard, briefcase or backpack, cap, pencil, pen. The answer must be affirmative when there are available basic materials in all HCA of the FHU.

3.5	BS	**E**	The FHT have complete equipment and dental instruments to the regular performance of its activities.	**(Y)** **(N)**

The standard refers to the equipment composed by compressor, patient chairs, reflector, auxiliary unit with a cup stand for waste container and/or suction system, equipment with holder for multifunction syringe and two handpieces, foot control to activate the equipment, dental stool, amalgamator, photopolymerizer, sterilizer or autoclave and equipments of individual protection (EIPs). Consider also the necessary instruments to attend the expected demand. The basic list of equipments, instruments and input is published in the project website: http://dtr2002.saude.gov.br/proesf/autoavaliacaoesf/index.htm (click on Technical Proposal, then go to Technical Areas and then Buccal Health).

3.6	BS	**E**	Considering physical installations, the FHU has, in all rooms, adequate conditions to the development of basic health actions.	**(Y)** **(N)**

The standard refers to illumination, ventilation, floor, walls and ceiling conservation, hydraulic installations, electric installations, doors, windows, glasses and fire extinguisher, according the sanitary rules (physical installations, equipments and procedures) existing to the basic health units.

3.7	BS	**E**	The FHU has a covered space destined to be a reception and waiting room, with a number of seats according the expected demand.	**(Y)** **(N)**

This standard refers to a space in the FHU destined to the waiting of the users, making it possible for the users who arrive during the first hour after the opening of the unit to stay seated. The kind of seat may be of different types, according the local culture.

3.8	BS	**E**	The FHU has a refrigerator destined only to vaccines with temperature control to the immune biological preservation.	**(Y)** **(N)**

This piece of equipment reserved only to the exclusive use of immunization activity with temperature control is considered quality a Primary Care quality criteria.

Q Development

3.9	BS	**D**	The FHU programs the use and suitability of the places to the realization of curatives, inhalations, suture and patient observation.	**(Y)** **(N)**

The standard, when using the expression "use and suitability" of the places, refers to the current understanding of the HD that the spaces in the FHU may be multi functional, as long as the rules for its functioning are respected.

3.10	BS	**D**	The gynecological obstetric equipments are in sufficient number for the work of the FHT.	**(Y)** **(N)**

The FHU has instruments and materials for the gynecological obstetric assistance in enough quantity and sterilized conditions for the expected demand (enough not to cause interruptions or damages to the assistance). Instruments: small, medium and big swabs, Pozzi pincer, Cheron pincer, auxiliary pincer, tubs. Consumable materials: gloves, cotton, gauze, acetic acid, compress, alcohol, lugol, fixer solution, microscope slide for cytology, Ayre spatula and endo cervical brush.

Q Consolidated

3.11	BS	**C**	The number of FHU consulting room enables the simultaneous work of the FH doctors and nurses.	**(Y)** **(N)**

The standard refers to the existence of consulting room with basic equipments (3.1) in enough number so that the doctors and nurses of the FHT are able to perform patient care concomitantly and without interruptions in any working period of the FHU.

3.12	BS	**C**	The tensiometers and scales of the FHU are balanced according technical parameters.	**(Y) (N)**
Consider the answer affirmative when balancing and maintenance of these equipments occur, at least, every six months.				

3.13	BS	**C**	The HCA has other equipment for external work.	**(Y) (N)**
Among this equipment may be: shoes, sunscreen, umbrellas and parasols.				

3.14	>100	**C**	The FHU has a telephone line.	**(Y) (N)**
It is a phone line belonging to the FHU, not including public telephones or employees' cell phones.				

3.15	>100	**C**	The FHU has a computer set.	**(Y) (N)**
The FHU must have a set composed by, at least: a tower, monitor, keyboard, mouse, stabilizer and printer that are compatible and in good conditions, as well as the necessary supply for its functioning (paper, ink cartridges).				

3.16	BS	**C**	The FHU has a room reserved for team meetings, internal activities of the HCA and Continuing Education activities.	**(Y) (N)**
This room may be of multiple and alternate use, however it must be destined only for these activities. This room may be made possible in different ways, according the local conditions.				

3.17	BS	**C**	The FHU has other equipment to teams' assistance.	**(Y) (N)**
The standard refers to the existence in the FHU of an electrocardiograph and opthalmoscope as equipments that enable an increase in the PC resolubility.				

3.18	BS	**C**	The FHU has equipment for a first care in urgencies and emergency situations.	**(Y) (N)**
The standard refers to the FHU having: ambu, masks, guedel airway, gelco for bodking of vessels solutions for parenteral hydration and basic medicine to use in cardiac arrest.				

3.19	BS	**C**	The transport of the FH professionals to programmed external activities occurs in a MSH vehicle.	**(Y)** **(N)**
The answer must be affirmative when there is a MSH vehicle available to the assistance of the external activities programmed by the FHT.				

3.20	BS	**C**	The FHU has electronic equipments to educational activities.	**(Y)** **(N)**
The standard refers to presence of a television, videocassette and/or DVD and a sound system.				

3.21	BS	**C**	The dental clinics enable the DH and dental surgeon to work in an integrate way.	**(Y)** **(N)**
The physical disposal of the clinics, equipments and instruments (listed in 3.5) enables the concomitant assistance by the dental surgeon and the DH, in an integrated way.				

Q Better

3.22	>100	**B**	The FHU is equipped to assist people with special needs: ramps, handrail, door width, bathrooms, wheelchair.	**(Y)** **(N)**
Even though these structures are fundamental in any FHU, their existence qualifies as assistance care, broadening the access, equity and resolubility of the PC.				

Q Advanced

3.23	>100	**A**	The FHU has internet access and makes it available to the FH workers according defined criteria.	**(Y)** **(N)**
Internet is considered as an important resource for communication, obtainment of technical information and technical update (continuing education). The broadband internet in the FHU, available to the FH workers (with criteria) is an important quality brand of the PC.				

3.24	BS	**A**	The rooms where the gynecological exams occur have their own bathroom.	**(Y)** **(N)**
This standard refers to the ideal conditions for gynecological assistance, considering the client's comfort and privacy.				

Supplies, Immune-biologic and Medicines

Q Elementary

3.25	BS	**E**	The FHU performs, routinely, all vaccination in the basic schedule of the National and State Immunization programs.	**(Y) (N)**
For the National program consider the definitions of the Secretariat of Health Surveillance, Ministry of Health: http://dtr2001.saude.gov.br/svs/imu/imu02.htm				

3.26	BS	**E**	The FHU supplies on a regular basis and in enough quantity basic medicines prescribed in the treatment of the most frequent parasitic infections.	**(Y) (N)**
The standard refers to the supply of these medicines, covering the needs of 80% of the territory, in a regular frequency and programmed in a way that shortages are eventual and do not compromise the resolubility of the treatment. It may be calculated through the non assisted demand.				

3.27	BS	**E**	The FHT/FH has materials and supplies for the performance of educational activities with the population.	**(Y) (N)**
The standard considers that minimum supplies to educational health activities are cartridge paper or similar, atomic brushes, string, glue, scissors, albums.				

3.28	BS	**E**	The FHU supplies in a regular basis and in enough quantity medicines prescribed in the prevention and treatment of deficiency anemia and hypovitaminosis.	**(Y) (N)**
When using the expression "on a regular basis and in enough quantity", the standard refers to the supply of these medicines, covering the needs of 80% of the territory, in a regular frequency and programmed in a way that shortages are eventual and do not compromise the resolubility of the treatment. It must provide the assistance to pregnant women and children.				

Q Development

3.29	BS	**D**	The FHU has basic supplies in enough quantity for the regular development of the health actions.	**(Y) (N)**
Consider as basic supplies: cotton, gauze, sticking plaster, syringe, proceeding glove, thread for suture, bandages, tongue depressor, thermometer, inhalation masks. Eventual interruptions in the supply that do not disturb the continuity and quality of the care should not be considered.				

3.30	BS	**D**	The FHU has BH supplies in enough quantity to the development of the actions on a regular basis.	**(Y)** **(N)**
Eventual interruptions in the supply that do not disturb the continuity and quality of the care should not be considered.				

3.31	BS	**D**	The FHU has printed material in enough quantity to the regular development of the health actions.	**(Y)** **(N)**
For instance: application blank, prescriptions and requirements. Eventual interruptions in the supply that do not disturb the continuity and quality of the care should not be considered.				

3.32	BS	**D**	The FHU has glucometers and tape supply in enough quantity.	**(Y)** **(N)**
Equipment and input considered indispensable in the care of the diabetic population. Consider, for the tapes, adequacy of 80% of the demand.				

3.33	BS	**D**	The FHU supplies in a regular basis and in enough quantity antibiotics prescribed in the treatment of the most frequent infectious diseases, present in the MSH antibiotic standardised list	**(Y)** **(N)**
The standard refers to the supply of the antibiotics used in Primary Care. Covering 80% or more of the territory needs, in a regular and programmed frequency, in a way that the shortages are eventual and do not compromise the resolubility of the treatment.				

3.34	BS	**D**	The FHU supplies in a regular basis and in enough quantity the basic medicine prescribed in the treatment of systemic hypertension.	**(Y)** **(N)**
The standard refers to the supply of these medicines, covering 80% or more of the territory necessities, with regular and programmed frequency in a way that shortages are eventual and do not compromise the resolubility of the treatment.				

3.35	BS	**D**	The FHU supplies in a regular basis and in enough quantity the basic oral medicine prescribed in the treatment of diabetes mellitus.	**(Y)** **(N)**
The standard refers to the supply of these medicines, covering 80% or more of the territories necessities, with regular and programmed frequency in a way that shortages are eventual and do not compromise the resolubility of the treatment.				

Q Consolidated

3.36	BS	**C**	The FHU supplies on a regular basis and in enough quantity NPH insulin to the treatment of diabetes mellitus, out of proper storage in a refrigerator.	**(Y)** **(N)**
The standard refers to the supply of these medicines, covering 80% or more of the territory necessities, with regular and programmed frequency in a way that shortages are eventual and do not compromise the resolubility of the treatment				

3.37	BS	**C**	The FHU has the basic medicine prescribed in the first care of patients with hypertensive crisis according the local protocols, stored in adequate conditions.	**(Y)** **(N)**
The standard considers the medicines defined in clinical protocols, in enough quantity to meet the specified demand. The existence of this resource contributes to an increase of the PC resolubility.				

Q Better

3.38	BS	**B**	The FHU has inhalation medicines for asthmatic crisis, stored in an adequate place.	**(Y)** **(N)**
Attend 100% of the demand. The existence of this resource contributes to an increase of the PC resolubility.				

3.39	BS	**B**	The FHU has medicine to the treatment of gastrointestinal diseases.	**(Y)** **(N)**
The standard refers to the supply of these medicines, covering 80% or more of the territories necessities, with regular and programmed frequency in a way that shortages are eventual and do not compromise the resolubility of the treatment				

Q Advanced

3.40	BS	**A**	The FHU has the basic medicine prescribed in the first care of patients with epileptic crisis according the local protocols, stored in adequate conditions	**(Y)** **(N)**
Attend 100% of the demand. The existence of this resource contributes to an increase of the PC resolubility.				

Notes

Evaluation for Quality Improvement of the Family Health Strategy

Tool nº 4

Consolidation of the Family Health Care Model

Organization of the Work in the Family Health Strategy

Q Elementary

4.01	**E**	The registry of families is updated every month.	**(Y)** **(N)**
The standard refers to the fact that the families within the area are visited every month, enabling the updating of the A file card from ISPC.			

4.02	**E**	The domiciliary visit is a systematic and permanent activity of all FHT members.	**(Y)** **(N)**
In the FH strategy DV is considered a fundamental action, which must be developed by all team professionals in an integrated and complementary way. Through the DV, the team can get to know the community better, the risks associated with the territory, broaden the bond and identify the cases that need domiciliary care such as patients that need to stay in bed or patients with special needs. It is recommended that the doctor and the nurse dedicate at least four hours a week, each, toward accomplishment of this activity.			

4.03	**E**	The FH unit works every weekday, in two shifts.	**(Y)** **(N)**
The standard refers to the FH unit working with care assistance at least eight hours per day.			

4.04	**E**	The team develops permanent actions of clarification to the population about the FH strategy characteristics.	**(Y)** **(N)**
The standard refers to the FHT acting together with the community, in a permanent and systematic way (at least once every three months), clarifying the characteristics of the FH model in use in that area.			

Q Development

4.05	**D**	The FHT uses the ISPC information for the work planning.	**(Y)** **(N)**
The standard refers to the usage of the information in the file card A from ISPC to the planning of the FHT work: population, age group, diseases and living conditions, among others.			

4.06	**D**	The FHT works with a map of its acting area where the micro areas under the HCA's responsibility are distinguished.	**(Y)** **(N)**
The map of the FHT actuation area, distinguishing the micro areas under the HCA's actuation, is one of the most important initial actions to the structuring of team work in relation to its territory.			

4.07	**D**	The team makes a diagnosis of the population's health situation, identifying the most frequent problems.	**(Y) (N)**

The standard refers to the gathering of information in the file card A (ISPC) associated to the mapping of the risky areas and interviewing community leaderships. Other sources of information can be the IBGE, health information systems and press data.

4.08	**D**	Domiciliary Care is planned considering the indications for the actuation of the FHT professionals.	**(Y) (N)**

The standard refers to the existence of a planning in domiciliary care considering professional specificity and the need of intervention, searching to improve and integrate the performance of the team professionals with a college degree.

4.09	**D**	The handbooks are organized by familiar nucleus, strengthening the FH care model.	**(Y) (N)**

The standard refers to the organization of the familiar handbook in which there are the individual handbooks. These may be organized by micro area. This way of organization may be developed in the cases of computer handbooks.

Q Consolidated

4.10	**C**	The FHT has registers of various aspects of the territory and its population.	**(Y) (N)**

It is a more advanced level compared to 4.5, showing a more profound analysis on the health situation of the families and people of the territory. The team aims to know and register demographic, socioeconomic, ethnic, cultural, environmental and sanitary aspects of the enrolled area.

4.11	**C**	The activities schedule is defined by the team members altogether and is based on the analysis of the area health situation.	**(Y) (N)**

It is a more advanced standard comparing to 4.3, showing that a work process is being improved: the team members gather to formulate the schedule and use the data of the analysis of the territory health situation, arranging the time and the kind of activity to be developed according the profile.

4.12	**C**	The FHT registers and monitors the references to other care levels.	**(Y) (N)**

The guiding to the references (specialized cares) is systematically registered in another medium besides the medical handbook, enabling flow monitoring: assisted/non assisted cases, waiting time and return of the information to the units (counter reference). The answer must be affirmative when the proposed actions are contemplated: register and follow up.

4.13	**C**	The FHT registers and monitors requirements of diagnostic exams.	**(Y) (N)**

The requirement of exams is systematically registered in another medium besides the medical handbook, enabling flow monitoring: assisted/non assisted cases, waiting time and return of the information to the units (counter reference). The answer must be affirmative when the proposed actions are contemplated: register and follow up.

4.14	**C**	The FHT notifies the users about scheduling of specialized appointments and or exams.	**(Y) (N)**

The standard refers to the team professionals locating and communicating, directly to the users, the time and place of the exams and appointments that were scheduled by the team.

4.15	**C**	The FHT dedicates a part of the week for the team meeting.	**(Y)** **(N)**

The standard refers to a period up to four hours per week that the team dedicates to a meeting with all it's the members, with or without the coordination. The goal of this activity is to discuss the cases, the actions planning, evaluations, conflicts resolution and knowledge exchange. To the teams that assist country areas, the standard considers two monthly meetings of four hours each.

4.16	**C**	The FHT dedicates a monthly meeting to the evaluation of the results reached and the planning of the continuity of the actions.	**(Y)** **(N)**

The standard refers to the FHT dedicates one of its meetings every month, with or without the coordination, to the evaluation of the results reached and the planning of the continuity of the actions. The standard does not consider the meetings dedicated to the operationalization of the data to the ISPC, in which evaluation and planning actions are not included.

Q Better

4.17	**B**	The FHT monitors the search for the types of service being required, verifying the assistance percentage.	**(Y)** **(N)**

The FHT studies the flow of assistances in the FHU making a register and monitoring the search for kind of care (consultations of children, women, hypertenses, exams, procedures and others), verifying the assistance percentage of the demand.

4.18	**B**	The maps of the team work are updated and show dynamics situations of the territory and its population.	**(Y)** **(N)**

It is a higher standard comparing to 4.6. Besides the areas under the HCA's responsibility, the FHT work maps distinguish the main community resources, the regions of greater vulnerability/risk, follow up of epidemiologic situations, among other things. It indicates the perfecting of the work with more dynamic and informative maps, the live maps.

4.19	**B**	The FHT works the diagnosis, the planning and the realization of the actions for the territory in an integrated way.	**(Y)** **(N)**

The standard comprehends that the members of the FH and BH teams develop actions of analyses of the health situation, planning and intervention together with the population, in an integrated and complementary manner.

Q Advanced

4.20	**A**	The FHT organizes a "situation panel" with maps, data and health information of the territory.	**(Y)** **(N)**

The standard refers to a resource of organization and planning also known as health scoreboard, health panel or yet billboard or situation room, depending on the region. It consists in a mural or panel in an accessible place, in which the FHT has the data, information and even maps of the region and of the team work, enabling visual follow up by the professionals and the community. Consider for an affirmative answer that it is updated every three months.

4.21	**A**	The FHT has a semester evaluation of achieved results.	**(Y)** **(N)**

Standard achieved, indicating the presence of an evaluative culture in the service. The team gathers every six months, with or without the coordination, and conducts a comparative analysis of the population's health profile, the coverage and impact of the actions, using indicators previously established.

Commitment, Humanization and Responsibility

Q Elementary

4.22	**E**	There is a differentiated assistance for the families in situations of risk, high vulnerability and or social isolation.	**(Y) (N)**

The team knows and assists in a different way the families in situations of risk, high vulnerability and or social isolation. Consider it an affirmative answer when concrete actions concerning these families may be presented, such as: greater number of DV, priority in the scheduling of consultations, mobilization of the social net, among others.

4.23	**E**	The information about the functioning of services is available to the users in a clear and accessible way.	**(Y) (N)**

The standard refers to the team being sensitized and provides the population information that enables a greater and better use of the available services. The standard considers that the information is transmitted to the users orally and in writing, through placards placed at the FHU reception, for instance. Consider it an affirmative answer when all members of the team act in the way indicated by the standard.

Q Development

4.24	**D**	There is special care and assistance for the users in illiteracy situation and social exclusion concerning the service access and utilization.	**(Y) (N)**

The team members are sensitized and bear special careand clarification to the individuals with difficulty to obtain information and/or comprehend the recommendations due to illiteracy and others situations of social exclusion. These actions of commitment and humanization are fundamental to broaden the access and equity. Consider the answer affirmative when all team members act in the way indicated in the standard.

4.25	**D**	There is guiding criteria differentiating situations of immediate care of the programmed ones.	**(Y) (N)**

The standard refers to the existence of a guiding document or protocol with orientations for the performance of resolutive commitment (distinguishing situations of scheduling and instant attendance), available to the team professionals. These may have been created by the team itself, as well as by the coordination, MSH or other instance.

4.26	**D**	Resources for the registering of suggestions and complaints are available to the users.	**(Y) (N)**

The standard refers to the availability and facilitation of the access to the urn, book, or other less formal mechanisms of register (notes taken by the professionals when in direct contact with the population), of suggestions and complaints, being that the users secrecy is guaranteed.

Q Consolidated

4.27	**C**	The FHT offers another schedule for the care of families that can not attend during the customary functioning period of the FHU or team work.	**(Y) (N)**

The standard refers to the FHT planning its 40 weekly hours enabling special schedules (after 6 p.m., or before 7 a.m., among others), to the assistance of family members who can not attend during the customary functioning period of the FHU.

4.28	**C**	During all the functioning period of the FHU people there are listening to and caring for the users.	**(Y) (N)**

The standard refers to the reception of the users in integral period, listening to the demand in an appropriate space of the FHU, by a team professional. From this qualified listening the actions and more appropriate services are determined, according the need of the users and the established clinical criteria.

4.29	**C**	The FHT evaluates and answers the suggestions and complaints, enabling attendance to requests.	**(Y) (N)**

A higher standard comparing to the 4.26 referring to the weekly analysis of suggestions and complaints formally received (written in urn, or book) or informally received, guiding the answers and actions to request attendance.

Q Better

4.30	**B**	The FHT develops initiatives to stimulate the development of autonomy, self care and the co responsibility of the users.	**(Y) (N)**

The standard refers to the FHT developing initiatives such as: operative groups, workshops or similar activities having as a main axle the development of autonomy, self care and the co responsibility of the users. Consider the answer affirmative when concrete experiences may be presented.

4.31	**B**	There is monitoring of the average waiting time for services.	**(Y) (N)**

The FHT studies the attendance flow (demand), monitoring the average time between the moment of the user's need (scheduling) and the attendance of that service. From this analysis one may find solutions to reduce the waiting time for the services. The standard considers only the services performed by its own team: consultations and procedures. This monitoring can occur by sampling.

Q Advanced

4.32	**A**	The FHT is sensitized to approach questions related to stigmas, prejudice and racism, promoting a better utilization of the health services.	**(Y) (N)**

The FHT is attentive and sensitized, noticing and approaching in the right way, at the FHU and at the community, situations in which subjective processes such as: stigma, prejudice and racism exclude and make more difficult the access of the users to the health services. Consider the answer affirmative when all team members act in the way indicated by the standard.

4.33	**A**	The services are available with no time restriction by life cycles, pathologies or specific population groups.	**(Y) (N)**

The standard refers to the offer of the services bases itself in a flexible and sensitive organization, which conciliates the action planning to the population needs. In this situation, the planning of the actions by life cycles, pathologies or specific population groups are references to assure the interests and needs of the users.

Health Promotion

Q Elementary

4.34	**E**	There are developed strategies to stimulate healthy nutrition, respecting the local culture.	**(Y)** **(N)**

The standard refers to the team getting acquainted with the habits, culture and food used by the local population and promoting the integration of its technical orientations to these aspects in the performance of health education activities (operative groups, lectures and workshops) to stimulate healthy nutrition.

Q Development

4.35	**D**	Actions directed at the promotion of health environments are organized, respecting the local culture.	**(Y)** **(N)**

Educational activities are developed such as lectures and operative groups, preferably with a participative methodology, searching to broaden the knowledge about situations of sanitary, environmental and ecologic risk. These actions may occur in partnership with NGOs or other institutions. To an affirmative answer consider the minimum frequency of every three months.

4.36	**D**	Strategies to face major local social problems are developed together with the population.	**(Y)** **(N)**

The standard refers to the team meeting the community, in a systematic way, aiming to know the social problems and formulate plans, projects and concrete strategies to fight them.

4.37	**D**	The FHT develops educational groups and groups of parent acquaintanceship, approaching subjects of children's health.	**(Y)** **(N)**

The standard refers to the FHT performing monthly, with the children's parents in puericulture follow up, groups with educational and acquaintanceship aspects, during which subjects related to children's global care are approached: nutrition, growth, stimuli to development, immunization, accident prevention, sleep, hygiene habits, limits and affection, among others.

4.38	**D**	The FHT organizes educational and acquaintanceship activities with the hypertension people under care.	**(Y)** **(N)**

The standard refers to the organization, by the FHT members, of educational and acquaintanceship groups with the hypertension people of the area, every two months, respecting the local culture and habits.

4.39	**D**	The FHT performs educational and acquaintanceship actions with the diabetics under care.	**(Y)** **(N)**

The standard refers to the performance, by the FHT members, of educational and acquaintanceship groups with the diabetics of the area, every two months, respecting the local culture and habits.

Q Consolidated

4.40	**C**	Systematic actions of health education at schools and child care centers talking about children's health are developed.	**(Y) (N)**

The standard refers to the development of actions and approaches to the subjects related to children's global health, performed at least twice a year by the FH teams. Consider the last twelve months to evaluate the standard.

4.41	**C**	Systematic actions of health education at schools approach the health of adolescents and young people are developed.	**(Y) (N)**

The standard refers to the development of actions and approaches to the subjects related to the health of adolescents and young people, performed at least twice a year by the FH teams. Consider the last twelve months to evaluate the standard.

4.42	**C**	The FHT develops educational groups approaching the subjects of sexuality and STD/AIDS prevention.	**(Y) (N)**

The standard refers to the FHT develops educational groups with the adult population of the area approaching themes related to sexuality and DST/AIDS prevention, at least, every three months.

4.43	**C**	The FHT develops collective actions of socialization, health promotion and improvement of the life quality for the elderly.	**(Y) (N)**

The standard refers to the FHT members developing monthly, collective actions of socialization, health promotion and improvement of the life quality for the elderly trough acquaintanceship groups or other activities in the community, such as: visits to cultural places, promenades, parties etc.

4.44	**C**	The FHT develops educational activities with the elderly approaching contents related to their rights and the Elderly Statute.	**(Y) (N)**

The standard refers to the FHT knows, values and develops educational activities with the elderly approaching subjects related to their rights and the Elderly Statute.

4.45	**C**	The FHT develops educational and/or preventive actions concerning domestic violence.	**(Y) (N)**

The team alone or in a partnership with a NGO, organizations and social movements performs campaigns and/or meetings for clarification concerning conflict solving, non violence attitudes/behaviors and disarmament. The main victims of domestic violence are children and women.

4.46	**C**	The FHT stimulates, develops and or follows up activities within the field of corporal practices with the population.	**(Y) (N)**

The standard refers to the performance of some activities such as stretching, capoeira, walking, dance and oriental practices (liang-cong, tai-chi-chuan, Chi-cong and others) by authorized professionals. Consider as affirmative, also, if the actions are developed in partnership with social organizations.

4.47	**C**	The FHT develops strategies to the integration between the popular knowledge and the technical scientific knowledge.	**(Y) (N)**

The standard refers to the development and register of concrete and systematic actions in the field of popular health practices. There may be considered actions developed together with the Child Pastoral and/or other pastoral, social movements, native magicians, among other social actors, in the perspective of knowledge exchange and integration.

Q Better

4.48	**B**	The team plans, executes and follows up the actions in its acting area in partnership and/or informal articulation with NGO, associations, councils, churches and social movements.	**(Y)** **(N)**

The FHT plans and executes projects and actions in partnership with public organisms, organizations and social movements, contemplating the diagnosis of the health necessities/ community problems and its confrontation.

4.49	**B**	The FHT develops operative groups approaching contents of sexuality and DST/AIDS prevention with the elderly.	**(Y)** **(N)**

The standard refers to the FHT being sensitized and able to approach contents of sexuality among the elderly and DST/AIDS prevention, developing these through operative groups with the elderly.

4.50	**B**	The FHT develops actions of health education with a problematic approach.	**(Y)** **(N)**

It is used the problematic approach, according the Net of Popular Education in Health. See site: www.redepopsaude.com.br

4.51	**B**	The FHT develops actions for the integration of the mental patients in regular collective activities.	**(Y)** **(N)**

The standard refers to the insertion of the mental patients in FHT operative groups, workshops, activities of community acquaintanceship, cultural, leisure etc. To an affirmative answer consider the participation of these users in monthly activities.

Q Advanced

4.52	**A**	The FHT performs educational and/or preventive actions concerning traffic accidents.	**(Y)** **(N)**

The team alone or in partnership with NGO, organizations or social movements performs campaigns and or/ elucidation meetings concerning traffic care, including orientations about trampling. Educational actions may occur at schools, public squares etc. the answer must be affirmative when the actions occur at least every six months.

4.53	**A**	There are initiatives in progress, performed together with the population, with emphasis in the community development.	**(Y)** **(N)**

The standard refers to the existence of initiatives emphasizing community development, in which the team participates or performs together with the population and or social movements: community vegetable garden, activities to gain money and literacy, among others. To an affirmative answer, consider experiences working continuously in the last 24 months.

4.54	**A**	The assistance of alcohol and other drugs users in the perspective of damage reduction and strengthening of the community and social network is performed.	**(Y)** **(N)**

The standard refers to the FHT aware of the perspectives of damage reduction and strengthening of the community and social network, and assisting the users of alcohol and drugs who are under treatment.

Community Participation and Social Control

Q Development

4.55	**D**	The FHT debates regularly with the community themes of citizenship, right to health and SUS functioning.	**(Y)** **(N)**

The standard refers to the FHT develops, at least once every three months, lectures, operative groups or other participative activities in which themes like citizenship, right to health and SUS functioning are the main focus. These actions may be developed together with other public organisms or social organizations.

Q Consolidated

4.56	**C**	The FHT meets with the community every three months to debate the local health problems, the assistance given and the results obtained.	**(Y)** **(N)**

The standard refers to meetings with the community and or its representatives, once every three months, to debate and evaluate health problems, the assistance given and the results of the developed actions, registering in the appropriate medium, the relevant aspects and guidance.

Q Better

4.57	**B**	The FHT takes part in meetings with health councils.	**(Y)** **(N)**

The standard considers the participation of one or more integrants of the team in meetings with health councils (Local Health Council, District and or Municipal Health Council). Consider as affirmative answer if the frequency is higher or equals to 75% of the reunions, being considered valid the participation in turns among the team integrants or the formally elected members, with right to vote.

Q Advanced

4.58	**A**	There is participation of representatives of the social movements and users in the process of FHT work planning.	**(Y)** **(N)**

The standard refers to community representatives and social movements participating in an effective way in the process of action planning to be achieved by the team, searching to broaden the comprehension towards the health needs of the population and improve interchange. To an affirmative answer consider the presence of the community representatives in monthly planning meetings in the last twelve months.

Health Surveillance I: General Actions

Q Elementary

4.59	**E**	The FHT develops monitoring actions of the nourishment and nutrition situation of the population.	**(Y)** **(N)**

It refers to the activities of identification, registering, assistance and follow up of children and pregnant women, registering data at SISVAN, according the Technical Norm of Nourishment and Nutrition Surveillance (http://portalweb01.saude.gov.br/alimentacao/documentos/orientacoes_basicas>_sisvan.pdf).

4.60	**E**	The FHT professionals perform an active search to the detection of new cases of Systemic Arterial Hypertension in the population.	**(Y)** **(N)**

The standard refers to the regular performance of activities in the community concerning the detection of arterial hypertension, including the measure of arterial hypertension (www.saude.gov.br/hipertensao-diabetes).

4.61	**E**	The HCA develop educational actions in the community aiming the eradication of domiciliary focus of *Aedes aegypti*.	**(Y)** **(N)**

The standard refers to the development of systematic actions by the FHT together with the community to the eradication of the domiciliary focus of *Aedes aegypti* orienting (and sometimes organizing quilting bees) towards tires, bottles, plant vases, water tanks etc. Consider to an affirmative answer, at least, one monthly activity in the period from September to March.

4.62	**E**	The FHT performs a compulsory notification of the diseases or sends a weekly negative report.	**(Y)** **(N)**

The FHT knows and performs proceedings related to the compulsory notification of diseases, contributing to the nourishment of the Reportable Health Events Information System – SINAN.

Q Development

4.63	**D**	The FHT performs actions in order to detect new cases of tuberculosis.	**(Y)** **(N)**

Actions to detect tuberculosis are performed, including active searches among the communicants and other suspicious cases (chronic cough).

4.64	**D**	The FHT develops actions having as a focus sanitary and environmental surveillance.	**(Y)** **(N)**

The standard refers to the team developing, with the population, in a regular and permanent way, actions focusing on the environment, of an educative or interventional character, approaching questions like: manipulation and conservation of the food etc.

Q Consolidated

4.65	**C**	The FHT performs an active search to detect new cases of diabetes Mellitus in the population.	**(Y)** **(N)**

The standard refers to the regular performance of activities in the community to detect new cases of Diabetes Mellitus, including the realization of capillary glycemia (www.saude.gov.br/hipertensao-diabetes).

4.66	**C**	The FHT performs actions to detect new cases of Hanseniasis.	**(Y)** **(N)**

Actions to the detection of Hanseniasis are characterized by the active search among communicators and other suspicious cases.

Q Better

4.67	**B**	The FHT develops actions to identify risky situations among the elderly population.	**(Y)** **(N)**

The standard refers to the FHT being sensitized and aware of the risky situations to which the elderly population is exposed: abandonment, depression, nutritional lacks, domestic accidents, intoxications through self medication, among others. In this way, domiciliary visits and meetings with the community may enable actions of identification of these situations. Consider the answer affirmative when all team members act in the way indicated by the pattern.

4.68	**B**	The FHT is sensitized to identify and act in situations of sexual and domestic violence.	**(Y)** **(N)**

The identification of cases through a direct communication channel through the victims/neighbors or during domiciliary visits constitutes a fundamental step to counseling, prevention and combating this kind of violence. Actions like notification and activation of the available resources in other public organisms are mandatory. Consider the answer affirmative when all team members act in the way indicated by the pattern.

Q Advanced

4.69	**A**	The FHT assists the population's health according its ethnics origins concerning the risks and vulnerability associated.	**(Y)** **(N)**

The standard refers to the team knows and be sensitized concerning health problems and risks that occur in a more intense manner in certain ethnic groups. Prejudice is of a positive aspect aiming a greater care to these segments of the population. In Brazil, there is the development of guidelines and actions concerning the health of afro-brazilian population. Consider the answer affirmative when all team members act in the way indicated by the pattern.

4.70	**A**	The FHT develops actions of surveillance in the territory, having as its focus the reduction of risks to the worker's health.	**(Y)** **(N)**

The FHT is sensitized to the occurrence of risks, diseases and health problems related to occupational health (http://www.opas.org.br/saudedotrabalhador). Consider the answer affirmative when all team members act in the way indicated by the standard.

Notes

Evaluation for Quality Improvement of the Family Health Strategy

Tool nº 5

Health Care

Children's Health

Q Elementary

5.1	**E**	There is an updated register of children up to five years old.	**(Y) (N)**

The standard refers to the FHT having, registered and documented on paper, its child population up to five years old, discriminated by age (year by year) and gender, updated monthly. From the knowledge of this population it is possible to develop many other actions indicated in the higher quality levels. Answer in an affirmative way when the updating is permanent, including the updating of the information system.

5.2	**E**	The child's card or note book is evaluated and filled out at every situation of search for care.	**(Y) (N)**

The standard refers to every team member knows the child's card or note book, and be sensitized to the importance of this tool in the follow up of the infantile population requiring its presentation by the parents or responsible ones and evaluating it (and filling it out whenever it is necessary), in all situations of search for care.

5.3	**E**	All FHT members are able to recognize and orient actions in cases of child dehydration.	**(Y) (N)**

The standard refers to all FHT members being able to recognize the main symptoms of child dehydration and being able to orient the preparation and giving of the oral re hydration solution or the oral re hydration salts distributed or bought in drugstores.

5.4	**E**	The FHT develops systematic, collective and individual actions of incentive to breastfeed in prenatal and puerperium.	**(Y) (N)**

The standard refers to the FHT stimulating and orienting breastfeeding, in groups of pregnant women or to each one individually when it is necessary, with programmed regularity. The ideal is that these actions happen every month, during prenatal appointments.

5.5	**E**	80% or more of the children of the area up to one year old are under growth and development assistance.	**(Y) (N)**

The standard refers to the coverage of the periculture actions, specifically the assistance component of G&D, in the population of children up to one year old within the FHT acting area. It is aimed the realization of, at least, seven consultations in the first year: 15 days, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months. Consider for an affirmative answer the coverage with seven consultations, no matter the moment they happened.

5.6	**E**	90% or more of the children of the area up to one year old have their vaccination updated.	**(Y) (N)**
The standard refers to the coverage of the puericulture actions, specifically the immunization component, in the population of children up to one year old of the FHT acting area.			

Q Development

5.7	**D**	The FHT performs the approach of the danger/risk signs in the children brought to the FHU assistance, establishing priority in the assistance and follow up.	**(Y) (N)**
The standard refers to the flow chart "Approach of children's risk in the health unit" presented at page 73 of the Agenda of Appointments for Children's Complete Health and Reduction of Infantile Mortality, published in 2004. If the FHT uses any other flow chart or protocol, it is mandatory that the situations of immediate assistance by the doctor are established (http://dtr2001.saude.gov.br/bvs/publicacoes/agenda_compro_crianca.pdf).			

5.8	**D**	80% or more of the children up to 5 years old, in situation of risk, are being assisted by the FHT.	**(Y) (N)**
The standard refers to the FHT having a register of the population up to five years old; identify the ones who are in situations of risk (Agenda of Appointments for Children's Comprehensive Health and Reduction of Infantile Mortality, MS, 2004 – http://saude.gov.br/bvs/publicacoes/agenda_compro_crianca.pdf) and follow them up every month through medical appointments and nursing, DV, guidance and regular operative groups. Period for evaluation: last 12 months. Calculate the percentage for each month as in the standard 5.5, considering as a denominator the total child population in situation of risk. Calculate the simple average among the 12 months evaluated.			

5.9	**D**	80% or more of the NB got two consultations within their first month of life.	**(Y) (N)**
The standard refers to the actions defined by the First Week of comprehensive Health (Agenda of Appointments for Children's Comprehensive Health and Reduction of Infantile Mortality, MS, 2004 – http://saude.gov.br/bvs/publicacoes/agenda_compro_crianca.pdf). Consider the last 12 months for the evaluation of the standard indicator.			

Q Consolidated

5.10	**C**	80% or more of the children between one and five years old of the area are being assisted by the FHT.	**(Y) (N)**
The standard refers to the FHT having a register of the population between one and five years old and assisting them through medical consultations and nursing, DV, guidance and regular operative groups, concerning the growth, development and immunization. Consider the last 12 months to the evaluation of the standard indicator. Consider at least two evaluations per year to children between 12 and 24 months. After this age, consider one consultation per year.			

5.11	**C**	The team assists the buccal health of the children up to five years.	**(Y) (N)**
The standard refers to the FHT having a register of the population between one and five years old and assisting them, concerning the buccal health, at least, when it comes to teeth development, maintenance of the buccal health and the continuance of oral habits harmful to the normal establishment of the bite pattern (suction of the finger and pacifier, for instance). It is included here the incentive to breastfeeding and parents guidance.			

5.12	**C**	The FHT develops actions of assistance of children with asthma according the clinic protocol established.	**(Y) (N)**
The standard refers to the conjunct of actions developed in an integrated way by the team professionals, considering their various attributions, to the detection, diagnosis and treatment of asthma in the infantile population, according the clinic protocol, aiming to reduce the hospitalizations and mortality due to respiratory diseases.			

5.13	**C**	The prevalence of exclusive breastfeeding up to 30 days is 90% or more.	**(Y) (N)**
The standard refers to the monitoring of the prevalence of exclusive breastfeeding up to 30 days of life. Period of evaluation: 12 months.			

Q Better

5.14	**B**	There was a reduction of the absolute number of hospitalizations by acute respiratory infections in the population up to five years old, or absence of cases.	**(Y) (N)**
Consider the period of 24 months to the evaluation of this standard indicator. The data are contemplated at the SIAB, being also one of the indicators in the Indicators of Primary Care Pact. It aims to evaluate if the actions directed to the infantile population are influencing the health indicators. The standard demands only that the hospitalizations in an absolute number are in constant downfall in this age group by the FHT members (see SIAB).			

5.15	**B**	The malnutrition among children under 2 years old is in downfall or does not exist.	**(Y) (N)**
The standard refers to the monitoring of malnutrition in the population up to two years old, observing if within the period comprehended by the last 24 months the curve is descendant or there were no cases. It implicates in the follow up of the weight of the population in this age group by the FHT members (see SIAB).			

5.16	**B**	There was a reduction of the absolute number or absence of cases of NB under weight at birth.	**(Y) (N)**
The standard refers to the monitoring of the weight of the NB in the population, observing whether, in the last 24 months, there has been a reduction or absence of the absolute number of NB who were born underweight. This standard reflects, mainly, the cares assisted during prenatal.			

5.17	**B**	All neonatal deaths are investigated.	**(Y) (N)**
The standard refers to the FHT participation in the investigation of all children's deaths between 0 and 27 days, weighting more than 1.500 g. The guidance to the investigations is described at the Manual of the committees of fetal and infantile death prevention of the HD (2004) - http://dtr2001.saude.gov.br/bvs/publicacoes/MS_manual_finalizadoOBITOS.pdf. Answer in an affirmative way to the standard in the case of absence of known deaths in the last 12 months.			

5.18	**B**	The prevalence of exclusive breastfeeding at 6 months old is of 60% or more.	**(Y) (N)**
The standard refers to the monitoring of the prevalence of exclusive breastfeeding up to six months old.			

5.19	**B**	The sealing of the four first molars occurs in cases with clinical advisement.	**(Y) (N)**
The standard refers to the action performed by the BHT in the infantile population between 5 and 7 years, according a clinic advisement.			

Q Advanced

5.20	**A**	80% or more of the children in the area between 5 and 10 years old are being assisted by the FHT.	**(Y) (N)**

The standard refers to the FHT having a register of the population between 5 and 10 years old and assisting them through medical and nursing consultations, DV, guidance and regular operative groups, concerning G&D and immunization. Consider at least one evaluation per year for the children between 5 and 10 years old.

5.21	**A**	All infantile deaths occurred in the last 12 months were investigated.	**(Y) (N)**

The standard refers to the FHT participation in the investigation of all deaths of children up to 1 year old, born weighting 1.500 g or more (neonatal and postnatal) and also the fetal deaths (stillbirths) weighting 2.500 g or more at birth. The guidance to the investigations is described at the Manual of the committees of fetal and infantile death prevention of the MH (2004) - http://dtr2001.saude.gov.br/bvs/publicacoes/MS_manual_finalizadoOBITOS.pdf. Answer in an affirmative way to the standard in the case of absence of known deaths in the last 12 months.

5.22	**A**	The prevalence of breastfeeding at 12 months is of 70% or more.	**(Y) (N)**

The standard refers to the monitoring of the prevalence of the non exclusive breastfeeding in the population up to 12 months.

5.23	**A**	80% or more of the NB got a consultation in their first week of life.	**(Y) (N)**

The standard refers to medical or nursing consultation. See actions defined in the First Week of Comprehensive Health (Agenda of Appointments for Children's Comprehensive Health and Reduction of Infantile Mortality, MS, 2004 – http://saude.gov.br/bvs/publicacoes/agenda_compro_crianca.pdf). Consider the last 12 months for the evaluation of the standard indicator.

5.24	**A**	There was a reduction of the ceo-d indicator in the population from 5 to 6 years old in the last 24 months.	**(Y) (N)**

This indicator demonstrates resolubility in the buccal health care, especially in its component of dental cavity prevention. Consider, for the evaluation of the standard indicator, the last 24 months.

Adolescent's Health

Q Development

5.25	**D**	The FHT has an updated register of the adolescents of the area.	**(Y) (N)**

The standard refers to the FHT having, registered and documented in paper, the number of teenagers (SIAB: 10 to 14 and 15 to 19 years old), distinguished by gender, of the FHT enrolled area, updated every six months. From the knowledge of this population it is possible the development of many other actions indicated in the higher quality levels. Answer affirmatively when the updating is permanent, including the updating of the information system.

Q Consolidated

5.26	**C**	50%or more of the registered adolescents have the vaccination updated.	**(Y) (N)**
The standard refers to the FHT having a register of the population from 10 to 14 and 15 to 19 and following them up through consultations, DV and regular operative groups, concerning immunization. Consider the vaccines recommended by the MH or SSH for the age group. Consider the last 12 months for the evaluation of the standard indicator.			

Q Better

5.27	**B**	50% or more of the adolescents assisted with a consultation for growth and development evaluation.	**(Y) (N)**
The standard refers to the FHT having a register of the population from 10 to 14 and 15 to 19 and following them up through medical and nursing consultations, DV and regular operative groups, concerning G&D. Consider an annual evaluation. Consider the last 12 months for the evaluation of the standard indicator.			

5.28	**B**	The FHT develops educational activities to the adolescents about sexual and reproductive health.	**(Y) (N)**
The standard points to the development of actions and approaches of specific contents of sexual and reproductive health of the adolescents, offering contraceptive methods (condoms, oral and injected contraceptives, according the advisement), and performed at least twice a year. Consider the last 12 months for the evaluation of the standard.			

Q Advanced

5.29	**A**	There was a reduction of the non planned pregnancies among the adolescents assisted by the FHT.	**(Y) (N)**
The standard refers to the monitoring of the incidence of non planned pregnancies among the population between 15 and 19 years old, assisted by the team. Consider the last 24 months. Consider to an affirmative answer the reduction of the absolute number of cases within the period.			

5.30	**A**	There was a reduction of the CPO-D indicator in the 12 year old population over the last 24 months.	**(Y) (N)**
This indicator demonstrates resolubility in the buccal health care, especially in its component of dental cavity prevention. Consider, to the evaluation of the standard indicator, the last 24 months.			

Adult Women and Men's Health

Q Elementary

5.31	**E**	The FHT has an updated register of the adults of the area by gender and age group.	**(Y) (N)**
The standard refers to the FHT having, registered and documented in paper, the number of adults (20 to 59 years old) of the FHT enrolled area, distinguished by age groups (see SIAB) and gender. From the knowledge of this population it is possible the development of many other actions indicated in the higher quality levels. Answer affirmatively when the updating is permanent, including the updating of the information system.			

5.32	**E**	There is a wide access to the low risk prenatal by the population.	**(Y) (N)**
The low risk prenatal, with offer of consultations, laboratory routine exams and tetanus immunization, performed in an alternate and complementary way (medical and nursing consultations), is considered one of the most elementary actions of the Primary Care, impacting in a very positive way the maternal-infantile indicators. It is recommended the realization of 4 to 6 consultations. The minimum evaluation has: nutritional evaluation, PA measure, uterine height, auscultation of the focus (after the 4º month).			

5.33	**E**	There are performed educational activities during prenatal approaching themes related to pregnancy, deliverance and puerperium.	**(Y) (N)**
The standard refers to the monthly performance of educational activities, linked to consultations, with the pregnancy population in prenatal care, in a regular and programmed way, approaching themes related to pregnancy, deliverance, puerperium and cares with the NB.			

5.34	**E**	The FHT has an updated register of the hypertenses of the area.	**(Y) (N)**
The standard refers to the FHT having, registered and documented in paper, the number of hypertenses referred to and confirmed, distinguished by age groups (see SIAB) and gender, updated every month. From the knowledge of this population it is possible the development of many other actions indicated in the higher quality levels.			

5.35	**E**	The FHT has an updated register of the diabetics of the area.	**(Y) (N)**
The standard refers to the FHT having, registered and documented in paper, the number of diabetics referred to and confirmed, distinguished by age groups (see SIAB) and gender, updated every month. From the knowledge of this population it is possible to develop of many other actions indicated in the higher quality levels.			

Q Development

5.36	**D**	The FHT monitors the frequency of the hypertenses to the programmed activities.	**(Y) (N)**
The standard refers to the FHT monitoring the frequency of the hypertenses to the programmed activities, trying to assure the adhesion to collective and individual activities and engaging in an active search of the absent ones.			

5.37	**D**	The FHT monitors the frequency of the diabetics to the programmed activities	**(Y) (N)**
The standard refers to the FHT monitoring the frequency of the diabetics to the programmed activities, trying to assure the adhesion to collective and individual activities and engaging in an active search of the absent ones			

5.38	**D**	The hypertenses under assistance have an individual consultation, at least, once in every three months.	**(Y) (N)**
The standard refers to the FHT having recommended and assured, at least, one individual consultation every three months for the hypertenses under assistance.			

5.39	**D**	80% of the diabetics under assistance have an individual consultation, at least, once in every three months.	**(Y) (N)**
The standard refers to the FHT having recommended and assured, at least, one individual consultation every three months for the diabetics under assistance.			

5.40	**D**	80% or more of the pregnant women with an early prenatal beginning.	**(Y) (N)**

The standard indicator refers to the FHT monitors and develops actions of early captivation of pregnant women (up to the first three months of pregnancy, that is, 90 days) to the beginning of prenatal care. The survey may occur trough the B-GES file card of the SIAB. Calculate the percentage, considering to the evaluation the last 12 months and verify if it meets the parameters established for the standard.

5.41	**D**	80% or more of the low risk pregnant women with 7 or more prenatal consultations attended.	**(Y) (N)**

The standard indicator refers to the monitoring of the percentage of pregnant women who had at least seven consultations or more of low risk prenatal during pregnancy, considering the last 12 months. Verify if this percentage considers the parameters established by the quality standard.

5.42	**D**	The FHT develops monthly actions of family planning.	**(Y) (N)**

The standard refers to the performance of educational monthly actions of family planning, individual or in groups, with guidance concerning the use and offer of basic contraceptive methods: condoms, oral and injected contraceptives, according advisement.

5.43	**D**	The FHT develops systematic actions, individual or in groups, of cervix uteri cancer prevention and breast cancer control.	**(Y) (N)**

The standard refers to the and performance of collective and individual actions of cervix uteri and breast cancer prevention, at least every two months, concerning actions of guidance and self examination to the sensitization and achievement of cervix uteri cytology aiming to reach coverage rates within the feminine population over 90%.

5.44	**D**	The FHT performs an active search of the positive cases of cervix uteri cytology.	**(Y) (N)**

The standard refers to the monitoring of all citologies gathered and sent to analysis, performing an active search of the users with a positive exam, guiding or performing the indicated procedure.

5.45	**D**	The professional perform the treatment of the prevalent STDs approaching the partner(s).	**(Y) (N)**

The standard refers to the partner(s)' approach being standardized and accomplished in all situations of therapeutic approach of the STDs by the FHT professionals with a college degree.

5.46	**D**	80% of women who have recently given birth with a puerperium appointment performed up to 42 days after deliverance.	**(Y) (N)**

The standard indicator refers to the continuity of the care actions during the puerperium, considering to the evaluation the last 12 months. The answer must be affirmative when, at least, one consultation (medical and/or nursing) is performed up to 42 days after deliverance.

5.47	**D**	It is performed syphilis diagnosis and treatment during pregnancy.	**(Y) (N)**

The standard refers to the professionals with a college degree of the FHT being sensitized to require routinely exams to the syphilis detection during prenatal, performing the recommended treatment when it is needed.

5.48	**D**	The FHT has an updated register of the mental patients.	**(Y)** **(N)**
The standard refers to the team having, documented in paper, the register of the mental patients, distinguishing kind of diseases, age, gender, address, family situation, autonomy degree and whether it is being assisted by the reference.			

Q Consolidated

5.49	**C**	The care to the hypertense population occurs from risk classification.	**(Y)** **(N)**
The planning of the hypertense care is performed using the classification according the hypertension type, adhesion and answer to the treatment, presence of associated risk factors, instruction and autonomy degree, among other factors. The frequency of medical and nursing consultations is proposed and achieved from this evaluation, according the consensus for the theme (www.saude.gov.br/hipertensao-diabetes).			

5.50	**C**	The care to the diabetic population occurs from risk classification	**(Y)** **(N)**
The planning of the hypertense care is performed using the classification according the diabetic type, adhesion and answer to the treatment, presence of associated risk factors, instruction and autonomy degree, among other factors. The frequency of medical and nursing consultations is proposed and achieved from this evaluation, according the consensus for the theme (www.saude.gov.br/hipertensao-diabetes).			

5.51	**C**	The BMI of all hypertenses assisted by the FHT happens every three months.	**(Y)** **(N)**
The standard refers to the trimestrial measure of the BMI of all hypertenses assisted by the FHT, with register in an individual file card, allowing monitoring of the past situations and evolution of the marking.			

5.52	**C**	The BMI of all diabetics assisted by the FHT happens every three months	**(Y)** **(N)**
The standard refers to the trimestrial measure of the BMI of all hypertenses assisted by the FHT, registering in an individual file card.			

5.53	**C**	The exam of the feet of the assisted diabetics is performed at every consultation.	**(Y)** **(N)**
The standard refers to the FHT having as a recommended routine and performing in a systematic way the exam of the diabetics feet in every consultation.			

5.54	**C**	The FHT analyses every six months the population of assisted hypertenses considering the estimated prevalence.	**(Y)** **(N)**
The standard refers to the FHT comparing, every six months, whether the population of diagnosed hypertenses under assistance is compatible with the expected number according the calculation of the hypertense estimated prevalence for the territory. The prevalence of the systemic arterial hypertension for Brazil is around 15 to 20%.			

5.55	**C**	The FHT analyses every six months the population of assisted diabetics considering the estimated prevalence.	**(Y)** **(N)**
The standard refers to the FHT compares, every six months, whether the population of diagnosed diabetics under assistance is compatible with the expected number according the calculation of the diabetic estimated prevalence for the territory. The prevalence of Diabetes Mellitus for Brazil is around 6 to 11%.			

5.56	C	80% of the pregnant women assisted in the prenatal are under FH assistance.	(Y) (N)
Consider for the evaluation of the standard indicator, the percentage of low risk pregnant women assisted by the team who received at least one dental evaluation by pregnancy trimester, over the last 12 months. The Dental Care for the pregnant women comprehends the achievement of a diagnosis evaluation, caterings and surgeries when indicated, considering the pregnancy period, besides the education and prevention actions.			

5.57	C	The clinic breast exam is a routine established in the service.	(Y) (N)
The standard refers to the clinic breast exams being performed, at least, once a year, systematically in all consultations of women from 40 to 69 years old as a service routine. Do not consider the refusals by the users, due cultural factors.			

5.58	C	The FHT develops sensitization actions together with the masculine population to the early detection of prostate cancer.	(Y) (N)
The standard refers to the FHT orients and sensitizes the population of men from 40 to 65 years old concerning the available measures to the early detection of prostate cancer.			

5.59	C	The FHT keeps follow ups of the mental patients assisted by the reference.	(Y) (N)
The standard refers to the FHT being acquainted with the mental patients of its territory who are being assisted by the reference, keeping a follow up through DV or consultations at the FHU, in a way integrated with the Mental Health team.			

5.60	C	The BHT develops preventive actions turned to the users with special needs.	(Y) (N)
The standard refers to the BHT developing actions aiming the prevention, directed to the people with special needs, such as: the sensitization and capacitation of the people in charge for the oral hygiene, among others.			

Q Better

5.61	B	The FHT keeps a follow up of the treatment by reference of the users of alcohol and other drugs.	(Y) (N)
The standard refers to the FHT being acquainted with the drug users of its territory who are being assisted by the reference, keeping a follow up through DV or consultations at the FHU, in a way integrated with the Mental Health.			

5.62	B	Male adults are assisted by the FHT.	(Y) (N)
The standard refers to the FHT having a register of the population between 20 and 59 years old and following them up through medical and nursing consultations, concerning the general health conditions and health problems prevention. To an affirmative answer, consider 50% of the male population of this age group.			

5.63	B	The adult men and women population is under systematic assistance by the BH.	(Y) (N)
The standard refers to the BHT developing actions of follow up of the population within this life cycle. Consider to an accurate answer 60% of the population considered over the last 12 months.			

5.64	**B**	There was a reduction of the absolute number of hospitalizations by Cerebral Vascular Accident.	**(Y)** **(N)**
The standard refers to the reduction of the absolute number of hospitalizations by vascular cerebral accident over the last 24 months, to the enrolled population between 40 and 69 years old, accompanied. It is one of the themes approached by the Indicators of Primary Care Pact.			

5.65	**B**	There was a reduction of the absolute number of hospitalizations by Acute Myocardial Infarct.	**(Y)** **(N)**
The standard refers to the reduction of the absolute number of hospitalizations by Acute Myocardial Infarct over the last 24 months, to the enrolled population, accompanied.			

5.66	**B**	There was a reduction of the absolute number of hospitalizations by complications due to Diabetes Mellitus.	**(Y)** **(N)**
The standard refers to the reduction of the absolute number of hospitalizations by ketoacidosis and diabetic coma over the last 24 months, to the enrolled population, accompanied. It is one of the indicators of the Indicators of Primary Care Pact.			

5.67	**B**	There was a reduction or absence of psychiatric hospitalizations of mental patients.	**(Y)** **(N)**
The standard refers to the reduction of the absolute number of psychiatric hospitalizations of the mental patients of the territory over the last 24 months.			

Q Advanced

5.68	**A**	The FHT develops activities of reintegration and community rehabilitation together with the mental Health teams of reference.	**(Y)** **(N)**
The standard refers to the FHT developing actively projects and actions of reintegration and community rehabilitation together or with the advisement of the mental Health team of reference.			

Elderly's Health

Q Development

5.69	**D**	The FHT has an updated register of the elderly people within the area.	**(Y)** **(N)**
The standard refers to the FHT having, registered and documented on paper, the number of elderly (SIAB: over 60 years old), discriminated by gender, enrolled area to the FHT, updated every month. The ideal is that there are references to the clinic situations: diseases, hospitalizations etc. From the knowledge of this population it is possible to development of many other actions indicated in the higher quality levels. Answer affirmatively when the updating is permanent, including the updating of the information system.			

Q Consolidated

5.70	**C**	80% or more of the elderly in the area have the vaccination updated.	**(Y)** **(N)**
The standard refers to the FHT monitoring vaccination coverage of the elderly. Compare the coverage reached with the value established for the quality standard.			

Q Better

5.71	**B**	The exam of the oral cavity of the elderly is a routine established in the service.	**(Y) (N)**
The standard refers to the FHT and BHT having as a recommended routine and performing in a systematic way the exam of the oral cavity of the elderly assisted, aiming the identification of cancerous lesion, in all consultations performed by professionals with a college degree.			

5.72	**B**	The elderly are under systematic assistance by the BH.	**(Y) (N)**
The standard refers to the BHT developing actions of assistance of the elderly population and monitoring the coverage of the consultations within this age group. Consider, to an affirmative answer, coverage of 60% of the population considered, over the last 12 months.			

5.73	**B**	The exam of the body surface of the elderly is a routine established in the service.	**(Y) (N)**
The standard refers to the FHT and BHT having as a recommended routine and performing in a systematic way the exam of the body surface of the elderly assisted, aiming the identification of cancerous lesion, in all medical and nursing consultations.			

Q Advanced

5.74	**A**	The FHT develops interventions concerning the family of the elderly, capacitating domiciliary care takers.	**(Y) (N)**
The standard refers to the FHT performing interventions together with the family of the elderly in the indicated cases, identifying and capacitating people to develop the appropriate family cares.			

5.75	**A**	There are developed appropriated interventions together with the elderly population to the early detection of dementia.	**(Y) (N)**
The standard refers to the FHT members being sensitized to recognize the main dementia characteristics incident over the elderly population (Parkinson, Alzheimer, micro vascular diseases etc).			

Health Surveillance II: Transmissible Disease

Q Development

5.76	**D**	The FHT monitors the regularity of the treatment of the tuberculosis patients.	**(Y) (N)**
The standard refers to the FHT monitoring the regularity of the users under tuberculosis treatment to the scheduled consultations, performing an active search of the absent ones and trying to guarantee the continuity of the initiated treatment.			

5.77	**D**	The FHT monitors the regularity of the treatment of the leprosy patients.	**(Y) (N)**
The standard refers to the FHT monitors the regularity of the users under leprosy treatment to the scheduled consultations, performing an active search of the absent ones and trying to guarantee the continuity of the initiated treatment.			

5.78	**D**	The differential diagnosis approach to dengue is performed every time it is advised.	**(Y)** **(N)**
The standard refers to the FHT doctor knows the dengue epidemiologic aspects and patho-physiological manifestations, performs a physical exam – especially testing of capillary resistance (lace testing), requires the proper laboratory examinations and interprets them, making the disease diagnostic.			

Q Consolidated

5.79	**C**	The diagnosis, prescription and follow up of the supervised treatment occur in the tuberculosis cases.	**(Y)** **(N)**
The standard refers to the FHT being able to perform all the described actions: diagnosis, treatment, prescription and follow up of the tuberculosis supervised treatment.			

5.80	**C**	The diagnosis, prescription and follow up of the supervised treatment occur in the leprosy cases.	**(Y)** **(N)**
The standard refers to the FHT being able to perform all the described actions: diagnosis, treatment, prescription and follow up of the leprosy supervised treatment			

5.81	**C**	The anti-HIV exam is offered with counseling to all pregnant women assisted.	**(Y)** **(N)**
The standard refers to the offering of the anti–HIV exam with counseling being standardized to all pregnant women under prenatal assistance. Consider the last 12 months to the standard analysis.			

5.82	**C**	The exam for the detection of hepatitis B and C is offered with counseling to the women and men assisted.	**(Y)** **(N)**
The standard refers to the offering of exams to the detection of hepatitis B and C, with counseling, to all adults assisted, being an established routine in the FHT.			

5.83	**C**	The dengue cases are leaded to hospitalization whenever necessary.	**(Y)** **(N)**
The standard refers to the follow up (of the evolution) of the dengue infection, with the recognition of the dangerous signs and of the situations that indicate hospitalization, whenever necessary.			

5.84	**C**	There are performed immediate interventions in cases of outbreaks by infectious contagious disease.	**(Y)** **(N)**
The standard refers to the FHT being able to and developing actions of epidemiologic surveillance, intervening on the contacts and communicators to the diagnosis, treatment and/or actions of blocking and prevention, in the cases of contagious diseases outbreaks.			

Q Better

5.85	**B**	90% of the tuberculosis patients diagnosed and treated are cured.	**(Y)** **(N)**
The standard is a result standard and evaluates the impact of the actions over the population's health. Verify the percentage of tuberculosis patients diagnosed, who went under complete treatment (with no interruptions), that were cured. Consider the last 24 months to evaluation.			

5.86	**B**	90% of the patients diagnosed with leprosy and treated are cured.	**(Y) (N)**
The standard is a result standard and evaluates the impact of the actions over the population's health. Verify the percentage of leprosy patients diagnosed, who went under complete treatment, which were cured. Consider the last 24 months to the evaluation			

5.87	**B**	The absence of neonatal tetanus in the area.	**(Y) (N)**
Consider to an affirmative answer the evaluation of the last 24 months. The standard refers to a final result on the health of the population covered by the FHT to which contributed all the actions previously performed of prevention and follow up, especially prenatal.			

5.88	**B**	Absence of congenital syphilis in the area.	**(Y) (N)**
Consider to an affirmative answer the evaluation of the last 24 months. The standard refers to a final result on the health of the population covered by the FHT to which contributed all the actions previously performed of prevention and treatment, especially prenatal.			

Health Surveillance III: Regional Health Problems

Q Development

5.89	**D**	The differential diagnosis approach to malaria is performed every time it is advised.	**(Y) (N)**
The standard refers to the FHT doctor knows the malaria epidemiologic aspects and patho-physiological manifestations (high fever in cycles, sweating, chills, myalgia and headache) being able to collect the anamnesis and perform the physical exam, require the proper laboratory examinations and interpret them, making the disease diagnostic.			

Q Consolidated

5.90	**C**	The malaria cases are leaded to hospitalization whenever necessary.	**(Y) (N)**
The standard refers to the FHT doctor prescribes the indicated medicine and follows up malaria evolution, being able to recognize the dangerous signs, complications and the situations that indicate the hospitalization.			

Suggestions of themes to Loco-regional Standards

Examples:

Violence/external Causes

Indigenous Health

Remaining Community of Quilombos

Initiatives related to natural Medicine and Complementary Practices (Homeopathy, Chinese Traditional Medicine, Anthroposophic medicine and Phytotherapy)

Notes

Notes

Notes

Avaliação para Melhoria da Qualidade
da Estratégia Saúde da Família

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