



INFORMATION SYSTEM OF PRIMARY CARE AS A POWER TOOL
SISTEMA DE INFORMAÇÃO DA ATENÇÃO BÁSICA COMO INSTRUMENTO DE PODER
SISTEMA DE INFORMACIÓN DE LA ATENCIÓN BÁSICA COMO INSTRUMENTO DE PODER

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ABSTRACT

Objective: to analyze how the Information System of Primary Care has been used as a power tool. **Method:** case study, with qualitative approach, from which, we interviewed 26 subjects at the municipal, state and federal levels of the Unified Health System, which use it. We applied the Content Thematic Analysis as a method of analysis. The study was approved by the Ethics Research Committee of the FUNED / UEMG, Opinion 61/2010. **Results:** information System of Primary Care has been used as a monitoring tool over the individual and/or collective body, as well as over the work process. The information stored in this system only meets the demands of the central level. **Conclusion:** there are power relations that involve the use of the SIAB, its processes and professionals. These power relations were forging the use of this system and promoting difficulties in its processes. **Descriptors:** Information Systems, Power, Primary Health Care.

RESUMO

Objetivo: analisar como o Sistema de Informação da Atenção Básica tem sido utilizado como instrumento de poder. **Método:** estudo de caso, de abordagem qualitativa, onde se entrevistou 26 sujeitos nos níveis municipal, estadual e federal do Sistema Único de Saúde que utilizam o sistema. Empregou-se a Análise Temática de Conteúdo como método de análise. O estudo foi aprovado pelo Comitê de Ética em Pesquisa da FUNED/UEMG, parecer 61/2010. **Resultados:** o Sistema de Informação da Atenção Básica tem sido utilizado como um instrumento de vigilância sobre o corpo individual e coletivo, bem como sobre o processo de trabalho. As informações armazenadas neste sistema atendem apenas às demandas do nível central. **Conclusão:** existem relações de poder que envolvem a utilização do SIAB, seus processos e profissionais. Estas relações de poder estariam forjando a utilização deste sistema e promovendo dificuldades em seus processos. **Descritores:** Sistemas de Informação; Poder; Atenção Primária à Saúde.

RESUMEN

Objetivo: analizar cómo el Sistema de Información de la Atención Básica ha sido utilizado como instrumento de poder. **Método:** estudio de caso de enfoque cualitativo en el cual se entrevistaron 26 sujetos que utilizaban el Sistema Único de Salud a nivel municipal, estatal y federal. Se empleó el Análisis Temático de Contenido como método de análisis. El estudio fue aprobado por el Comité de Ética de la Investigación de la FUNED/UEMG, Opinión 61/2010. **Resultados:** el Sistema de Información de la Asistencia Básica ha sido utilizado como un instrumento de vigilancia sobre el cuerpo individual y/o colectivo, como así también sobre el proceso de trabajo. Las informaciones almacenadas en este sistema satisfacen solamente las demandas del nivel central. **Conclusión:** existen relaciones de poder que envuelven el uso de este sistema, sus procesos y profesionales. Estas relaciones de poder estarían falseando el uso de este sistema y ocasionando dificultades en sus procesos. **Descriptores:** Sistemas de Información; Poder; Atención Primaria de la Salud.

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INTRODUCTION

The Information System of Primary Care - *Sistema de Informação da Atenção Básica* (SIAB) as one of the representatives of the nationwide information systems was developed aiming at monitoring and assessing of activities and services performed in the Family Health Program - *Programa de Saúde da Família* (PSF).¹ The SIAB, theoretically, would have the potential to detect inequalities, carefully search for sanitary problems, assess interventions, accelerate the use of information, produce indicators and, consequently, assist the decision-making process of teams and managers.²

In 2006, the Family Health Teams and the Community Health Agents Program - *Programa de Agentes Comunitários de Saúde* (PACS) already covered 58.7% of the Brazilian population, encompassing a total of 103.976.897 accompanied and assisted inhabitants.³ Currently, the Brazilian Ministry of Health has chosen the SIAB to monitor the Program for Improvement of Access and Quality of the Primary Care - *Programa de Melhoria do Acesso e Qualidade da Atenção Básica* (PMAQ) all over the Brazilian territory.⁴ Despite the importance of this system and the amount of generated information, the SIAB presents a set of problems that remain since its implementation. These problems can be summarized as follows: the inefficiency in data collection, as well as in its interpretation; flaws in the system upgrade, numerous data collection instruments that do not cover all the needs of the population; data duplicity; lack of specific data with regard to health prevention and promotion; and poor feedback.^{2, 5-6}

Some authors emphasize that the problems identified earlier arise from the historical evolution of health informative practices in Brazil.⁷⁻⁹ From this perspective, the information on health constitute one of the devices of fragmented State and several social, political and economic courts aimed at subsidizing the actions of their apparatus, favoring the hegemonic interests in the health field. It should be highlighted, at this point, the power relations that hypothetically could be contributing to the inefficiency, as well as the slow evolution of the nationwide health information systems.

It is necessary to dive into this invisible scenario of power relations to understand how they determine, directly and indirectly, the health informative phenomena.⁷ The author also highlights that is necessary to develop strategies that enhance the democratization

of access to the health information. Thus, it is necessary to understand how the power relations are manifested in the Information System of Primary Care, as well as how they influence it. Then, this issue has guided this study.

To subsidize the discussions from the theme of power, we used the theoretical framework of Michel Foucault and Max Weber. The choice of the referential of Foucault is due the concept of Biopower, which introduces itself in discussions on power relations that are established in the social body.¹⁰ Probably, the SIAB is inserted within this context, serving as an instrument of power.

For Foucault, the Biopower is the manager power of the human species, of life. In the Foucault's perspective, the watchful gaze of the State and its institutional levels on the individual and/or collective body comprises an area of dispute of power relations and knowledge production.¹⁰ These power relations in the health field are held by the discipline of individuals (anatomo-politics) and the regulation of populations (biopolitics) acting in order to ensure its existence. Both anatomo-politics and biopolitics, comprise the Biopower.¹¹

The power will not be seen as something static, centered on the figure of the State, or in a particular social apparatus, but overall, heterogeneous, dynamic, and thus going through constant changing. Under this view, the exercise of power permeates the targeting of conducts and pursues the management of the probabilities.

The choice of the referential of Weber is due to the necessity of seizing the power relations manifested in the SIAB, in a perspective of gazing on organizations and their managerial mechanisms. So, It should be highlighted the Weber's reflections, especially, on the legal power - bureaucratic.¹³ The legal power can be characterized by the sustainment of statutes, or any device that legitimates the dominant association. Here, the rationally created rules will sustain the dominant practices. This is nothing more than the power exerted on the structure of the bureaucracy, which keeps the interests of a specific social class. This type of power has as fundamental principles the functional hierarchy; the administration based on documents; the obedience, not to the individual, but the previously established rules that legitimize the power of authority.

Finally, the objective of this research is to analyze how the Information System of

Primary Care has been used as an instrument of power.

METHOD

This is a case study in which we used the qualitative approach of research. It is expected to investigate the object from the perception of the subjects, their speeches, their expressions and, even, the related processes. It is believed that the power relations do not cover something static, fixed on a point of the information network, on the contrary, are in constant motion, and are related to the social subjects, with the political and economic structures.¹²

The questionings on the theme led us to the following assumptions: The conception of the SIAB as an instrument of power influences their current placement and allow the enlargement of the State's gaze on the social body; The inefficiency of the SIAB is, partly, like an influence of the power relations established between the federal, state and municipal management levels, as well as within them.

We chose the semi-structured interview as a method of data collection. The tracked path to the execution of the interviews was guided by the information flow of the system itself at the municipal, state and federal management levels of the Brazilian Unified Health System. For each level of informative flow of the SIAB, it was used a semi-structured script due to the particularities of professionals, managers and technicians in these instances.

At the municipal level, the subjects included in the study were professionals of two Family Health Teams - *Equipes de Saúde da Família* (ESF), the oldest and the youngest, deployed in a medium-sized city, from the

state of Minas Gerais. Due to the fact it is a case study, it was chosen one of the cities from the mid-west macro-regional of health. Regarding the justification for choosing one oldest ESF, it is expected that the flows and processes related to the SIAB, are already more consolidated. By contrast, the choice of a younger ESF is justified by the need to understand if the same phenomena related to the SIAB happen even when the work processes are still in consolidation. Still at the municipal level, the managers and administrative technicians of the Municipal Secretariat of Health - *Secretaria Municipal de Saúde* (SMS) and the Regional Health Headquarter - *Superintendência Regional de Saúde* (SRS), co-responsible for the use of the SIAB and the analysis of its data, were included in this study.

At the state and federal levels, we interviewed managers responsible for the SIAB, as well as other professionals who use its data. At all levels where the interviews were conducted, we used as a criterion for inclusion of subjects the fact of possessing more than a year of work in these places. Furthermore, it was requested to the immediate responsible of the mentioned levels for that he listed the professionals responsible for the SIAB, its information flow, as well as those who use the system in their daily work. The Table 1 accurately describes the levels and subjects included in this current study.

The study was approved by the Ethics Research Committee of the FUNED / UEMG, Opinion 61/2010.

Table 1. Interviewed subjects from the informative flow of the SIAB at municipal, state and federal levels of the Unified Health System.

Level	Local	Subjects	n	%
Federal	Coordination of Monitoring and Assessment of Primary Care(Known as CAA)	Professional Staff of the CAA - Department of Primary Care	04	15,4
State	State Secretariat of Health of Minas Gerais	Head of Primary Care of the State de Minas Gerais	01	3,8
		State Technical Benchmark of the SIAB - MG	01	3,8
		Statistician	01	3,8
Municipal	Municipal Health Service	Head of Primary Care	01	3,8
		Coordinator of Primary Care	01	3,8
		Technical Benchmark of the Primary Care Nursing	01	3,8
		Typist of the SIAB	01	3,8
	Regional Health Headquarter	Coordinator of Primary Care	01	3,8
	Family Health Teams - <i>Equipes de Saúde da Família</i> (ESF)	Nurse	02	7,7
		Doctor	02	7,7
		Health Community Agent - <i>Agente Comunitário de Saúde</i> (ACS)*	06	23
		Nursing Assistant	02	7,7
Dentist		02	7,7	
Total			26	100

*Regarding the number of ACS included in the study: of the 08 subjects to be interviewed, only 06 were within the established criteria (more than a year of work and want to participate in the study).

The Content Analysis, thematic modality, was used to organize and analyze the data collected in the interviews.¹⁴ This study was approved by the Ethics Research Committee of the FUNED / UEMG, under Opinion 61/2010.

RESULTS

• The SIAB as monitoring tool on the individual and/or collective body: manifestation of the Biopower

In the Family Health Unit - *Unidade de Saúde da Família* (USF), you can identify that the SIAB has been a monitoring instrument. Firstly, the gaze over the individual is conducted from the description that the data of the SIAB shows on the reality experienced by this subject, within the environment in which it is inserted, in its family. This occurs through the description of domiciles, with their family components, their socioeconomic conditions, as well as the presence or absence of certain pathologies which are considered priority for controlling and monitoring.

I'll give you an example: the number of pregnant women, there are so many pregnant women and such of these pregnant women is not doing monitoring. Why are not you doing? Then, I'll look, but this one is not doing the follow-up, why? Where is she? Or this child is not with the vaccine up to date, why? This one was born and it has not exclusive breastfeeding, why? (E2)

Upon the vaccine itself, you get based on SIAB, which have so many children and not all of them are with vaccination up to date; you will know why and you'll be doing a work. Why are not these children with the vaccine on-time? So, let's chase. Is the number of teenage pregnancies too big? What can we do about it? Let's go to schools and talk about family planning. Let's see there what the number of children being born with low birth weight is. (E5)

In this sense, professionals, through the SIAB, seek to know what goes in the body of the individual, as well as the situations that can be configured as a risk to its health. The SIAB has the task to inform health professionals towards disciplining the body. This discipline can be represented by the criteria that must be followed by patients, by examination that must be conducted, by procedures, to which the users must be submitted.¹⁵ It should be emphasized the relationship between a disciplined body and a disciplining force constituting a combination of building of the welfare rather than a force canceling another one. It builds a political anatomy for the competence of the body; the body is framed in an established standard, in

a previously defined guideline for that category of user. For Foucault, the body is transformable, workable and (re)workable by disciplinary techniques. It is a possible locus of manifestation of power relations.¹⁵

In a second moment, even partially, the SIAB also provides to the professionals a "gaze" on the social corpus. In this case, the focus is on the collective, in the community where the individuals live, get sick and die. It should be noted the manifestation of the biopolitical gaze that enhances the generation of information aiming at promoting the social body.¹⁰⁻¹¹ In the speeches of interviewees, it is possible to see the SIAB as an instrument of the Biopower, in its biopolitical component.

The SIAB is a statistical survey of living conditions, housing of the community. (E8)

The SIAB intends to draw a diagnosis. So, as the word says, the diagnosis is really for this reason. You collect data, understand what population you have, draw and articulate some action plan to be done. (E2)

The SIAB is for us to diagnose our area, which has to be done and know where we have to act. (E1)

It is noticed that the SIAB provides the opportunity of pronouncement to the speeches of the social corpus. In the biopolitics, the population is still suffering the action from disciplinary mechanisms, it should be intensified the incentives to talk about oneself to better govern or be governed.¹¹ The SIAB is a system capable of informing, in part, on the social, economic, health and even pathological conditions of the population.

The watchful gaze of the professionals over the individuals and the community has yet been focused on the disease control ambit and, consequently, on the systematization of the records of the care process, emphasizing the healing model.

The SIAB is a database of movements, attendances that we perform here in the unit. We do nursing consultation, medical consultation, procedures, such as: temperature measuring, pressure, vaccination, all production on the done actions here at the unit is registered. (E8)

This is worrisome and contradictory, since the creation of the SIAB had in its core the need to collect, store, systematize data resulting from the Brazilian Community Health Agents Program - *Programa de Agentes Comunitários da Saúde* (PACS) and Family Health Program - *Programa de Saúde da Família* (PSF), government programs, structured to reorganize the Primary Health Care - *Atenção Primária em Saúde* (APS) and

disseminate the generated knowledge. The latter as reorienting axis for the health services, whose policy favors the health promotion, disease prevention, recovery, rehabilitation and the health maintenance of populations.¹⁶

On the other hand, professionals recognize that the SIAB is not the unique instrument used to observe the population. The exercise of monitoring is also done by other means, even in a non-systematized way.

We analyze both the SIAB, as we made an active observation at the PSF; we also made interview with people of the community. We need more data. Then, we do it, but without a script. The things are done the way we think have to be done, according to our demand and need. But, again, I say he (SIAB) cannot and is not the entirety of the process. (E2)

So, you have specific characteristics of the territory that the team gives an answer that goes beyond the SIAB. If I could think of a way of saying this would be like this: that the SIAB is an important database, but this is also beyond, or is it more important that the SIAB yet. (E3)

The monitoring is also made from the observation of the professional itself, its individual perception about the community. In this sense, the watchful gaze, component of the power relations, is influenced by the subjectivity of the subject itself who emits an effect of power, because from their point of view, also watch and decide. Anyway, the SIAB is not considered the entirety of the biopolitical and anatomo-politic process, but it is part of a network of information that is woven in the context of daily work of health professionals and their relation with the population.

• The SIAB as a monitoring tool of the work process of the family health team: a manifestation of the bureaucratic legal power

The SIAB also allows the monitoring of the work process of the professional of the family health team. This monitoring is internal, within the ESF itself, and also external, from the power relations that are established between the management levels, which intertwine and complement each other. Internally, in the ESF, the nursing professional and the Community Health Agent - *Agente Comunitário de Saúde* (ACS) stand out in this power relationship, where, on the one hand, an effective data collection from the SIAB is required, and, on the other hand, the collected data is presented according to the established goals.

The community health agents launch up these data and they are transmitted to the nurses, who end up being responsible for the teams, this happens in most of teams, I will not guarantee that at all, but most of the teams. (E5)

Even because every month we do a report where we analyze the visits of the health agent and see if he is actually fulfilling the goal that has to be fulfilled, that is 90 to 100% of the families, which have to be monitored every month. (E4)

It is a database related to a production of family health that allows me, in quantitative terms, I have an idea. It's logically associated with the number of each team managed to produce, mainly, within the risk groups. It allows us to roughly know if the community agent is fulfilling his goal. (E12)

The aforementioned speeches refer to the fact that there are goals to be achieved and that drive the productivity of the working process of some professionals, especially the ACS. It should be verified, in this sense, elements of the legal power exercised in the structure of the bureaucracy, such as rules and goals. Accordingly, they both, when respected, legitimize the power of the authority.¹⁷

The external monitoring is understood from the information flow of the SIAB itself, where the top, or the locus of centralization of the collected data, appears, in the statements of the subjects, as the Ministry of Health and the Municipal and State Secretariats of Health.

We have to give an account of all that we do, the Ministry requires [...] then, the team works on it and this data is given to the office, where they are typed and are launched in the Ministry. (E1)

So, if they are doing the service, if the number of visits of this community agent is reaching the goals of the Ministry. But some noted data are not required by the system and we only prepare the data sheet here and send it. (E6)

It emerges from these statements the fact that SIAB still is a centralized system, which maintains the relations of forces and involves delegation of competencies without shifting the decision-making power. This character of centralization of health information is also verified in the government about life.¹⁸

It should be realized a power relation where the Ministry of Health determines the goals and parameters to be followed by local management. Sometimes what is collected, no one knows the real meaning of it, but sends up the numbers, that are believed to be stored and analyzed at the federal level of the management of the SUS.

• The centralized flow, emptying of the local planning and impaired quality of data

The respondents highlighted that the work routine focused on performing tasks fosters a certain detachment from the possibility of analysis of the produced data, as well as the possibility of making a local planning from information of the SIAB. As a result, the data are produced, as one more task, and sent to the central level.

It's because the SIAB is a cool number. The team need planning and working with these indicators, but the unit's routine is full of task. Then, we'll be only talking about numbers. Because in the routine, even though we have this vision, we have no time to do it. The unit fills up us with the task, so we only give back the number and not get it back. (E3)

As we cannot, from the central level, make this monitoring of the teams, in terms of this data analysis, they ended up not giving much importance, much value to this discussion on data which is consolidated at the end of the month, then it only serves to be sent to the Ministry. (E12)

On the one hand, there is the need to meet the demand of the population, where the work process is focused on the pathological aspect; on the other hand, it requires the production of numbers and achievement of goals that should describe the productivity of professionals. It is possible that the need of transforming data into information are influenced towards it does not reflect up on this information and, not even, the execution of the local planning.

It is assumed that this emptying of the local planning is an answer, even if unintentional, from the professionals who are in the family health unit to the centralization of the informative flow. In this sense, there is, between the power relations, a counter-power mechanism that always implements itself.¹² This time, it keeps the flow of production of data, which must be sent to the central level and, they are underutilized for the local decision-making.^{6,19}

This difficulty that professionals have, in not to use, in fact, the SIAB for the local planning, may also be related to something broader. It is the difficulty that health professionals have to analyze data, contextualizing them and produce information. This difficulty is not generated by the SIAB, it is something prior to the use of the system, and it may be in the genesis of the training of health professionals. For some interviewees, the misuse of the data from the

SIAB is due to they are not prepared for it during the professional training.

We were formed to produce and not to sit and think that sitting, talking, planning is also working. We are pretty trained for the task. So, the task sometimes does not make the person think, because the task overload is thoughtless. (E2)

We have not trained coordinators, with enough knowledge to make that kind of data analysis with the team. Most of these professionals are from healthcare field, but they have no managerial training, as for the epidemiological even less. (E12)

Given the above mentioned, if the professional team is not prepared to analyze the collected data to generate information, it should be realized, from the interviews, the impairment of the data quality from the SIAB.

The data quality is very bad; we cannot say that the number represents the present. When you'll cross the data with the follow-up, it does not work. The agent gets concerned about the quantity and let the quality drops out, because he does not want to harm itself with an activity that does not count him as visits and monitoring. (E12)

The situation of data quality of the SIAB is not different, unfortunately, of the majority of Information Systems from Brazil, poor quality of information. It is noted, however, that this problem has deeper roots than merely the bad filling, or even, lack of knowledge about the information input form into the system, what is observed is that the vast majority of responsible actors underlines the importance of a consistent and constantly updated basis. (E13)

For some authors, the SIAB has problems related to the quality of its data. The generated reports are incomplete, there are difficulties in completing the system forms and, there is lack of knowledge.²⁰⁻¹

Still regarding the data quality of the SIAB, and, certainly, to their reliability, some respondents highlighted the possibility of occurrence of data manipulations in this system. This manipulation could be stimulated from the configuration of the system itself, which is linked to the transfer of federal funds to municipalities.

Municipalities charge the system seeking resources and the data, often, are not trustworthy. (E11)

For that the Ministry of Health sends money, he (municipality) needs a certain number of users, needs a certain number of visits, the ACS has to make a number of visits, by 90%, for example, and if you do not do the 90%, it blocks the funds. Manipulation is for not losing the fund. This is the main reason. (E8)

If there is manipulation as for the presentation of not real data, I think it can happen. And regarding the interest in it, perhaps to keep the regular power the system, without quality/consistency of the data, and not be penalized with regard to the transfer of federal financial resources. (E18)

On another level it can be, at times, there is the will of manipulating the data in order to drive some kind of action and the data needs to be changed for the implementation of such type of action. (E2)

As with other systems of Ministry of Health, for not being a system with individualized data entry and, somehow, the sending of information is linked to a payment of funds, there is always the risk of having this manipulation to meet particular interest. (E15)

In this sense, the data manipulation of the SIAB follows a logic determined by outcome or productivity goals, which are defined and agreed between managerial entities. The financial transfer, in this context, seems to be an incentive for this process of manipulation. Some features of these pacts that are established in the Unified Health System - *Sistema Único de Saúde* (SUS) are described by some authors, namely: the strong character of the bureaucratic pact focused on a norm previously established and understood as a demand from the Ministry of Health to municipalities and states; a punctual pact, fragmented and without systematic monitoring by its managers; a pact that is still very much related to political interests and, even, private.¹⁷⁻¹⁸ In summary, municipalities and states adhere to the agreement of goals and indicators, often motivated by the transfer of funds to the detriment of local priorities, and this reality has influenced the processes related to the SIAB.

Nonetheless, the outcome goals established in the pacts do not seem to be the only way to encourage the data manipulation of the SIAB. The forces emanating from the political intentions can also go through and forge informative practices related to the SIAB. The report below shows the influence of this political game on the informative flow of the SIAB, since the agreements tend to charge the electioneering machine and the partisan hegemony.

It's a game of interests... maybe from the political side. Ah, Brazil managed to achieve this goal - a certain amount of vaccinations - I don't know - decrease the mortality rate. But this is interesting. I think this interest only favors this political game; because there is this political game. It will bring

some votes for deputies, for some governors, for the mayor. (E1)

Another aspect of the power relations present in the flow of the SIAB emerges in this discourse. The need of achieving the outcome goals in pacts that are defined in agreements is influenced from political interests. And this tends to reflect over the data production by professionals, especially those who corroborate the previously established goals.

It should be realized, through the speeches, that the data manipulation of the SIAB is attributed, largely, to the Community Health Agents - *Agentes Comunitários de Saúde* (ACS), mainly because they are the professionals responsible for the initial collection of data, as well as its dissemination.

The community agent manipulates it, often increasing the number of visits. And it is complicated for we control. It is not possible to get there with a GPS over him all the time. So, there really is a manipulation, because they know they will be called upon. This is a reality that we live for a long time and it is hard for dealing. The ACS, it does not reach the target from the Ministry of Health, may have its extra income cut off, hence he manipulates it much more than other professionals. (E1)

The ACS has to reach a number of visits by 90%, for example, and if you do not do the 90% the federal fund will be blocked. I think, in this cases, he manipulates it. (E8)

The manipulation performed by ACS is sustained by this relationship of forces that go through its work process. These forces require and discipline this worker toward ensuring the achievement of previously established goals and produce a docile body, especially to guarantee the fulfillment of its role. It is the obligation of creating a true.

We are subjected, by the power, to the production and can only exercise it through the production of truth. On the other hand, we are also subjected to the truth in the sense that it is the law and produces the true discourse that decides, transmits and reproduces, at least partially, the effects of the power. After all, we are judged, condemned, sorted, forced to perform tasks and intended for the right way to live or die, depending on the true speeches that bring with themselves the specific effects of power.

12:180

The ACS, subject to production of truths, emits power effects when reacts to this force and produces truths, because they are previously established laws in the agreement of the productivity goals for this professional. What we see now is the process of disciplining

of this professional (ACS), seeking normalize it. The body of this worker suffers an action of the forces that shape it, structure it, built its docility, establishing its professional identity aiming at establishing a determined informative flow. This professional may be being marginalized in the process of understanding of the collected data and the importance of the SIAB. In this context, the ACS sees its work routinized, bureaucratized, only in the sense of producing numbers, decontextualized data, with few possibilities of analysis.²²⁻³ Finally, the ACS is surrounded by power relations that stimulates it to emit the effects of power, in this case, the action of manipulating some data, in order to achieve the established goals. The targets, in this case, assist in body modulation.

It should be noted, through the following statements, that the practice of manipulation is not linked only to this professional (ACS). Similarly, some respondents came to contradict themselves and / or show concerns when questioned about the possibilities of the SIAB's data being manipulated.

There are some colleagues who also manipulate the data of the SIAB, but it is not as blatantly as the ACS. (E1)

I trigger the team when the SIAB gives me very bad indicators. It is part of the game and it makes the game get interesting and very healthy. I realized this week, for example, several units sent "0" of vaccination. I know this is not true, because if it were, we were lost. We give back and question and they get right the process. And I already know what happened. It is the same person who registers and that person became sick and the group forgot to look. So, we interfere. I think there is technical interference. It is there in the team that generates the data, which should make the modification. (E3)

What I do is only type the data. Then, the decision is a task of the board, coordination of the PSF. Now ... (expression of fear) this question of manipulation (spoke softly) is in the coordination of the PSF. (E4)

But that (manipulation) only favors the population. I say, in this sense, there really is an interest, but it is a good interest. (E1)

We observed that some interviewees confirm the manipulation, others contradict themselves, others blame the other instances and, surprisingly, some professionals believe that manipulation favors the population. It should be highlighted, at this time, the disciplinary mechanisms and also the production of the individual by the bureaucracy.^{13,15} At this point, the discipline and the bureaucracy align with each other. What individuals believe about the

manipulation was disciplinary built and from the established bureaucratic process on the conception of the collection and dissemination of data from this system. It should be realized a certain standardization from a discourse that justifies the data manipulation as a necessary and healthy practice, which is producer of truth. It is the docile body aiming at producing.

CONCLUSION

We found that the use of the SIAB is also due to the need of ensuring the exercise and maintenance of the power relations / Biopower in the Primary Health Care. We found that the power relations / Biopower established over the SIAB can comply with its inefficiencies. This can be verified through the centralization of its flow, mainly, in the Ministry of Health. Due to this flow is centralized, this can empty, at the municipal level, the necessity and possibility of a local service planning, as well as favors the poor data quality of this system. However, it is recognized that other variables may also promote this phenomenon of the lack of local planning, and other studies are needed to understand this issue. The data manipulation of the SIAB, found in this study, conforms a possible cancellation of the reality of the situation in the assistential locus, because what is presented as real data of the population, often, are caricatures on something that is intended to be shown.

From the findings observed in this study it is not noticed, in the informative flow of the SIAB, an information management process as a structured set of activities that include how the companies obtain, distribute and use information. What happens, regarding the SIAB, are unstructured, inefficient, non-systematized practices for collection, storage, analysis and dissemination. The information management should be focused on the target audience of the informative process in focus. But, we have verified that there are practices aimed at expanding the watchful gaze of the central levels, and, in an incipient way, is the possibility to use up the information of the SIAB to qualify the health actions for the local population.

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