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PRODUCTION OF THE FAMILY HEALTH STRATEGY TEAMS BEFORE AND AFTER THE IMPLEMENTATION OF PMAQ-AB

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ABSTRACT
This study aimed to analyze the production of the Family Health Strategy teams, based on indicators from the Basic Care Information System, before and after the implementation of the Program for Quality Improvement in Primary Care. A quantitative, cross-sectional approach was used in two moments (2011 and 2013), based on secondary data from the Health Situation Reports and Household Follow-up of the families. Of the 49 basic health units, 112 teams were included that were active in the National Register of Health Establishments, which were divided into two groups: teams that joined and teams that did not adhere to the program. A descriptive analysis of the set of indicators was carried out, and the exploratory and analytical statistics were used to compare the differences between the groups. The results showed that the teams, regardless of whether or not they joined the program, obtained an increase in the records of the information system, showing an awareness of the entire network to improve their records. Despite this increase, the monitoring of families did not occur in the same proportion as the registrations.

Keywords: Primary health care. Family health strategy. Information systems.

INTRODUCTION

In primary health care, it is imperative to know the attributes of the population and the determinants of the health-disease process for local planning based on health needs[1].

The Family Health team (ESF), in creating link with the population, establishes the exchange of information about the individual and family health status[2]. The data collection mechanisms collected from the community provide the analysis of the health satus, focusing on the planning and implementation of local actions[3]. These data are mostly health indicators, which produce relevant information about certain attributes and dimensions of the population's health status[4].

The Primary Care Information System (SIAB) is one of the primary tools for managing primary care, by providing support to the ESF in the election and management of priority actions. Data from this system are collected by the Community Health Agents (ACS) and professionals of the Family Health Strategy (ESF) and generate information of interest to managers, multiprofessional team and the population served[2-5]. It is important to consider, however, that the work object of the ESF presents a high degree of complexity and, in addition to the individual and biological dimension, it also includes the need to understand social determinations and their relationships within the family and social context[6].

The health indicators components of the SIAB allow to characterize the health situation of a territorial space. Among the indicators of the SIAB, we highlight those of monthly follow-up of priority groups by ESF professionals, such as family registration, home visits, follow-up of children and pregnant women, and the registration and follow-up of people with hypertension and diabetes mellitus, among others[4].

As an initial step in the planning process in primary care, knowledge of the health situation supports the formulation of strategies and actions defined for each situation. However, they need to be reviewed and reanalysed regarding their success, seeking to strengthen or establish new intervention measures.

The National Program for Improving Access and Quality of Primary Care (PMAQ-AB) is one of the management strategies of the Unified Health System (SUS), which aims to increase the population's access to primary care and improve the quality of care provided in these services[7]. In this context, this program enables the monitoring and evaluation of the Basic Health Units (UBS) infrastructure, equipment,

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medicines availability and citizen satisfaction, valuing the teams that offer improvements in the quality of care, by a comparative standard[8-9].

Considering that the information obtained through the SIAB provides support for the knowledge of the demographic and epidemiological situation of the population served by the ESF, and that the PMAQ-AB aims to increase access and improve the care provided to the community, it is questioned: how did it turn out the registry of the data collected for the SIAB after the implementation of PMAQ-AB? In view of the above, this study sought to analyze the production of the Family Health Strategy teams, based on indicators of the Basic Attention Information System, before and after the implementation of the Program for Improvement of Quality in Primary Care.

METHODS

A quantitative, cross-sectional study in two moments, developed with secondary data, available by the Municipal Health Department of Florianópolis, Santa Catarina, Brazil. The Health Situation and Family Monitoring Reports in the Area (SSA2 File) referring to the active ESFs were consulted in 2011, the year prior to the implementation of the PMAQ-AB in the municipality, and in 2013, the year after its implementation. Of the 49 UBS of Florianópolis, 112 teams were included that were active in the National Register of Health Establishments in the two moments studied. Inactive teams were excluded in 2011 and/or 2013, totaling seven teams.

Initially, eight baseline indicators were analyzed, selected from the reports, adopting the consensus of experts - research professors in the field of collective health, who considered the usefulness of such indicators in the local planning of health actions. Number of families enrolled, number of hme visits, number of pregnant women enrolled, number of diabetics patients enrolled, number of diabetic patients followed, number of hypertensive patients enrolled, number of hypertensive patients followed. The mean number of ACS/year by ESF was included in the analysis. The indicators worked on in this study are derived from the SIAB report SSA2, which are fed by the ACSs. There is, therefore, a direct influence of the work of ACS in the collection and inclusion of the data in the family register, and, consequently, in the reports derived from it.

From the first analysis were derived another 12 indicators: average of families registered by ACS; average number of visits made by ACS; proportion of visits made by families registered by ACS; average of pregnant women registered by ACS; mean of pregnant women followed by ACS; proportion of pregnant women followed by pregnant women registered by the ACS; mean number of diabetics registered by ACS; proportion of diabetics followed by ACS; proportion of diabetics accompanied by diabetics registered by ACS; mean number of hypertensive patients registered by ACS; mean of hypertensive patients registered by ACS; and proportion of hypertensives accompanied by hypertensives enrolled by ACS.

A descriptive analysis of the set of indicators was carried out for two groups: one for ESFs registered in PMAQ-AB (G1); and another, to non-registered ESFs (G2). Afterwards, the analytical statistic was performed to compare the differences between the groups[10].

The study was approved by the Research Ethics Committee of the Federal University of Santa Catarina (UFSC) under opinion n.o 146.152/2012. The ethical aspects of confidentiality were considered throughout the process of selection, organization, analysis and reference of the teams included in this study.

RESULTS

The mean number of ACS per ESF in the analyzed period decreased about 50% in both groups of this study. In G1, the average number of ACS was 37 in 2011, and 18 in 2013. In G2 the average number of ACS was 39 in 2011 and 18 in 2013.

It was observed that the average number of families registered by the ESF in the municipality of Florianópolis presented a small variation between the years 2011 and 2013. About 8,210 families were registered on average in G1 in 2011 and 8,111 in 2013. The same situation was observed for G2, approximately 9,660 in 2011 and 9,690 in 2013. Regarding to this indicator, in an established ESF, the number of new registrations tends to decrease with the passage of time in a first moment, and then tends to stabilize, according to population fluctuation.

Although the average number of registrations was small, when this number was analyzed

proportionally to the number of ACS, a large increase was observed. In G1, the increase was 173% and, in G2, it reached 215%.

The mean number of visits decreased between the analyzed years, for both G1 and G2. The fall was respectively 34% and 11%.

When the average number of visits is analyzed, considering the number of ACS, an increase actually occurred. In G1, this increase was 83%, while G2 was even higher, around 176%. For the proportion of registered families visited, there was a decrease in the analyzed period. In G1, 56% of the registered families were visited in 2011, already in 2013 this figure was 37%. For G2, there was lower variation: in 2011, 40% of registered families were visited and, in 2013, this value reduced to 35%. Table 1 shows the distribution of these data by group.

Table 1. Distribution of indicators: registered families, families visited and derived indicators in the years 2011 and 2013, whether or not they joined the PMAQ

Indicators analized	Teams that joined PMAQ - G1						Teams that did not joined PMAQ - G2					
	N	Min	Max	Average	%	Standard deviation	N	Min	Max	Average	%	Standard deviation
Average number of families Registered by ESF in 2011	89	131	32.841	8,212,42	1.24	4,610.91	23	180	30,751	9661.17	0.30	7857.29
Average number of families Registered by eSF in 2013	89	757	18.469	8,110,62		3,697.87	23	1,719	27,745	9690		6954.89
Average number of visits per ESF in 2011	89	271	11.928	4,549,36	33.90	2,343.05	23	120	8,567	3743.87	10.91	1994.93
Average number of visits per ESF in 2013	89	112	7.042	3,007,27		1,546.28	23	959	8,548	3335.35		1970.82
No. of ACS in 2011 by ESF	89	2	103	36.78	50.22	15.04	23	1	67	38.52	52.60	19.24
No. of ACS in 2013 by ESF	89	3	28	18.31		3.84	23	11	27	18.26		5.08
Average number of families registered by ACS in 2011	89	66	5.603	2,454.27	172.96	934.74	23	180	7,195	2574.66	214.92	1827.40
Average number of families registered by ACS in 2013	89	757	15.947	6,699.11		2,976.97	23	1,719	22,915	8108.08		5677.23
Average number of visits made by ACS in 2011	89	136	3.413	1,367.62	82.88	536.28	23	120	2,408	1022.22	175.70	485.2
Average number of visits made by ACS in 2013	89	112	5.985	2,501.15		1,230.52	23	959	6,781	2818.27		1512.79
Proportion of registered families visited by ACS in 2011	89	2	13	55.72%	33.00	2.72	23	1	14	39.70%	12.45	3.81
Proportion of registered families visited by ACS in 2013	89	0	11	37.34%		2.05	23	1	11	34.76%		2.75

The descriptive analysis of the indicators related to pregnant women showed, in a general way, difference between the groups: G1 presented slightly higher indicators than G2. The number of pregnancies

registered by ESF was higher in G1, however, both groups presented increase in the number of records at the end of the period, 11.1% in G1 and 9.8% in G2. The evaluation of the mean number of pregnant women followed by eSF followed the same upward trend in both groups. The mean number of pregnant women followed by the ESF was also higher in G1, and followed the same upward trend for both groups in the analyzed period. In G1, the percentage increase in the average number of registered pregnant women was 7%, and in G2 slightly higher, 7.8%.

When the number of ACS was taken into account, G1 continued to present higher values of two indicators - number of pregnant women registered and number of pregnant women followed by ACS. However, at the end of the period, these indicators were higher in both groups.

Analyzing the proportion of pregnant women enrolled in the two periods, it can be observed that the values are similar in both groups. There was a small decrease in G1 (from 92% in 2011 to 88% in 2013), while in G2 this figure increased (81% in 2011 to 89% in 2013). Table 2 shows the evolution of the indicators of pregnant women registered and followed by group.

Table 2. Distribution of the indicators: registered and followed pregnant women and indicators derived in the years 2011 and 2013, whether or not they joined the PMAQ

Indicators analized	Teams that joined PMAQ - G1						Teams that did not joined PMAQ - G2					
	N	Min	Max	Average	%	Standard deviation	N	Min	Max	Average	%	Standard deviation
Average number of pregnant women registered in 2011 by ESF	89	2	441	105.34	11.11	68.94	23	1	232	86.84	9.74	67.33
Average number of pregnant women registered in 2013 by ESF	89	9	367	117.04		71.80	23	4	232	95.3		66.46
Average number of pregnant women monitored in 2011 by ESF	89	1	373	96.69	7.00	62.81	23	1	209	78.47	-7.77	63.31
Average number of pregnant women monitored in 2013 by ESF	89	7	295	103.46		65.15	23	4	208	84.57		58.18
Average number of pregnant women registered in 2011 by ACS	89	1	97	30.95	211.11	15.48	23	-	78	25.07	-213.16	17.70
Average number of pregnant women registered in 2013 by ACS	89	9	283	96.29		57.13	23	4	207	78.51		53.18
Average number of pregnant women followed in 2011 by ACS	89	1	83	28.44	198.91	14.68	23	-	42	20.4	-241.13	13.16
Average number of pregnant women followed in 2013 by ACS	89	7	231	85.01		51.32	23	4	182	69.59		45.45
Proportion of registered pregnant women followed by ACS in 2011	89	1	12	91.89%	3.92	2.18	23	1	123	81.37%	-8.93	24.04
Proportion of registered pregnant women followed by ACS in 2013	89	3	12	88.29%		1.78	23	4	12	88.64%		1.68

The registries referring to the indicators related to the diabetic population are presented in table 3. Only the Proportion of registered diabetics monitored by ACS in G1 index showed a decrease in the number of records in the evaluated years. The other indicators related to diabetes showed an increase in the number of records in both groups. The mean number of diabetics registered by ACS presented the highest percentage increase (225%) in G1, and the mean number of diabetic patients followed by ACS, the highest (251%) in G2.

Of the records related to hypertensive patients, only the proportion of hypertensive patients regitered with ACS showed a decrease. In G1, this decrease was of 18% and in G2, of 7%. The mean number of hypertensives registered was the indicator with the highest percentage increase in the years studied for both G1 (253%) and G2 (308%), whose data are presented in table 4

Table 3. Distribution of indicators: diabetics registered, monitored, and indicators derived in 2011 and 2013, whether or not they joined the PMAQ

Indicators analized	Teams that joined PMAQ - G1						Teams that did not joined PMAQ - G2					
	N	Min	Max	Average	%	Standard deviation	N	Min	Max	Average	%	Standard deviation
Average number of diabetics registered in 2011 by ESF	89	29	2,774	646.19		406.96	23	20	1,598	785.01		491.52
					16,23						14.58	
Average number of diabetics registered in 2013 by ESF	89	49	1,914	751.08		390.10	23	66	1,909	899.48		561.95
Average number of diabetics followed in 2011 by ESF	89	23	1,678	515.38		312.87	23	20	1,183	488.26		319.32
					1,85						13.68	
Average number of diabetics followed in 2013 by ESF	89	49	1,739	524.91		301.92	23	66	1,406	555.04		372.37
Average number of diabetics registered in 2011 by ACS	89	15	524	190.38		85.42	23	20	578	213.81		128.40
					224,96						251.08	
Average number of diabetics registered in 2013 by ACS	89	49	1,629	618.65		314.08	23	66	1,598	750.65		447.63
Average number of diabetics followed in 2011 by ACS	89	12	477	152.59		71.61	23	20	304	132.14		71.43
					183,69						251.41	
Average number of diabetics followed in 2011 by ACS	89	41	1,472	432.88		243.86	23	66	1,109	464.35		288.42
Proportion of registered diabetics followed by ACS in 2011	89	1	12	80.15%		2.10	23	1	11	61.80%		3.00
					-12,70						0.09	
Proportion of registered diabetics followed by ACS in 2013	89	3	12	69.97%		2.21	23	2	12	61.86%		2.91

Table 4. Distribution of indicators: registered and followed hypertensives, and indicators derived in 2011 and 2013, by adherence to or not to the PMAQ

Indicators analized	Teams that joined PMAQ - G1						Teams that did not joined PMAQ - G2					
	N	Min	Max	Average	%	Standard deviation	N	Min	Max	Average	%	Standard deviation
Average number of hypertensives registered in 2011 by ESF	89	63	9,086	1,912.93		1,291.17	23	48	4,341	2191.36		1430.91
					- 25.24						- 28.78	
Average number of hypertensives registered in 2013 by ESF	89	130	5,979	2,395.76		1,259.01	23	330	5,821	2822.09		1718.17
Average number of hypertensives followed in 2011 by ESF	89	57	5,484	1,470.19		951.57	23	48	3,413	1305.82		953.28
					- 3.11						- 21.54	
Average number of hypertensives followed in 2013 by ESF	89	129	5,417	1,515.89		858.00	23	330	3,901	1587.04		1083.51
Average number of hypertensives registered in 2011 by ACS	89	32	1,347	557.84		260.42	23	48	1,316	577.08		338.60
					-253.29						-308.48	
Average number of hypertensives registered in 2013 by ACS	89	130	5,114	1,970.79		1,009.46	23	298	5,104	2357.26		1382.74
Average number of hypertensives followed in 2011 by ACS	89	29	1,152	430.83		203.58	23	48	736	353.74		213.16
					-189.37						-278.39	
Average number of hypertensives followed in 2013 by ACS	89	129	4,588	1,246.71		688.18	23	294	3,074	1338.53		855.05
Proportion of hypertensive patients registered with ACS in 2011	89	1	12	77.23%		2.24	23	1	33	61.30%		6.36
					18.09						7,37	
Proportion of hypertensive patients registered with ACS in 2013	89	3	12	63.26%		2.42	23	2	12	56.78%		3.11

In order to verify the significance of the differences between the studied groups, for the analyzed indicators, the differences between the records of the first year after the PMAQ-AB implantation and the year before its implantation, Student's t test differences between means, with a confidence level of 95% and a significance of 5% were used[10].

It was found that the "number of visits" made by ESF, the "number of ACS", the "average visits by ACS", the "proportion of registered families visited" and the "proportion of registered diabetics followed" show significant values between G1 and G2, with p values respectively 0.040, 0.043, 0.014, 0.001, and 0.004.

DISCUSSION

The health care of the population by the ESF is supported by data and information obtained mainly through the SIAB. The analysis of the records of the production carried out by the ESFs becomes an important instrument of qualification of the Primary Attention in Health (APS), whose performance results from an internal and external evaluation. One of the duties of the ESF carried out by the ACS is to collect information regarding the health needs of the population. This worker has na importante role in the process of data consolidation in primary care, through home visits[3].

At the Municipal Health Department (SMS) in Florianópolis, there was a significant decrease in CACS in the period analyzed in both groups. The rotating or leaving of professionals in primary care compromises the quality of the data. This situation directly reflects the survey of the territory information, which may result in inaccurate information to program the local actions[11]. A study carried out in the city of Campinas on the registers of users and households of ten health centers also corroborates this analysis, indicating that the incompleteness found in filling in the registers reinforces the importance of collecting and completing data[12].

he high rotating of professionals has a direct relation with the quality of the filling of the records, since it is necessary time for apprehension and assimilation of the routine of this collection and filling function that, in addition to familiarity with the printed documents, there is a need for computational knowledge to insert them in the family register[2,5].

Allied to the work process of the ACS, another source of high rotation is related to the hiring of these professionals. The difficulty of fixing these workers is one of the problems faced in many town halls. Study on the rotation of professionals identified the admission by public competition of those of medium and higher level and the ACS, in general, by means of temporary contracts[13]. In Florianópolis, the hiring process has caused difficulties for the entry of new ACSs, due to the lack of legal agreement for this purpose. Vacancies open for any reason of disconnection have not received a replacement. The lack or insufficient number of ACSs causes the so-called "unattended áreas", resulting in a shortage of information system and, therefore, causing the data consolidation process to fail in APS.

The indicator that deals with the average number of families registered by ACS showed that both groups (G1 and G2) had an increase in the number of records. The family register is an indicator that quantifies and qualifies the data of the population when showing the health situation of the people of a certain territory. This information guides the work process of the health team by showing where, how and when professionals should proceed[11]. More than a normative task, the ESF has an opportunity to talk about problems and develop actions geared to local needs and the social context of individuals and families[14].

The benefits promoted by family registration are also added to the indicators of home visits. These indicators, besides being an instrument of intervention that enables the professional to know the life context of the individual and their needs, allow a closer approximation and development of the link[11,14].

It is task of the ACSs to carry out at least one monthly household visit to each household in the area of coverage, considering that the visit should be repeated if there are situations that determine their need[15]. In Florianópolis, G2, which presented the greatest difference in the number of ACS among the analyzed years, had a more favorable situation in relation to the number of visits. In both groups, there was a decrease in the number of home visits by ESF.

This was probably due to the decrease in the number of ACSs, which would lead to a decrease in the capacity of ESFs visits. The highest number of visits verified in the G2 could have happened due to a joint movement of the SMS, that mobilized the teams that had interest in registering in the future. Similar to that presented for the number of visits by ACS, the non-participating ESFs of PMAQ-AB (G2) presented a more favorable situation when compared to the teams participating in the program.

Regarding the average number of pregnant women registered by ACS; mean of pregnant women accompanied by ACS; and the proportion of pregnant women followed by pregnant women registered with ACS, there was an increase in the two groups studied, emphasizing that the largest increase occurred in G2. These indicators are related to prenatal and puerperal care and include different activities for the promotion, prevention and health care of pregnant women. These include the recruitment, registration and follow-up of pregnant women; consultations; immunizations; educational meetings.

Gaps and deficiencies are still observed in prenatal care, both in the provision of tests and in educational actions, reinforcing the importance of the link and dialogue between professionals and pregnant women to increase adherence and satisfaction with prenatal care[16]. A study describing quality indicators of prenatal care in Brazil within the framework of PMAQ-AB showed that of the 6,125 pregnant women interviewed who had their last prenatal care in the family health units, only 15% received prenatal care proper. This percentage reveals that actions are needed to qualify the work processes of the ESFs in order to minimize the social and individual inequalities that still persist in the health services[17].

The registration and follow-up of most pregnant women in the coverage area is an action that helps to plan the actions developed by the ESFs in the attention to women's health. This practice demonstrates the quality of primary care by playing an important role in reducing maternal and infant mortality, as well as in identifying factors that may interfere in the development of a gestation risk. In the perspective of integral care, the care provided to the mother-child binomial should be carried out by the multiprofessional team that works in the UBSs. The reception of the woman and her family will obtain better results if there are conditions of accessibility, encouragement to stay and bond, qualification of the professionals and training of the ESFs, especially regarding the management of the territory and the risk protocols[17-18].

In the evaluated period, the only indicator related to diabetes that decreased was the proportion of diabetics registered with ACS in G1. When this data is analyzed in light of current epidemiological data on the prevalence of diabetes, an inverse situation is observed, that is, the average percentage estimate of the population referred to in this disease has increased over the years, from 5% in 2008 to 6.2% in 2013 in the National Household Sample Survey (PNAD)[19].

The similar increase presented in both G1 and G2 in relation to the mean number of diabetic patients registered by ACS, mean number of diabetic patients followed by ACS, and proportion of diabetics followed by diabetic patients registered by ACS may have occurred due to the movement of SMS to the qualification of the teams and incentive to join in the subsequent PMAQ-AB cycle. Of these, the most significant were the mean number of diabetic patients registered by ACS, in G1 (225%), and the mean number of diabetic patients followed by ACS, in G2 (251%).

Regarding the hypertension indicators, the decrease in the proportion of hypertensive patients registered and followed by the ACS was observed, in G1 of 18% and in G2 of 7%. Similar to other indicators, this decrease appears to be associated with the lower number of ACSs available for territorial monitoring. On the other hand, the mean number of hypertensive patients registered was the indicator with the highest percentage increase in the years studied for both G1 (253%) and G2 (308%), an indicator in which calculation does not consider the number of ACS in the period.

The control of hypertension and diabetes, after diagnosis and registration, is done with the follow-up by the team of the patients with these pathologies[20]. Therefore, a failure to follow-up the enrolled patients may lead to compromising of the APS function in promoting care measures to those with an already defined diagnosis in the territory.

In addition, failure on data completion and collection of SIAB may compromise its effectiveness, which shows the need for measures to train professionals in order to understand the importance of information as a potential inducer of surveillance practices[20].

CONCLUSION

The comparison of the total team record in the two years (2011 and 2013) showed that although there was no significant improvement in all the indicators studied, there was a significant difference in favor of those who joined (G1) to the program in the indicators: number of visits made by ESF; ACS number; average visits by ACS; proportion of registered families visited; and proportion of registered diabetics.

Furthermore, it was verified that ESFs, whether or not adherent to PMAQ-AB, were found to have similar evolution regardless of their classification.

However, it can be affirmed that the production of the teams, before and after the implementation of the program in the municipality of Florianópolis, revealed an awareness of the professionals to follow the groups of continuous monitoring, improving the SIAB data. There was also an increase in enrollment indicators, however, there was no increase, in the same proportion, in the follow-up indicators.

PRODUÇÃO DAS EQUIPES DA ESTRATÉGIA SAÚDE DA FAMÍLIA ANTES E APÓS A IMPLANTAÇÃO DO PMAQ-AB

RESUMO

Estudo com o objetivo de analisar a produção das equipes da Estratégia Saúde da Família, com base em indicadores do Sistema de Informação da Atenção Básica, antes e após a implantação do Programa para Melhoria da Qualidade na Atenção Básica. Utilizou-se abordagem quantitativa, transversal em dois momentos (2011 e 2013), com base em dados secundários constantes dos Relatórios da Situação de Saúde e Acompanhamento das Famílias, referentes às equipes. De 49 unidades básicas de saúde, foram incluídas 112 equipes que estavam ativas no Cadastro Nacional dos Estabelecimentos de Saúde, as quais foram divididas em dois grupos: equipes que aderiram e equipes que não aderiram ao programa. Realizou-se análise descritiva do conjunto de indicadores e procedeu-se à estatística exploratória e analítica para comparar as diferenças entre os grupos. Os resultados mostraram que as equipes, independentemente de aderirem ou não ao programa, obtiveram incremento nos registros do sistema de informação, sinalizando uma sensibilização de toda a rede para melhoria dos seus registros. Apesar deste aumento, o acompanhamento das famílias não ocorreu na mesma proporção que os cadastramentos.

Palavras-chave: Atenção primária à saúde. Estratégia saúde da família. Sistemas de informação.

PRODUCCIÓN DE LOS EQUIPOS DE LA ESTRATEGIA SALUD DE LA FAMILIA ANTES Y DESPUÉS DE LA IMPLANTACIÓN DEL PMAQ-AB

RESUMEN

Estudio con el objetivo de analizar el trabajo de los equipos de la Estrategia Salud de la Familia, con base en indicadores del Sistema de Información de la Atención Básica, antes y después de la implantación del Programa para Mejoría de la Calidad en la Atención Básica. Fue utilizado el abordaje cuantitativo, transversal en dos momentos (2011 y 2013), con base en datos secundarios presentes en los Informes de la Situación de Salud y Acompañamiento de las Familias, referentes a los equipos. De 49 unidades básicas de salud, fueron incluidos 112 equipos que estaban activados en el Registro Nacional de los Establecimientos de Salud, de los cuales fueron divididos en dos grupos: equipos que adhirieron y equipos que no adhirieron al programa. Se realizó el análisis descriptivo del conjunto de indicadores y se procedió a la estadística exploratoria y analítica para comparar las diferencias entre los grupos. Los resultados mostraron que los equipos, independientemente si adhirieron o no al programa, obtuvieron incremento en los registros del sistema de información, señalando una sensibilización de toda la red para mejoría de sus registros. Pese este aumento, el acompañamiento de las familias no ocurrió en la misma medida que los registros.

Palabras clave: Atención primaria a la salud. Estrategia salud de la familia. Sistemas de información.

REFERENCES

1. Junges JR, Barbiani R, Zoboli ELCP. Strategic planning as an ethical requirement for primary healthcare teams and local management. Interface (Botucatu). 2015; 19(53):265-74.

2. Radigonda B, Conchon MF, Carvalho WO, Nunes EFPA. Sistema de Informação da Atenção Básica e sua utilização pela Equipe de Saúde da Família: uma revisão integrativa. Espaç Saúde. 2010; 12(1): 38-47.

3. Senna MH, Andrade SR. Indicators and information in local health planning: the perspective of the family health strategy nurses. Texto Contexto Enferm. 2015; 24 (4):950-8.

4. Rede Interagencial de Informações para a Saúde. Indicadores básicos de saúde no Brasil: conceitos e aplicações. 2ª ed. Brasília(DF): Organização Pan-Americana da Saúde; 2008.

5. Carreno I, Moreschi C, Marina B, Beckel Hendges DJ, Rempel C, Celestina de Oliveira MM. Análise da utilização das informações do Sistema de Informação de Atenção Básica (SIAB): uma revisão integrativa. Ciênc Saúde Coletiva. 2015;20(3):947-56.

6. Brito GEG, Mendes ACG, Santos Neto PM. O objeto de trabalho na Estratégia Saúde da Família. Interface (Botucatu) [Internet] [citado 2017 out 30]. Epub jul 20, 2017. Disponível em: http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S1414-32832017005015101&lng=en

7. Savassi LCM. Qualidade em serviços públicos: os desafios da atenção primária. Rev Bras Med Fam Comunidade. 2012; 7(23): 69-74.

8. Pinto HA, Souza ANA, Ferla AA. O Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica: várias faces de uma política inovadora. Saúde Debate. 2014; 38(n. esp):358-72.

9. Pinto HA, Souza ANA, Florêncio, AR. O Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica: reflexões sobre o seu desenho e processo de implantação. RECIIS [Internet]. 2012 [citado 2015 abr 16]; 6(2):Supl. Disponível em: http://www.reciis.icict.fiocruz.br/index.php/reciis/article/view/492/1142

10. Barbetta PA. Estatística aplicada às ciências sociais. 9ª ed. Florianópolis: Ed. da UFSC; 2012.

11. Silva SA, Oliveira N. Diagnóstico de saúde de uma população atendida pelo programa de saúde da família em Alfenas - MG. Rev APS. 2010; 13(2): 182-9.

12. Nakamura HY, Lima SM, Nobre MIR, Vianna NG, Arruda SMCP, Silva EM. Pet Saúde da Família: avaliação da qualidade do preenchimento de cadastros na atenção básica. Vita et Sanitas. 2013; 1(7):99-110.

13. Magnago C, Pierantoni CR. A percepção de gestores dos municípios de Duque de Caxias e Rio de Janeiro quanto à rotatividade de profissionais na estratégia saúde da família. Rev Cereus. 2014; 6(1): 3-18.

14. Kebian LVA, Oliveira AS. Práticas de cuidado de enfermeiros e agentes comunitários de saúde da estratégia saúde da família. Cienc Cuid Saúde. 2015; 14(1):893-900.

15. Ministério da Saúde (BR). Secretaria de Atenção à Saúde, Política Nacional de Atenção Básica. Brasília(DF): Ministério da Saúde; 2012.

16. Silva RM, Costa MS, Matsue RY, Souza GSS, Catrib AMF, Vieira LJES. Cartografia do cuidado na saúde da gestante. Ciênc Saúde Coletiva [Internet]. 2012 mar [citado 2017 out 30] ; 17(3): 635-42. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232012000300009&lng=pt.

17. Tomasi E, Fernandes PAA, Fischer T, Siqueira FCV, Silveira DS, Thumé E et al. Qualidade da atenção pré-natal na rede básica de saúde do Brasil: indicadores e desigualdades sociais. Cad Saúde Pública [Internet]. 2017 [citado 2017 out 30]; 33(3):e00195815. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2017000305001&lng=pt

18. Janssen M, Fonseca SC, Alexandre GC. Avaliação da dimensão estrutura no atendimento ao pré-natal na Estratégia Saúde da Família: potencialidades do PMAQ-AB. Saúde Debate [Internet]. 2016 dez [citado 2017 out 30]; 40(111):140-52. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-11042016000400140&lng=pt

19. Iser BPM, Stopa SR, Chueiri OS, Szwarcwald CL, Malta D, Monteiro HOC et al. Prevalência de diabetes autorreferido no Brasil: resultados da Pesquisa Nacional de Saúde 2013. Epidemiol Serv Saúde [Internet]. 2015; 24(2): 305-14.

20. Malfatti CRM, Assunção NA. Hipertensão arterial e diabetes na Estratégia de Saúde da Família: uma análise da frequência de acompanhamento pelas equipes de Saúde da Família. Ciênc Saúde Coletiva. 2011; 16(Supl. 1): 1383-88.

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