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STRATEGIC AND PARTICIPATORY MANAGEMENT IN THE SUS (UNIFIED HEALTH SYSTEM): IMPLEMENTING NEW DELIBERATIVE INSTANCES

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Abstract: The income from social control in the SUS (UNIFIED HEALTH SYSTEM) is seen in a form of transformation as actions. For this, the management must have as a strategy the valorization of social participation through the implementation of strategies that aim at the popular to the managerial processes. **Objective:** Humanize municipal health management, through the intensification of the Strategic and Participatory Management process, democratically qualifying the services. **Methodology:** This is a cross-sectional observational analytical study carried out in the city of Paulo Jacinto. To carry out the study, the actions were divided into two stages. The first is called conversation rounds, which are configured as home meetings and the second is called the Interdisciplinary Health Committee, composed of representatives of all classes of health professionals, with the function of deliberating solutions to the demands found in all of the rounds. of conversations. **Result and discussions:** There were 21 rounds of conversations, with one meeting in each micro health area belonging to the four basic health units in the municipality. 84 improvement requests were cataloged, of which 77% were resolved. **Conclusion**: Thus, the resolution of the demands arising from the rounds of conversation ensures the user's access to management, serving as a deliberative subsidy for the interdisciplinary health committee, directs actions to the unique needs for the managerial routines. This way, the interrelation between the two instances promotes the qualification of the work process, making health actions more humanized, democratic and effective.

Keywords: S.U.S. (Unified Health System) management, Humanization, Popular participation.

INTRODUCTION

The construction of the Brazilian Unified Health System involved, throughout its process, the participation of several social peers, based on the Health Reform Movement, which defended a design of a health system, based on public policies capable of providing collective protection against diseases, ensuring your health in all aspects (COELHO, 2012).

With the enactment of the 1988 Constitution, based on the health field, the fruits of the struggle of all the actors involved in the health reform process, the presence of the community became one of the basic conditions for the implementation and consolidation of the Health System. Single Health. After that, laws 8080/90 and 8142/90 were published, which institutionalize and regulate popular participation and social control in health management, with health conferences and councils as legally established bodies (BISPO JÚNIOR, 2008).

The National Health Council published Resolution 333/2003, which creates parameters for the arrangement and structuring of health councils. These councils are permanent and deliberative and their main role is to operate in the definition of public policies and in the supervision of management, including economic and financial attributions (BISPO JÚNIOR, 2008).

The implementation of social control in the SUS (UNIFIED HEALTH SYSTEM) is seen as a way of transforming health actions. For this, management must have as a principle the valorization of social participation through the implementation of strategies aimed at popular access to management processes (BRASIL, 2009; COELHO 2012).

Law 8,142/90 discusses community participation in the management of the SUS (UNIFIED HEALTH SYSTEM), through the creation of Conferences and Health Councils, promoting a participatory system, supported

by the ideological principles of the SUS (UNIFIED HEALTH SYSTEM). (BRAZIL, 1990).

The Health Council is a collegiate, deliberative and permanent body of the SUS (UNIFIED HEALTH SYSTEM), in each sphere of Government, integrating the organizational structure of each managing body in these spheres, with composition, organization and competences. They are environments for community participation in the construction of public policies and health management, acting in the formulation and proposition of strategies and in the control of the execution of Health Policies, including the economic and financial aspects. (ALAGOAS, 2017).

Paulo Jacinto is a municipality located in the Alagoas countryside, with 7756 inhabitants, it has a low Municipal Human Development Index (HDI-M) (0.589). This index takes into account longevity, education and income and maintains a close relationship between living conditions and the health-disease process experienced by the population. Most of the population of Paulo Jacinto is low-income99 (72%) and has an illiteracy rate of 30% and a child labor rate of 11%. In the municipality there are 153 households without a bathroom or toilet (7%), meaning that for almost 610 people the destination of waste is inadequate, contaminating soil and water sources (IBGE, 2012).

The city of Paulo Jacinto has 100% coverage of its population with the Family Health Strategy (ESF) through the work of 3 health teams. It has 1 Family Health Support Center (NASF). The municipality does not have the Mais Médicos Program108 or a health academy, which is a space equipped with equipment, structure and qualified professionals, aimed at promoting health and producing care and healthy lifestyles for the population (ALAGOAS, 2017).

In view of this scenario, in order to improve the process of shared management of comprehensive health care, the study proposes the creation of two deliberative instances, one called a conversation round, which has an integrative character of management with the community and the second, called Interdisciplinary Health Committee, of a strategic nature, which aims to solve obstacles identified by the community. Both instances seek to welcome and analyze local health-related problems, proposing solutions aimed at improving care.

OBJECTIVES

To humanize municipal health management, through the intensification of the Strategic and Participatory Management process, democratically qualifying services.

METHODOLOGY

This is a cross-sectional observational analytical study carried out in the city of Paulo Jacinto - Alagoas. To carry out the study, the actions were divided into two stages. The first is called rounds of conversation, which are configured as home meetings composed of citizens residing in the microareas and the municipal management team. 21 monthly meetings were scheduled in the 21 micro health areas of the municipality. The meeting place in each microarea is agreed between the resident who wants to host the meeting and the community health agent responsible for the territory. The health manager, coordinators, UBS professionals in the locality and all residents who wish to participate in the discursive process will attend the discussion. During the occasion, information will be provided on services and flows of primary care, as well as those of greater complexity. It is expected that a discursive scenario will be generated, where users will be invited to express their understanding and

setbacks found in the service offered in that location. Demands arising from the discursive process will be cataloged and presented to the second deliberative instance, called the Interdisciplinary Health Committee, composed of representatives of all classes of health professionals, with primary care and as medium complexity. With the objective of deliberating solutions, the Demands are found in all health microareas of the municipality. In the monthly meetings, internal and intersectoral articulations are established with guidance in solving problems.

RESULTS AND DISCUSSIONS

Between 12/01/2017 to 04/01/2019, there were 21 rounds of conversations, with one meeting in each micro health area belonging to the four basic health units in the municipality. 84 requests for improvements were cataloged. All were welcomed and directed to the Interdisciplinary Health Committee. Among the Demands, we obtained 39 referring to Primary Care, 15 Specialized and medium complexity care, 12 Pharmaceutical Assistance, 18 Health Surveillance. Among the main requests are: reforms in the units, transport, medical specialties, stray animals and quality of municipal drinking water. Through strategic and participatory management actions, 52 requests were met, among them: adjustments to flows and structures in UBS, surveillance actions, medium-complexity exams and intersectoral directions.

BASIC ATTENTION

According to Ordinance number 2,436/17, Primary Care must be understood as a grouping of individual, family and collective health actions, which develops actions of promotion, prevention, protection, diagnosis, treatment, rehabilitation, harm reduction, care palliative care and health surveillance, and aimed at the population in a defined territory, for which the teams assume health responsibility. As a future of the claims collected in the meetings, we were able to meet 61% of the tabulated Demands. All requests compiled in Table 1 below.

SPECIALIZED ATTENTION

These are specialized actions of health services, those that are performed in an outpatient environment, using medical-hospital equipment and specialized professional care for the construction of care in medium and high complexity. In this axis, ten improvements were requested, of which six were met, which represents a percentage of 73% resolution.

Table 2.

PHARMACEUTICAL CARE

Pharmaceutical Assistance must be understood as actions that go beyond the production and distribution of medicines, reaching events that promote the promotion, prevention and recovery of health, individual and collective, centered on the medicine. The Demands related to this area were directed to episodes of pharmaceutical shortages, soon after referrals, we managed to supply the missing items and we reached 100% of meeting the Demands.

Table 3.

HEALTH SURVEILLANCE

The validity in health proposes and the understanding of the problems that structure a situation of health of a certain territory. This collects, analyzes and proposes solutions to the identified problems. From this perspective, the municipality started to present a large number of stray dogs, roaming the streets and functioning with zoonosis reservoirs. Another fact identified was the low quality in the supply of water

Request	Número de Demand	Situation
Transport for users in the assistance field	07	Solved
Ambulance permanently allocated in rural communities	05	Not solved
Health promotion for hypertensive and diabetic patients in a rural community	02	Solved
Therapeutic group for users of alcohol and other drugs	03	Solved
Structural adequacy in UBS	07	Solved
Post in all rural locations	07	Not solved
More effective participation of Nasf in rural units	01	Solved
Suggestion boxes for rural community (Ombudsman)	02	Solved
Return of the operation of dental care in Odontomovel	03	Not solved
Creating a Seniors Group	02	Solved

Table 1: Demand of Primary Care.

Request	Demand	Situation
Unsatisfactory number of ultrasound exams	05	Solved
Municipal outpatient service in Gynecology	02	Solved
Municipal outpatient care in Pediatrics	02	Not solved
Municipal outpatient service in Ophthalmology	02	Not solved
Door-to-door transport for users	01	Solved
Structural improvements in the Mixed Marina Unit: Lamenha	03	Solved

Table 2: Demand of specialized care.

Request	Demand	Situation
Depletion of Reagent Strips for measuring capillary blood glucose	07	Solved
Metformin 850mg drug shortage in tablet presentation	05	Solved

Table 3: Demand of Pharmaceutical Assistance.

Request	Demand	Situation
Increase in the number of stray dogs in the municipality	08	Solved
Deviations in the quality of the water used in the supply of the municipality.	10	Solved

Table 4: Demand of health surveillance.

and sanitation developed by the local supply service. After referrals, 100% of requests were resolved.

Table 4.

CONCLUSION

Thus, meeting the demand of the community collected in the conversation rounds guarantees user access to management, while the interdisciplinary health committee directs actions to the unique needs of health microareas, directly contributing to the strengthening of social control. in management routines. Thus, the interrelationship between the two instances promotes the qualification of the work process, making health actions more humanized, democratic and effective.

REFERENCES

BISPO JÚNIOR, José Patrício; SAMPAIO, José Jackson Coelho. Participação social em saúde em áreas rurais do Nordeste do Brasil. **Revista Panamericana de Salud Pública**, v. 23, p. 403-409, 2008.

BRASIL. Constituição (1988). Constituição da República Federativa do Brasil. 18.ed. Brasília, DF: Senado, 1988.

BRASIL. Lei n° 8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. *Diário Oficial da União*, Brasília, DF, 20 set., 1990a. Seção 1, p. 18055.

BRASIL. Lei 8.142, de 28 de dezembro de 1990. Dispõe sobre a participação da comunidade na gestão do Sistema Único de Saúde (SUS (UNIFIED HEALTH SYSTEM)} e sobre as transferências intergovernamentais de recursos financeiros na área da saúde e dá outras providências. Diário Oficial da União, Brasília, DF, 31 dez. 1990b. Seção 1. Disponível em: Acesso em: 20 fev. 2022

BRASIL. Ministério da Saúde. *Política Nacional de Gestão Estratégica e Participação no SUS (UNIFIED HEALTH SYSTEM)*. Brasília; Brasil. Ministério da Saúde; 2009. 41 p. (Série B. Textos básicos de saúde).

COELHO, Juliana Sousa. Construindo a participação social no SUS (UNIFIED HEALTH SYSTEM): um constante repensar em busca de equidade e transformação. **Saúde e Sociedade**, v. 21, p. 138-151, 2012.

CORTEZ, Daniela Xavier; CORTEZ, Francisca de Oliveira Xavier; LEITE, Renata Miranda. Assistência farmacêutica no SUS (UNIFIED HEALTH SYSTEM). **Revista Interfaces: Saúde, Humanas e Tecnologia**, v. 2, n. 5, 2014.

IBGE – INSTITUTO BRASILEIOR DE GEOGRAFIA E ESTATISTICA. Censo Brasileiro de 2010. Rio de Janeiro: IBGE, 2012.

MONKEN, Maurício; BARCELLOS, Christovam. Vigilância em saúde e território utilizado: possibilidades teóricas e metodológicas. **Cadernos de Saúde Pública**, v. 21, n. 3, p. 898-906, 2005.

Portaria nº 2.436, de 21 de setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS (UNIFIED HEALTH SYSTEM)). Brasília, DF: Ministério da Saúde, **2017**.