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BASIC ATTENTION INFORMATION SYSTEM: SUPPORT FOR DECISION ON FAMILY HEALTH STRATEGY MANAGEMENT

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ABSTRACT

O Sistema Único de Saúde brasileiro tem a atenção básica como primeiro ponto de atenção e principal porta de entrada do sistema aos usuários para a rede de saúde sendo a Estratégia de Saúde da Família o modelo de reorganização assistencial do país. Para registrar o trabalho que é feito na ESF é utilizado o Sistema de Informações de Atenção Básica que é um sistema do Departamento de informática do Sistema Único de Saúde idealizado para agregar e para processar as informações sobre a população visitada. Este estudo pauta-se pelo objetivo de compreender, através do discurso dos gestores das unidades de saúde, como ocorre o gerenciamento da Estratégia de Saúde da Família. Esse estudo é resultado de uma pesquisa de campo, de caráter exploratório e descritivo realizada com dezoito enfermeiras dos serviços de saúde dos distritos sanitários do município de João Pessoa. Após a aplicação do questionário norteador utilizou-se para análise dos dados, o método do Discurso do Sujeito Coletivo. Os resultados foram organizados sinalizando a percepção e a compreensão sobre o gerenciamento da equipe de saúde. Ao término do estudo foi possível verificar que o Sistema de Informações de Atenção Básica ainda não alcançou o objetivo de ser um instrumento de reorganização das práticas de trabalho, sendo necessário, que a gestão municipal amplie seus investimentos em tecnologia e na educação permanente dos profissionais que atuam na estratégia de saúde da família para estimular que a informação em saúde seja utilizada como instrumento gerencial para a tomada de decisão em saúde.

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INTRODUCTION

The construction of the object of study: The Unified Health System (SUS) was created by the Federal Constitution of 1988 and had the organization of its service network, as well as health planning, care and interfederative articulation provided for in the Organic Health Law (Law nº 8.080, of September 19, 1990) which was recently regulated by decree nº 7.508 of June 28, 2011. It defines and organizes Health Care Networks (RAS) as a strategy for comprehensive care and directed to the health needs of the population. The RAS constitute an organization model formed by health actions and services with different technological configurations and assistance missions, articulated in a complementary and territorial basis, and with several attributes, among them, the following stand out: structured primary care as the first point of care and the main gateway to the system, consisting of a multidisciplinary team that covers the entire population, integrating, coordinating care and meeting health needs (Ministério da Saúde, 2011). Primary care is characterized by a set of health action, both individual and collectively, considering the subject in its uniqueness and sócio-cultural insertion, including health promotion and protection, disease prevention, diagnosis, treatment, rehabilitation, harms reduction and health maintenance in order to develop comprehensive care that impacts the health conditions of communities. Primary care is guided by the principles of universality, accessibility, bonding, continuity of care, comprehensive care, accountability, humanization, equity and social participation (Ministério da Saúde, 2011). To ensure the implementation of the Primary Care Policy, the Ministry of Health in 1994 launched the Family Health Strategy (FHS),

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which aims at reorganizing and reorienting care model in the country, in accordance with SUS principles. Therefore, the FHS was adopted in Brazil as a model of care reorientation, organized through the implementation of multiprofissional teams in basic health units. These teams are responsible for monitoring a defined number of families, located in a defined geographical area, having as their main strategy the establishment of bond and co-responsibility between users and health professionals (Ministério da Saúde, 2000). Within the National Policy of Primary Care are the pacific and common attributions to all professional of the Family health team respecting the competences and responsibilities common to the team and each FHS professional. Some of the responsibilities shared among all higher education professional that make up the Family Health Team is participation in the management of the necessary inputs for the proper functioning of the UBS; ensuring the quality of the record of activities in the information systems in primary care and the holding of team meetings, in order to discuss together, the planning and evaluation of team actions and from the use of available date (Ministério da Saúde, 2012). To record the work that is done in the Family Health Strategy is used the Primary Care Information System (SIAB) which is a DATASUS system designed to aggregate and process information about the population visited. This information is collected in registration and monitoring forms and analyzed from the data consolidation reports (Ministério da Saúde, 2012). The Primary Care Information System (SIAB) was created in 1998 by the Department of Primary Care / Secretariat of Health Care, in conjunction with the Department of Informatics and Information of the Unified Health System (DATASUS). It is a territorialized information system, whose data are generated by health professionals from the Family Health Strategy teams. Information is collected at home and in basic units in the areas covered by the Family Health Strategy and the Community Health Agents Program (PACS) (Ministério da Saúde, 2012). This system is a support tool for Family health teams to identify individual and collective problems, providing elements for the analysis of the health/disease process, having territorialization as an ally to identify health problems and identify inequalities, contributing to the implementation of health policies reduction and inequities, also favoring the evaluation of the effectiveness of actions developed by health services (Ministério da Saúde, 2006). In this sense, this study is guided by the following objective to understand, through the discourse of managers of health units, how the use of the Primary Care Information System (SIAB) occurs, as a tool to support decision-making in the exercise of health management of the Family Health Strategy.

MATERIALS AND METHODS

To analyze the universe of complexity of this study the qualitative approach was used. As described by Minayo, 2010 qualitative research answers particular questions, concerned with a level of reality that cannot be quantified, with a deeper space of relationships, processes and phenomena that cannot be reduced to the operationalization of variables. This approach was developed from an exploratory and descriptive study, whose purpose was to observe, describe and explore aspects relevant to the problem investigated. Thus, the present study was conducted in the city of João Pessoa – Paraíba, having as a research scenario, the Family Health Units (SF) of the five health districts. The municipality has a Family Health Strategy (FHS) coverage, corresponding to 88.3% of the resident population. Currently, Primary Care has 180 Family Health Teams, territorializes as follows: Health District I has 45 family health teams (FHS) distributed in 26 establishments or USF, in Health Distract II there are 38 FHS in 22 establishments, in Sanitary District III there are 53 FHS housed in 33 establishments, in Sanitary District IV there are 26 FHS in 16 USF and in District V there are 18 FHS in 13 Family Health Units (João Pessoa, 2012). As for the study participants, they comprised eighteen nurses being delimited considering the recurrence of information or data saturation (Richardson, 2011). Thus, the following inclusion criteria of the study participants were used: to be acting in the Family Health Team; expressing interest in participating in the investigation; have read and signed the Informed Consent Form (ICF). The exclusion criteria adopted were: not accepting to answer the questionnaire and not signing the consent form. Thus exposed, participated in the study, nurses managers of health services of health districts totaling 18 (eighteen) nurses. For the collection of empirical materials was used a questionnaire, understood by Minayo, 2010 as a technique that articulates the modality that presupposes previously formulated questions, such as the one where the informant freely addresses the proposed theme. The semi-structured questionnaire also recognizes the importance of the investigator's presence, as it gives the informant the chance to respond spontaneously to the questions, based on their reasoning, but within the focus proposed by the investigator. To start date collection, the researcher presented the Health Units and the nurses requesting the collaboration of professional with the research so that the objectives under study were reached, and a commitment was made to return the results achieved by the research to the USF, Thus, after understanding the objective of the study and the acceptance of participation in the research, the Free and Informed Consent Form was presented and the participant's signature was requested before the recording began. The questionnaires were individually applied in a quiet place, following the script built for the research, consisting of the questions that can be read in the second appendix of this work. The recordings were made with the FHS nurses using mp3 recorder and later rigorously transcribed for analysis and discussion.

However, before starting this procedure the Project was submitted to Platform Brazil and analyzed by the Research Ethics Committee of the Health Sciences Center (CCS) of the Federal University of Paraíba, obtaining the registration of CAAE nº11694512.9.0000.5188. After reading the Informed Consent Form, recommended by the National Health Council of the Ministry of Health, through Resolution nº 466/2012 and according to the nurse's acceptance and signature, the questionnaire was applied (Ministério da Saúde, 2013). For data analysis, we used the Collective Subject Discourse (DSC) data analysis technique, which can be seen as a set of devices designed to allow collective thinking as an empirical reality to express itself or, using complexity theory, self-organizing, enabling the rescue and bringing to light the social representations in the form of instituting discourses of collective subjects (Lefèvre, 2000). The construction of the CSD is performed in the first person singular in order to be closer to collective thinking, and it is necessary to identify and "qualitatively add" similar or complementary discourses obtained Through interviews, ie: "a general discourse made of individual discourse aggregates" (Lefèvre, 2005). At this point the CSD is not concerned with the adherence of collective discourse, but rather with obtaining a "discursive description

or representation of the social imaginary, a cutoff, whose greater commitment is to its own clarity, semantic coherence and didacticism" and concepts with basis or methodological figures of the DSC (Lefèvre, 2005). The date analysis technique of the Collective Subject Discourse (CSD) is based on the application of four methodological figures, namely:

- Key Expressions – These are "literal transcriptions of parto f the discourse" or "continuous or discontinuous pieces or segments or segments of discourse that must be underlined, iluminated, colored by the researcher and which reveal the essence of the underlying discourse of theroy" (Lefèvre, 2005).
- Central Idea – Reders to the "name or linguistic expression. That reveals and describes as synthetincally and precisely as possible the meaning or theme of each of the discourses analyzed ando f each homogeneous ensemble or even" the statement that allows to translate the of contented" (Lefèvre, 2005).
- Anchoring – It is defined as "the expression. Of a given theory, ideology, religious belief that the author professes and which is embedded in his discourse as if it were any statement" (Lefèvre, 2005). A discourse is considered anchored when it finds a foundation of assumptions, theories, concepts and hypotheses, reaffirming that it is the theory that supports the practice.
- Collective Subject Discourse – It is defined as "a meeting in one homogeneous speech-synthesis of Key Expressions that has the same Central Idea or Anchor" is "the individual discourse, expanded, socializes, but never misrepresented" (Lefèvre, 2005).

Data were presented as a transcript of statements, followed by analysis and discussion in the light of the literature that supported the theoretical framework of this study.

RESULTS AND DISCUSSION

Within the National Policy of Primary Care, there are specific and common attributions to all professional of the Family health team, respecting the competences and responsibilities common to the team and each FHS professional. Some of the responsibilities shared among all higher education professionals who make up the Family Health Team is participation in management. As well as the National Nursing Curriculum Guidelines point to the end for undergraduate training that enables the exercise of the competences and general skills of health professionals that enables the following skills: heath care, decision making, communication, leadership, administration, management and continuing education. Among the six competences pointed out, five stands out that can be characterized as managerial competences (Barbosa Simone de Pinho, 2017). According to the ministry of education 2018, the foundation for nurses skills acquisition is built based on management knowledge such as: administrative theories, specific management tools, the work process, management ethics, knowledge about organizational culture and power, negotiation, teamwork, quality of life at word, worker health, people management, personnel sizing, material resource management, costs, physical resources, information systems and decision making. Importantly, nursing management refers to a controversial activity since, increasingly, it has required competencies that adjust the administrative trends that converge to the wishes of the organization and mangers of health institutions. And that with the decentralization of the SUS, many changes occurred in management and service delivery. Making municipalities managers of the organization, control, and evaluation of health services and actions, as well as responsible for the planning and organization of the health services network, which increases local responsibility in the management work process (Mintzberg, 2004). Chart X reveals nurse's perceptions of their role in the healthcare team.

Table 1. Central idea and discourse of the collective subject in response to the question: what is its role in the management of FHS activities?

Central Idea I	CollectiveSubject Speech
Management is done by the team	*[...] everything from the unit goes through us. I consider myself an instructor, advisor, coordinator, supervisor, an active eye on problems within the area. But, I think the manager is very strong, because here we do not send anything we work in teams and if we work in teams, everyone can be like managers.*
Central Idea II	
Coordinating rola	[...] *I am the unit coordinator, as far as the ACS and the medium level are concerned.*
Central Idea III	
Does not develop management actions	*[...] I don't feel like a manager anymore! I felt before, not today. With the arrival of matrix support, we lost the managerial functions and today, I do not have autonomy and I do not feel with space to make decisions.*

In this process, nursing actively participated, mainly, with regard to the Family Heath Strategy, being pointed out as one of the most articulated categories involved with the management of health units, being responsible for bringing together the other professional and enabling the team's work. The management of a health service is characterized by analysis of the work process, identification of problems and search for solutions for the reorganization of care practices. Being and extremely dynamic dialectical activity, in which the technical, political and communicative dimensions are in permanent articulation requiring constant reflections and decision making by the manager (Weirich, 2013). Being the nurse trained to develop managerial skills such as: critical analysis for decision making, organization of the health services network, health situation assessment and development of intervention strategies. Thus, the nurse as a member of the FHS has developed care assistance actions, as well as managerial actions organizing group work and collective activities, supervising the CHA and nursing technicians (Ministério da Saúde, 2018). To broaden the scope, resoluteness and terrirtorialization of the Family Health Strategy in the service network. The Ministry of Health created the Family Health Support Centers (Nasf), through GM Ordinance nº 154, of 24 of January of 2008 (Ministério da Saúde, 2008). Nasf is made up of a team of different professional, defined by local managers according to the identified priorities, and they work together with Family health team professional, sharing and supporting health practices in the territories under the teams responsibility. Nasf's work is centered on matrix support, the expanded clinic, the unique therapeutic Project and the territory health Project. It is necessary to emphasize here that the understanding of matrix support represents a type of arrangement that seeks to redesign

responsibilities within the FHU, not necessarily placing the NASF professional as the manager of the Family health team, but as another co-professional responsible for the work that is being carried out by the local primary care, as the reference team proposal assumes that there is interdependence among professionals (Ministério da Saúde, 2008). Thus, I understand that matrix support is formed by a set of professional whose tasks will be to provide support to the reference teams and not to properly manage them. Once again, the understanding and operating logic of the FHS depend on the decision of the local manager who needs to be guided mainly by the ordinances and technical manuals of the Ministry of Health.

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Final Considerations: This research had as its main stage the Primary Care Policy in force in the country and the Family Health Strategy, but the lights were focused to analyze the Primary Care Information System and how it is used as a decision support tool for the management of the main health promotion strategy in force. In the health field, information systems provide the collection, processing, analysis and transmission of information necessary to organize and operate health services enabling the investigation and planning of the health / disease process. Therefore, health work is broad and of multiple dimensions, consisting of a network of relationships and interactions in which the nursing professional is inserted. And one of the defining elements of the Nurse's profile is the performance of the manager function, which is the ability to organize, in the political and technical dimensions, the work process, with the aim of making it more qualified and productive. This study achieved the expected results as it answered the initial questions of the research being possible to verify them by analyzing the speeches constructed from the discourse of the collective subject allowing to reach the following conclusions:

Regarding the use of the SIAB by nurses of the Family Health Strategy of de city of João Pessoa, it was possible to perceive the disagreement of opinion reflecting negatively on the way health information is treated and managed, showing that the SIAB as a tool for decision making within the FHS is not used in the perspective for which it was created. It was impossible to achieve the objectives of this study without asking the nurses what role they played in managing the family health team. In response to this question, divergences are observed, as some nurses state that in the practice of the service they develop management actions, others are only responsible for supervising community agents and nursing technicians, and a third group denies the role of manager. Against the FHS of the city of João Pessoa due to the presence of the family health support professional, who according to them, the NASF supporters assumed the role of manager and ended up limiting the management of the unit and the work process by the other professional team's. Thus, the results of the study allow us to infer that the SIAB has not yet reached the objective of being a decision support tool in the management of the Family Health Unit, and it is necessary for the municipal management to expand its investments in technology and in the permanent education of professional working in the Family health strategy to encourage health information to be used as a management tool for the planning and evaluation of health promotion, prevention and rehabilitation actions. Thus, it is hoped that this study can contribute to a better understanding of the use of health information as a management tool and support decision-making and effectively assist the municipal health management of João Pessoa to know its strengths and weaknesses so that it can rethink the strategies used and build new practices that favor the strengthening of primary care and the effectiveness of the services of the local single health system.

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