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INTRODUCTORY TO FAMILY HEALTH TEAMS: CONTRIBUTIONS TO THE STRENGTHENING OF PRIMARY CARE

INTRODUTÓRIO PARA EQUIPES DE SAÚDE DA FAMÍLIA: CONTRIBUIÇÕES PARA O FORTALECIMENTO DA ATENÇÃO BÁSICA

INTRODUCCIÓN PARA LOS EQUIPOS DE SALUD DE LA FAMILIA: CONTRIBUCIONES AL FORTALECIMIENTO DE LA ATENCIÓN PRIMARIA

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ABSTRACT

Objective: identifying the contributions of the Introductory Course for expansion of knowledge about the Primary Care Policy. **Method:** a descriptive, cross-sectional study, of a quantitative approach, with 251 professionals in Primary Care. Data were collected through a questionnaire with open and closed questions, before and after the course and analyzed using the SPSS software, after approval of the project by the Research Ethics Committee, protocol 142.1712-10. **Results:** the results show the Feminization of belief and teams of professionals in Strategy as a driver of change in the setting of primary care; knowledge of the principles of the Health System and 648/2006 Ordinance; limited domain information system and tools for evaluating teams. **Conclusion:** the course promoted the work process, reflected in the quality of care and contributes to the strengthening of health policies. **Descriptors:** Primary Health Care; Unified Health System; Family Health.

RESUMO

Objetivo: identificar as contribuições do Curso Introdutório para ampliação do conhecimento acerca da Política de Atenção Básica. **Método:** estudo descritivo, transversal, de abordagem quantitativa, com 251 profissionais da Atenção Básica. Os dados foram coletados por meio de questionário com questões abertas e fechadas, antes e após o Curso e analisados com auxílio do software SPSS, posteriormente à aprovação do projeto pelo Comitê de Ética em Pesquisa, protocolo 142.1712-10. **Resultados:** os resultados evidenciam a feminização das equipes e crença dos profissionais na Estratégia como propulsora de mudanças no cenário da Atenção Básica; conhecimento dos princípios do Sistema Único de Saúde e da Portaria 648/2006; domínio limitado do Sistema de Informação e dos instrumentos de avaliação das equipes. **Conclusão:** o Curso favoreceu o processo de trabalho, repercutiu na qualidade da atenção e contribui para o fortalecimento das políticas de saúde. **Descritores:** Atenção Primária à Saúde; Sistema Único de Saúde; Saúde da Família.

RESUMEN

Objetivo: identificar las contribuciones del Curso Introductorio para la expansión de los conocimientos acerca de la Política de Atención Primaria. **Método:** estudio descriptivo, transversal, con un enfoque cuantitativo, conducido con 251 profesionales de la Atención Primaria. Los datos fueron recolectados a través de un cuestionario con preguntas abiertas y cerradas, antes y después del curso y analizados utilizando el software SPSS, después de la aprobación del proyecto por el Comité de Ética de la Investigación, el protocolo 142,1712-10. **Resultados:** los resultados muestran la Feminización de la creencia y equipos de profesionales en estrategia como un impulsor del cambio en el contexto de la atención primaria; conocimiento de los principios del Sistema de Salud y Ordenanza 648/2006; sistema de información de dominio limitado y herramientas para la evaluación de los equipos. **Conclusión:** el curso promovido el proceso de trabajo, que se refleja en la calidad de la atención y contribuye al fortalecimiento de las políticas de salud. **Descriptores:** Atención Primaria de Salud; Sistema de Salud; Salud de la Familia.

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INTRODUCTION

In Brazil, the working process of family health teams goes through numerous changes, especially related to professional qualification, towards a model of comprehensive care and health promoter, with emphasis on practices that promote the (co) accountability and links (inter) professional. It is considered that the incentive to training and human resource development process imply the improvement of the quality and resoluteness of Primary Health Care (PHC) and, consequently, the consolidation of the Unified Health System (SUS).

The Family Health Program, nowadays called Family Health Strategy (FHS) was created in 1994 and comes as a proposed reorganization and strengthening of PHC. Brings with it the need for professionals with a different profile, prepared to operating in the territory, based on the collective, interdisciplinary work with family and community focus and approach problems of intersectoral way.¹

Since its deployment, one of the most critical aspects of FHS lies in the lack of trained personnel to operating at this level of health care. Essentially, the requirement is that the professionals start to act at PHC based on a general perspective, considering that the problems and health needs of the population, which requires a number of measures in the field of vocational training, since training of short duration to proposals changes in graduate.²

In 2007, the Ministerial Decree No. 1996 revises the National Policy on Permanent Health Education (PNEPS), which currently sets up a fundamental strategy for reorientation of training practices, care, management, policy and social control in the health sector. The proposal is based in the need for accountability of health services to transforming the practices of workers, through the construction of knowledge committed to the social reality of the subjects/citizens care (Brazil, 2007a). The PNEPS recommends conducting studies to identify the impact of actions in order to verify the performance of the most qualified professionals, managers and other social subjects, aiming to (co) responsibility for the improvement of public health at all its levels of care.³

In 2011, the School of Public Health of Santa Catarina (ESP/SC) of the State Department of Health, the Health Offices of the Secretaries of State for Regional Development (SDRS) Chapecó and Xanxerê and

the Municipal Health 46 municipalities that make up the Inter-Regional Commissions (CIR) of Macro-region west of this State, offered the introductory Course for Professional Health Teams and Family Support Centers for Family Health (NASF) who work in PHC in this region, according to the Ministerial Decree No 648/06 (Brazil, 2006a), which regulates the PHC, obeying the minimum content defined by Ministerial Decree nº 2.527/06.⁴

The four modules of the course problematized themes, as follows: MODULE I - Primary Care in the context of Public Health Policy; MODULE II - Interdisciplinary Practice and popular participation; MODULE III - The work process of Teams and MODULE IV - The Organization of Local Health Systems The classroom methodology was oriented according to the questioning of daily practice teams, with multidisciplinary participation of workers, from the perspective of Continuing Education Health (EPS). Before this initiative, one of the emerging issues of the process was: what contributions the Introductory Course in expanding the knowledge of professionals about the recognition of the National Primary Health Care?

This manuscript presents the results of a study aimed at identifying the contributions of the introductory course to expand the knowledge of professionals about the National Policy on Primary Health Care (PNABS)⁵, especially with regard to change in the healthcare scenario, the area of SUS and 648/2006 Ordinance, as well as the Health Information System and tools for evaluating the teams.

METHOD

This is a descriptive cross-sectional study with a quantitative approach. This offered 88 hours of class, divided into four modules concentration (classroom) activities, interspersed by dispersal activities (distance), totaling approximately 370 professionals enrolled.

320 health professionals participated in the first moment (M1) that preceded the beginning of the Introductory Course; and in the second moment (M2), which occurred four months after the start of the course, in the final class, 251 professionals. These act by the FHS or NASF located in West macro-region of Santa Catarina, which covers 46 counties, making up two CIR. These municipalities have currently has 147 teams deployed FHS and 38 teams NASF, and other structures that make up the health system, to assist the population of approximately half a million inhabitants.⁶ Participation in the course was mandatory for

professionals who were not screened when offered previously in this region in 2008, as recommended by the Ministry of Health (MOH).⁴ The activities took place during working hours and the teams were certified by ESP/SC.

There were used as inclusion criteria for the research: including professionals working in the FHS, or NASF, who never performed the Introductory Course, who agreed to participate voluntarily in the study and signed a consent form, and that they had participated in the two moments of data collection. After the application of the criteria remained 251 subjects.

For data collection there were used a questionnaire with objective and subjective questions that assessed the knowledge of health professionals about the NHS and the guidelines of the FHS, as well as the contributions of the introductory course to the work process and the recognition of NBSAPs. This instrument was applied in the first and last day of the Course, being built on a previous literature review. The first stage of data collection was conducted in May 2011 and the second in October of the same year.

To organize data of the 502 instruments were identified by the initial of the professional category, M1 and M2 for the first time for second and order number. The data tabulated quantitative form in Excel and willing qualitative data into four categories: knowledge of the principles of the Health System; Ordinance 648/2006; Domain Information System in Health and tools for evaluating teams.

Quantitative data were analyzed using the Statistical Package for Social Science for Windows (SPSS), seeking to explore and verify the profile of the study participants, knowledge acquired before and after completion of the course, by using the Chi-square (X^2) for qualitative variables and descriptive statistical tests (percentage, media, fashion and amplitude) for quantitative analysis of continuous variables. The qualitative data advance the understanding of the past.

The research followed all ethical precepts recommended by Resolution 196/1996 and was approved by the Research Ethics Committee of the State Health Department of Santa Catarina, under protocol number 142.1712-10.

RESULTS

Participated in the two moments of the study 251 (71,71) subjects. Of these, 222

(89,52%) are female, 26 (10,48%) are male and two participants did not respond. There was a higher frequency of participants between the ages of 20 to 30 years old (52,67 percent), followed by the range of 30 to 40 years old (25,51%) of 40 to 50 years old (13,58%) over the age of 50 (4,53%) and professionals have been identified yet, with less than 20 years (3,7 percent). The average age of the participants was 30,51 years, signaling the joviality of the professionals working in the FHS in the macro-region.

Studies have identified the predominance of female professionals, especially among nurses in teams of FHSs.^{7,8} Regarding age, research has demonstrated the predominance of age between 20 and 30 years of professionals working in teams, in different scenarios of the national territory.⁷ It is considered that this reality should be looking for recent graduates, even without residency courses completed, by such labor activity, which demands generalist medical professionals. For nurses and other health professionals, it is observed that the FHS has absorbed much of the workforce in health in Brazil, through special contracts that facilitate the processes of hiring and firing and allow wages to be competitive specific categories, above those received by health professionals in other services, equally qualified.⁹

The FHS has enabled the expansion of the labor market for health professionals, incorporating a diversity of categories.² Yet, studies¹⁰ have signaled that the municipal sphere of health is often responsible for 54,2% of new jobs these workers as a result of the decentralization of the Brazilian health system process.

Table 1 allows us to observe that different professional groups have been active in the FHS teams. The Strategy signals the need for support from other professional categories, proposed that guided the implementation of the NASF. In part, this diversity and difference in participation between the categories are due to the course being in its second edition, due to the inclusion of the NASF and turnover of Community Health Agents (ACS), which represent an ever greater quantity than other workers.

Table 1. Distribution of subjects who participated in the study by professional category.

Professional Category	n	%
Community Health Agent	126	50,20%
Nursing technician	28	11,16%
Others-services workers *	25	9,96%
Nurse	13	5,18%
Dentist	10	3,98%
Pharmacist	8	3,19%
Nursing Assistant	7	2,79%
Nutritionist	7	2,79%
Doctor	6	2,39%
None	6	2,36%
Physical Therapist	5	1,99%
Psychologist	5	1,99%
Social Worker	4	1,59%
Audiologist	1	0,40%
Total	251	100%

* Workers from other areas (administrative technicians, managers without training in the area of health and drivers).

The FHS together with NASF brings new setting in health systems and services in Brazil, to reorient the model of care in the NHS. These seek to comply with the principles of PHC, proposes greater rationality in the use of other levels of care, greater access to health actions and changes in morbidity and mortality profile of Brazilian.^{11,12}

With the Pact for Life¹³ BANP becomes a priority for the NHS and rescues the need for consolidation and upgrading of FHS as a clinical center and originator of networks of health care model. In this context, the NASF, whose implementation started in 2008 (NASF), represents an important milestone in the expansion of opportunities to achieve better results, with a focus on health promotion and care to the population. The inclusion of new

health professionals, linked to the FHS teams, increases the possibility to respond to new and old challenges morbidity of Brazilians. The NASF provide the ability to expand the supply of complementary and integrative health practices in PHC.¹¹

In Table 1, we observe that the professionals who make up the minimum team strategy, physicians were those who achieved less representatively in the ACS study and totaled about 50% of the total, followed by the nursing staff.

The analysis of Table 2 reveals that the participants mostly have little time professional experience in the healthcare modality, legitimizing the importance of doing the job training, monitoring and support teams.

Table 2. Time of performance of the professionals.

Time of performance at FHS	n	%
<= 6 months	32,27%	81
> 6 months and < 12 months	11,16%	28
>=12 months and < 24 months	33,86%	85
>= 24 months	13,15%	33
none	9,56%	24
Total	100	251

Having in mind the short time experience of these professionals and the expansion of the FHS teams are required continuous investments in their formation. In this situation, universities can guide the process in compliance with the qualification requirements of PHC in Brazil. That depends on structural changes in training, especially in the area of health, expansion of residency positions in family health, as well as professional profile to work with a focus on community and SUS.¹¹

The Office of Labor Management and the Continuing Education in Health (SGTES), which comprise the Ministry of Health (MOH) since 2003, aim to equate the existing problems in the area of human resources in the field of labor management and education toward effective performance of SUS. This initiative

involves the MOH as a federal manager, as articulation of policy guidelines of the formation and development of people in health care, from the planning, management and regulation of the labor force. Among the structural axes of the SGTES policy are the PNEPS and its proposed strategic action to promote the transformation of health practices, the organization of activities and services, the training processes and pedagogical practices for training and development workers.³

Other strategies lie at the approach of MOH with the Ministry of Education, with which devices have been proposed designated "ministerial structuring actions" for the reorganization of education in the area, in order to approach the university with public health services. Among these devices are: the

National Programme of Reorientation of Vocational Training in Health (Pro-Health), the (PET-Health) Education Program for Health at Work, the Open University of SUS (UNA-SUS), the Telehealth Brazil, among others. These mechanisms aim at the transformation of teaching with a view to preparing for work in the NHS.¹⁴

Following are presented the issues that emerged from the evaluation conducted with the participants worked on the main content in the Course, Spotlight: the belief of the professionals in the FHS as a driver of change in the PHC and knowledge gained with the Course about the principles of the NHS and 648/2006 Ordinance; the use of Health Information System (SIS) and the largest area of the instrumental assessment of the work of the teams.

• The belief in the FHS as a promoter of change of PHC and the knowledge gained from the course

In M1, 87,81% of professionals believe in the potential of the FHS as favoring the PHC in the macro-region and country. M2 after completion of the course, the percentage rose to 94.82% indicating that it strengthened the belief of the participants in the care modality.

Professionals, in general, refer to improvements in the quality of the health system through closer ties with the community, the bond of the teams with families and community and greater accessibility to services. Such expressions contribute to expanding the knowledge and debate about the PHC as the main strategy for reorienting the SUS.

The understanding of the group on the NHS, the M1 converges with the ideals of a free health plan, a call to people of low income and perceptions related to the principles of universality and equality of care. At the end of the course, there was subtle shift in perception of health professionals in the contents discussed, highlighting increasing the understanding of the group in relation to the work process in PHC, with an emphasis on teamwork and attention to the individual and society, so integral. The answers to the open questions point to the SUS as a social right.

Throughout the process of restructuring the current health care model in Brazil is not always visualized that the principles and guidelines of SUS were treated with equal importance. Rather, in each environment, certain hierarchy of importance is constituted between them, either as a result of the heterogeneity within the sanitary movement with respect to the importance attached to

one or other principle or as a result of policy options on certain political obstacles.^{15,16} The principles of equity and universality associated with the integration of services by levels of complexity network, seek to ensure the ideals of the Health Reformation movement.¹⁵ Thus, in addition to identifying the principles and incorporate them into his speeches, professionals and health managers of PHC should use them as guiding their practices, and effectively commit themselves to them.

On Ordinance No. 648, approving the PNABS¹, establishing a review of guidelines and standards for the organization of the PHC, for the FHS and the Community Health Agents Program (PACS), we identified an advance in knowledge of 14,06% to 68,13%.

Product review of previous editions of SUS legislation, the current Ordinance No 2.488¹⁷, which repeals Ordinance 648, establishing a review of guidelines and standards for the organization of Primary Care and the Family Health Strategy (FHS) proposes adjustments in view of the present transformations in the process of developing the PHC of the country. It highlights that PHC should develop and promote individual and collective actions, articulately with a participatory and democratic management practice, with a focus on teamwork, considering the context in which people live. Remember that the Ordinance adds the dimension of uniqueness and complexity of the subject seeking assistance.^{17,18} It is worth noting that its Ordinance was seen as one of the main guidelines of the professional activities of the FHS and seeks to strengthen the idea of Health family as the structuring axis of AB\S, and not just a program and others offered by MOH.

• Use of Health Information System

The Health Information Systems (SIS) in SUS are highlighted as instruments to identify the epidemiological profile of the population, should guide the actions of planning, management and evaluation of services offered, as well as possible, in part, the follow-performance of activities under Family Health, its expansion and consolidation.

On the SIS, the survey indicated that 48,75% and 65,34% of the participants in the M1 and M2, respectively, revealed learn and use the systems in their everyday life.

Among those who expressed this statement stood out the ACS (M1: 85 ACS - 54,48% / M2: ACS 95 - 57,92%), followed by members of the nursing team, as most workers who use the SIS (M1: 21 nursing technicians - 13,46%; 17

nurses - 10,89% / M2: 18 nursing technicians - 10,97%; 09 nurses - 5,48%).

The SISs represent the manner of recording the activities of the teams. Nurses often assume the registration of all productivity, including being delegated, activities performed by physicians. Such systems have been used to quantify the registration of important contributions to the work of the teams at the local level, with a view to reorganizing and definition of health, and yet, can be considered auxiliary instruments for decentralization of SUS.

It was found that the use of SIS is uneven across different scenarios and actors of healthcare practice, and often the information does not depict reality or are employed as guiding services and health practices.

Information technologies in PHC are considered by the team at the time of its implementation, as sources of increased workloads. However, after adaptation, and domain knowledge for use, become sources of reduced workload because give more security and quality of services.¹⁹

Part of the limitations to the use of SIS is due to incipient presence of continuing education, which creates limitations on involvement from the team until the total ignorance by the FHT professionals. We highlight the importance of SIS as a tool for reorganizing the work and fundamental database for the PHC process, even if their use by professionals is uneven and incipient compared their usage possibilities.²⁰

● Field of occupational assessment instruments of teams

The evaluation of social policies and programs is seen by experts as strategic and essential procedures to give transparency to public actions, democratizing the state and civil society, to know and understand the policies in the state action, directing changes in implementation and results of the SUS.

Most professionals, when asked about the instruments of evaluation and monitoring of their work, in M1 (53,44% -171 participants) said he did not know them. A representative number abstained from the question (10,94%, 35 participants). M2 in the percentage of participants who still did not understand the instruments dropped to 26.69%. Abstentions were maintained between 9,56% of the subjects. These data demonstrate that professionals have come to know the tools for evaluating the work of teams; however a representative number of participants

remained without understanding them and or abstained.

The weakness in knowledge of assessment tools by health professionals is pointed in the literature as limiting aspect for making new interventions and creation of device that can provide valid and legitimate information, able to qualify the NHS management.²⁰

When considering the assessment tools as strategies used at the beginning, the middle and the end of a process, which guide the planning and management of health, it was understood that the teams must take ownership of these instruments and knowledge to rearranging their activities in order to accommodating the needs of the public who attends.

CONCLUSION

In summary, the survey revealed that the course increased the belief of the professional potential of FHS as empowering the PHC in the region in which they operate, expanded the understanding of the work process in this care modality, the guiding principles of the NHS and Ordinance 648, as main guiding document of team activities, however, the Course potentiated to a limited extent the domain of SIS, which partly justified by the difficulty of the technologies and the unequal access to these, among the participants.

The findings confided that the seizure of instruments of evaluation and monitoring of work remain to be a problem for the professionals, this is an aspect little achieved the Course and something that needs investment by managers of politics in the country.

Concerns that mark the field of EPS gain status of central policy in the spheres of NHS management and signal potential to consolidate the system, however, the macro-region investigated, it is clear that we still need to move towards strengthening managerial accountability and participation of educational institutions in the process of EPS. This statement is a result of the weaknesses found in the study: blank questions, number of professionals that quit the survey (M2) and lack of other studies for comparison.

It is assumed that the results of this research will be important to strengthen the actions of EPS in the region, through subsidies that will explain other initiatives ongoing training, focused on the constant improvement of professionals working in PHC.

Although the methodology of the course, the proposed modular and based on the questioning of everyday service, seems to favor the incorporation of the contents labor

practice teams, we consider the need for further research evaluative nature, in order to measure its impact the qualification of the labor process.

REFERENCES

1. Ministério da Saúde. Secretaria de Atenção Básica. Departamento da Atenção Básica. Portaria no 648, de 28 de março de 2006. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica para o Programa Saúde da Família (PSF) e o Programa Agentes Comunitários de Saúde (PACS). Brasília: Ministério da Saúde; 2006.
2. Campos FE, Haddad AE, Pierantoni CR, Brenelli SL, Cury GC, Morita MC, et al. O Programa Nacional de Reorientação da Formação Profissional em Saúde: Pró Saúde. In: Pierantoni CR, Viana ALA (org.) Educação e Saúde. São Paulo: Hucitec; 2010. p. 25-36.
3. Ministério da Saúde. Portaria GM/MS no 1.996, de 20 de agosto de 2007. Dispõe sobre as diretrizes para a implementação da Política Nacional de Educação Permanente em Saúde e dá outras providências. Brasília: Ministério da Saúde; 2007.
4. Ministério da Saúde. Portaria Nº 2.527, de 19 de outubro de 2006. Define os conteúdos mínimos do Curso Introdutório para profissionais da Saúde da Família. Brasília: Ministério da Saúde; 2006.
5. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política Nacional de Atenção Básica. 4. ed. Brasília: Ministério da Saúde; 2007.
6. Secretaria de Estado da Saúde de Santa Catarina. Gerência de Atenção Básica. Florianópolis; Brasil. 2012. Available from: http://portalses.saude.sc.gov.br/index.php?option=com_content&view=article&id=203&Itemid=164
7. Cotta RMM, Schott M, Machado AC, Castro FSC, Eloísa PS, Glaucé D. Organização do trabalho e perfil dos profissionais do Programa Saúde da Família: um desafio na reestruturação da atenção básica em saúde. Epidemiol. Serv. Saúde [Internet]. 2006 [cited 2013 June 19];15(3):7-18. Available from: http://scielo.iec.pa.gov.br/scielo.php?script=sci_arttext&pid=S1679-49742006000300002&lng=pt
8. Gil CRR. Formação de reCursos humanos em saúde da família: paradoxos e perspectivas. Cad. Saúde Pública [Internet]. 2005 [cited 2013 June 19];21(2):490-8. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2005000200015&lng=en&nrm=iso
9. Victora CG, Barreto ML, Leal MC, Monteiro CA, Schmidt MI, Paim J, et al. Condições de saúde e inovações nas políticas de saúde no Brasil: o caminho a percorrer. The Lancet [Internet]. 2011 [cited 2013 June 19];6:90-102. Available from: <http://download.thelancet.com/flatcontentassets/pdfs/brazil/brazilpor6.pdf>
10. Machado MH. Mercado de trabalho em saúde. In: Barros AFR. Observatório de reCursos humanos em saúde no Brasil: estudos e análises. Rio de Janeiro: Fiocruz; 2003.
11. Mendonça GS. Saúde da Família, agora mais do que nunca. Ciên saúde Coletiva [Internet]. 2009 [cited 2013 June 19];14(1):1493-7. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232009000800022&lng=en
12. Facchin LA, Piccini RX, Tomasi E, Thumé E, Silveira DS, Siqueira FV, et al. Desempenho do PSF no Sul e no Nordeste do Brasil: avaliação institucional e epidemiológica da Atenção Básica à Saúde. Ciên saúde Coletiva [Internet]. 2006 [cited 2013 June 19];11(3):669-81. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232006000300015&lng=en
13. Ministério da Saúde. Portaria Nº 399, de 22 de março de 2006. Divulga o Pacto pela Saúde 2006 - Consolidação do SUS e aprova as Diretrizes Operacionais do referido Pacto. Brasília: Ministério da Saúde; 2006.
14. Ministério da Saúde. Ministério da Educação. Programa Nacional de Reorientação da Formação Profissional em Saúde - Pró-Saúde: objetivos, implementação e desenvolvimento potencial. Brasília: Ministério da Saúde; 2007.
15. Cohn A. Os princípios do Sistema Único de Saúde e a atenção Básica (Programa Saúde da Família): o perigo mora ao lado. Cad Saúde Pública [Internet]. 2008 [cited 2013 June 19];24(1):23-4. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2008001300006&lng=en&nrm=iso
16. Mattos RA. Princípios do Sistema Único de Saúde (SUS) e a humanização das práticas de saúde. Interface [Internet]. 2009 [cited 2013 June 19];13(1):771-80. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-32832009000500028&lng=en&nrm=iso
17. Ministério da Saúde. Portaria GM/MS no 2.488, de 21 de outubro de 2011. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e

normas para a organização da Atenção Básica, para a Estratégia Saúde da Família (ESF) e o Programa de Agentes Comunitários de Saúde (PACS). Brasília: Ministério da Saúde; 2011.

18. Pereira MJB, Fortuna CM, Mishima SM, Almeida MCP, Matumoto S. A enfermagem no Brasil no contexto da força de trabalho em saúde: perfil e legislação. Rev Bras Enferm [Internet]. 2009 [cited 2013 June 19];62(5):771-7. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-71672009000500022&lng=en&nrm=iso

19. Trindade LL. Implicações de dois modelos assistenciais em saúde nas cargas de trabalho dos profissionais da Atenção Básica [Tese]. Florianópolis (SC): Programa de Pós-graduação em Enfermagem, Universidade Federal de Santa Catarina, Florianópolis; 2011.

20. Freitas FP, Pinto IC. Percepção da equipe de saúde da família sobre a utilização do sistema de informação da atenção básica-SIAB. Rev Latino-Am Enfermagem [Internet]. 2005 [cited 2013 June 19];13(4):547-54. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-11692005000400013&lng=en&nrm=iso

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