Revista da Escola de Enfermagem da USP
ISSN: 0080-6234
reeusp@usp.br
Universidade de São Paulo
Brasil

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Revista da Escola de Enfermagem da USP, vol. 43, núm. 2, diciembre, 2009, pp. 1156-1167
Universidade de São Paulo
São Paulo, Brasil

ORIGINAL ARTICLE

Health needs & primary care: validation of the Needs Assessment Tool*

NECESSIDADES EM SAÚDE E ATENÇÃO BÁSICA: VALIDAÇÃO DE INSTRUMENTOS DE CAPTAÇÃO

NECESIDADES EN SALUD & ATENCIÓN PRIMARIA: VALIDACIÓN DE INSTRUMENTOS DE CAPTACIÓN

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ABSTRACT

Health needs is easy to say but it is very difficult to recognize and do something about in health services in Brazil. This study aimed to validate needs assessments' tools built to be use to know how primary care services and family health team recognize population health needs. As a methodological study, we built tools based on a guide adopted to characterize primary care services and their family health team. We established a minimum percentage agreement of 85% among the 11 peers who participated in the study. It comprehended two phases: first was general validation and second the validation of items that didn't reach agreement score. The results allow to considerer validated the Tools to assess how primary care services and family health team recognize health needs of territory population. Finally these Tools will contribute to best practice in primary care services to qualify health assistance.

KEY WORDS

Needs assessment.
Health Services needs and demand.
Validation studies.

RESUMO

O estudo objetivou validar dois instrumentos, para identificar como os serviços de saúde e as equipes de saúde da família reconhecem as necessidades de saúde da população. Trata-se de um estudo de desenvolvimento metodológico, para o qual foram elaborados instrumentos baseados em um guia de captação da realidade objetiva, adaptado para caracterizar a realidade de serviços de saúde e equipes de saúde da família. Para validação dos instrumentos, estabeleceu-se o grau de concordância mínimo de 85%, participando como *juízes* docentes pesquisadores do tema Necessidade em Saúde e enfermeiros que atuam em unidades de saúde da família, totalizando 11 *juízes*. A validação ocorreu em duas etapas pois, na primeira, alguns itens não atingiram a meta de concordância proposta. Após a segunda validação, obteve-se concordância acima de 85% nos itens avaliados. Os Instrumentos de captação propostos visam a contribuir para a prática dos serviços de saúde na identificação de necessidades em saúde da população.

DESCRITORES

Determinação das necessidades de cuidados de saúde.
Necessidades e demandas de Serviços de Saúde.
Estudo de validação.

RESUMEN

Este estudio de desarrollo metodológico buscó validar instrumentos para conocer las herramientas utilizadas, por servicios de salud y equipos del programa salud familiar brasileño, para reconocer las necesidades en salud de la población. Se crearon instrumentos, basados en una guía de captación de la realidad objetiva, adaptada para caracterizar la realidad de servicios y equipos de salud familiar. Para validar los instrumentos, se estableció 85% como porcentaje mínimo de concordancia entre los 11 jueces participantes, que fueron docentes, investigadores del tema necesidades en salud y enfermeros de unidades de salud familiar. La validación ocurrió en dos etapas, dado que en la primera, algunos ítems no alcanzaron 85% de concordancia. En la segunda etapa se obtuvo 85% de concordancia. Los resultados permiten considerar validados los instrumentos para alcanzar los fines propuestos. Se espera contribuir para que los servicios de salud mejoren el reconocimiento de las necesidades en salud de la población.

DESCRIPTORES

Evaluación de necesidades.
Necesidades y demandas de Servicios de Salud.
Estudios de validación.

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Received: 15/09/2009
Approved: 12/12/2009

Portuguese / English: www.scielo.br/reeusp

INTRODUCTION

The organization of a health system based on the dialectics of need satisfaction expresses the viewpoint of the universal protection of health, based on the premise of social wellbeing[1].

Need can be defined as a

> conscious desire, aspiration, intention directed at any time towards a certain object and that motivates the action as such. The object in question is a social product, independently of the fact that it refers to goods, a way of life or another person[2].

Two types of needs can be distinguished: *natural needs*, related to the conservation and perpetuation of life, and *necessary,* radical or characteristically human needs; both are socially determined. The former include food, shelter, sexual, social contact and cooperation needs, related to self-conservation and preservation of the species. They cannot be considered *natural* because they are produced in social contexts, as well as their volume and the way they are satisfied. Necessary needs include freedom, autonomy, self-accomplishment, self-determination, moral activity and reflection, among others. Hence, not all needs are lacks because, what necessary needs is concerned, their continuous improvement makes us progressively human[2].

With regard to health needs, they are also social and historically determined and are located between nature and culture, that is, they do not only refer to the preservation of life, but to the accomplishment of a project in which the individual, as a bridge between the private and the generic, becomes progressively human. Health needs cannot be considered mere medical needs, nor can health problems be considered diseases, suffering or risks. Instead, they also refer to lacks or vulnerabilities that express ways of life and identities, expressed in the question about what is necessary to be healthy and involving the conditions needed to enjoy life to the full[3]. The complexity of these Collective Health practice objects requires that health professionals be equipped so as to adequately respond to its collective nature[4].

Health needs cannot be considered mere medical needs, nor can health problems be considered diseases, suffering or risks. Instead, they also refer to lacks or vulnerabilities that express ways of life and identities.

Needs can function as *analysts* of health practices, as recognizing and coping with health needs is linked with the principles of the Single Health System (SUS), which implies that health teams need to make efforts to translate and respond to the needs the population presents[6]. When they get organized with a focus on the population's needs, it is believed that health services can or tend to be more efficient, in the sense of greater capacity to listen and respond to the health needs[5]. Adopting instruments that can recognize the needs of different social groups can contribute to recognize health practices, so that these are put in practice in response to the needs that originated them, in a circular relation between health needs and health work. At the same time, by permitting the complementariness between objective aspects of reality and the population's subjective conceptions, this also values the possibilities of expression the involved subjects have at their disposal and the meanings attributed to their ways of life, health and suffering[5].

It is in the spaces where articulations between health services and the population are put in practice that health needs are defined, distinguished, objectified and recognized. It is also in these spaces, integrated with other parts of the health care network, that efforts are made to respond to health needs[6].

OBJECTIVE

This study aimed to validate instruments to get to know health services' practice and the tools health professionals use to recognize the health needs and vulnerabilities of the population in a given territory.

METHOD

This methodological development study focuses on the elaboration, assessment and improvement of instruments and methodological strategies[7]. To verify the validity of the proposed instruments, they were submitted to the assessment of *judges* who are considered specialists on the theme of health needs. *Judges* are persons who are considered properly prepared to analyze the content, presentation, clarity and understanding of the instrument. Content validity represents the domain of a given content construct or universe that provides the structure and base to formulate questions that adequately represent the contents. Concerns with whether the questions contained in the tool are representative of the content domain the researcher intends to measure can be solved by submitted the tool to a group of *judges* who are considered specialists on this concept[8].

The instruments proposed in this study were elaborated based on the experience of the researchers involved in this investigation and on the qualitative script to capture the objective reality[9], adapted to the realities of the research areas, aimed at characterizing the health services and family health teams, and complemented by questions related to the recognition of health needs and vulnerabilities, as mentioned. Starting from the script to capture the objective reality, two instruments were elaborated, one for health teams and the other for health service managers.

The first version of the instruments consisted of open questions, which the participants could answer freely. A pilot study was carried out in two administrative districts

of São Paulo City in the context of the Family Health Strategy (FHS): Butantã and Capão Redondo. The range of results found, including incomplete and ignored answers made data analysis more difficult. This implied the need to improve the instruments. Therefore, closed questions were used.

A convenience sample was used for this research and data were collected in the first semester of 2009. *Judges* were selected according to the following criteria: faculty members in the Collective Health area with a Ph.D. degree, researchers on health needs and nurses working in the FHS. Initially, they were contacted formally through an invitation letter. When they accepted to participate in the study, participants signed the Free and Informed Consent Term and received the two instruments for assessment. The *judges* were asked to return the material, including their suggestions, within four weeks. The collected data were organized in an Excel 2000 worksheet and subject to descriptive treatment. An interrater agreement level of 85% or higher was set to consider items as validated. In compliance with Resolution 196/96, the Research Ethics Committee at EEUSP approved the project (opinion No 783/2008).

RESULTS

Fourteen *judges* received the material to participate in the study, 11 of whom responded. Hence, the research involved nine Collective Health faculty members and health needs researchers, as well as two FHS nurses. All *judges* were women and nurses, the mean age was 44.5 years, with a minimum of 31 and maximum of 58 years. Time since graduation ranged from 4 to 38 years and mean activity time in Collective Health was 16.6 years. For each part of the instrument, space was provided where the *judges* could make the corrections and recommendations they considered necessary. The instruments were validated in two phases as, in the first validation, some instrument items did not reach the 85% agreement level. The results of the instrument validation will be presented according to the data obtained during the first and second validation phase.

Analysis of first validation

As for the first part of the data collection instrument for the team, which refers to the identification of the health service, the interrater agreement level for the instrument items was 72.7%. The unit nurse was set as the standardized person to respond to this instrument, to be replaced by another health team member in her absence only. This decision was made in the belief that nurses are the health unit professionals able to answer the instrument questions more completely. With respect to the participant's identification, one *judge* added that it would be interesting to include how long that professional had been working at the unit, as some experience in the team and territory was needed for some of the questions asked.

The second part of the instrument aims to characterize the population and coverage area. This received the largest number of suggestions that were considered pertinent and referred to all items, which were later reformulated. As the initial mean agreement level was merely 50%, comments on the changes made are considered important. Two *judges* suggested clearly including that information were based on the most recent Basic Care System (SIAB) records, so as to standardize the data.

With a 36.4% agreement level, the item that characterizes the work situation in the area was reformulated. Suggestions referred to the need to clarify that this item aimed to identify the income and job situation of people living in the coverage area, considering that the alternatives mentioned retired and unemployed people, situations that are not considered as work, as well as drugs traffic. Another *judge* found it convenient to add the option *household work*, so as to include people who took care of their household activities at home.

The item related to the house includes alternatives related to state of conservation, health conditions, number of dwellers, also considering realities that could be present in the study reality, such as alleys and popular housing blocks. As for the item about the neighborhood, one *judge* thought it was pertinent to add risks for flood, run-over and landslide. The item about morbidity in the family and house dwellers in the last 12 months reached a 63.6% agreement level. Suggestions referred to including malnutrition and cerebrovascular accident. The latter was responsible for the large number of bedridden individuals at home. Distinguishing between types of violence was suggested, as these indicate distinct needs and interventions.

The third part of the instrument is the broadest, asking about infrastructure and organization activities for care delivery to the population, such as activity organization (scheduling, programs, community actions), existing human resources and their activities and ways to involve the population in the health system. All items attained the proposed interrater agreement level of 85%. As for the health professionals' activities, suggestions were made to add other activities not mentioned in the instrument. About the questions related to the responsible for training, supervision or assessment, one *judge* suggested including the alternatives *manager (Social Health Organization, Municipal Health Secretariat)* and *partner* as, in some regions, management contracts and public-private and public-public partnerships coexist.

The last part of the team instrument to collect information about health needs obtained a mean interrater agreement level of 90.9%. Only one of the items in this part, related to the identification of health vulnerabilities, did not reach the proposed level and only scored 72.7%. One *judge* suggested considering population data (IBGE and others). Two *judges* mentioned the need for a note to explain the definition of vulnerability adopted in the study.

As for the instrument for data collection among unit managers, the interrater agreement level for the first part of the instrument was 67.9%, aimed at identifying and characteriz-

ing the Basic Health Unit (BHU). Most of the suggestions were accepted. Only one of these was not incorporated, which referred to opening up the question *goal and objective* to permit reflections that could provide information about the line of work the interviewees base their activities on. However, the researchers decided to maintain the question with alternative answers so as to facilitate data analysis.

Six *judges* suggested clarifying whether questions such as the number of family health teams, families attended by the FHS and population in the coverage area referred to a specific health team or to the health unit as a whole. The health team was chosen, which allows respondents to interpret their own coverage area only in case they are not managers. This part of the instrument included questions like *participant's profession*, *activity time at the unit*, *responsible for data collection* and *service time*. The second part of the instrument, related to infrastructure and organization activities, reached an interrater agreement level of 91.2%. Items related to referral and counter-referral were reformulated according to the suggestions of five *judges*. Alternatives for the item asking whether the BHU is a referral unit included knowing whether the BHU is a referral unit for the district or for the city, as well as the option *is not a referral unit*. As to the identification of team professionals and the activities they develop, dental surgeons and speech therapists were included, as well as the alternative *others* for the remaining professionals. Reaching interrater agreement levels of 87.8%, some items with questions about the pharmacy were reformulated due to the pertinence of the suggestions. With respect to the documents needed to have access to distributed drugs, one *judge* suggested including the alternative *prescription with copy*, as one copy should remain at the pharmacy and the user should get the other copy. Another *judge* questioned whether the prescription should come exclusively from the public network. The researchers decided to include the alternatives *prescription* and *prescription with copy*.

The third part of the instrument for data collection about health services refers to Nursing, asking questions about the existence of specific Nursing Care Systemization (NCS) instruments, which theoretical base is adopted at the unit and where nursing actions are registered, with an interrater agreement level of 90.9%. Two *judges* suggested replacing the acronym SAE by the full term.

In the initial proposal, only the team instrument covered questions about health needs. However, after the validation process, the researchers decided to include the fourth item, as one *judge* had suggested, asking only one question about health needs. An open question was used: *According to you, which activities does the service perform to identify and attend to users' needs?* This decision was made because asking questions about the theme in both instruments was considered fundamental.

Analysis of second validation

In this phase, the researchers worked with the instruments sent by the 11 *judges* who participated in the first validation. The analysis of their answers revealed that all items reached or exceeded the proposed interrater agreement target level. In the first part, agreement for the team instrument increased from 72.7% to 90.9%. Only one *judge* suggested that the question about work time at the unit should include closed alternatives so as to facilitate results processing. This alteration was not made due to the importance of knowing the participants' time of work at the health service and also because, if this time were determined according to pre-established periods, reliability would decrease.

For the second part, aimed at characterizing the population and the coverage area, after the reformulation, the agreement level increased from 50% to 94%. However, one *judge* suggested including the alternative disease aid by the social security service in the item about the income and job situation. After the reformulation, the item about housing reached a 100% interrater agreement level. As for morbidity, suggestions were made to evidence domestic violence and other types in distinct items. Although interrater agreement levels for the third part were already higher than 85%, items with suggestions were changed because of the suggestions' relevance. In the item about the programs developed at the health service, one *judge* suggested including the program *Mãe Paulistana*. About the forwarding institution or service, as suggested, the Reference Center for Sexually Transmitted Diseases/Aids was included, as this can occur quite frequently. Despite the interrater agreement level of 90.9% on the first validation, two *judges* suggested including the following alternatives in the item about the health needs identification instrument: team meeting to discuss cases, screening and welcoming.

Interrater agreement levels on all parts of the health service data collection instrument were higher than 85% during the second validation phase. The level for the first part of the instrument was 100%, without any suggestions. Although the second part had reached the proposed level of 85% during the first validation phase, the changes made were forwarded to the *judges*. However, only two *judges* returned some considerations about including the option *to other BHU in the neighborhood* when asked whether the BHU is a referral unit. Other suggestions were to include the option *Emergency Care* and to remove the *Social Organization* in the question about the forwarding service. As for the examinations collected at the BHU, one *judge* suggested including the option *Electrocardiogram*. It should be highlighted that all suggestions given in the second validation phase were taken into account with a view to improving the instrument. The third and fourth parts were also considered validated, as they reached an interrater agreement level of 100% after the second validation phase.

DISCUSSION

As evidenced during the first validation phase, most suggestions referred to changing some terms or expres-

sions that were difficult to understand. Both the instrument construction and validation considered the importance of content objectiveness and clearness. In the second validation phase, all *judges* approved the changes made. This moment was important to analyze whether the instrument can comply with the proposed objectives.

The researchers believe that the validated instruments can facilitate and support decision making, to the extent that they systematically permit the collection of data that recognize the population's health needs, and also contribute to cope with these needs in the practice of family health teams.

The National Basic Care Policy highlights the role of Family Health in health promotion actions, as teams can often offer an immediate response to the health needs, risk and protection factors present within their territory[10]. It is considered a priority strategy to redirect health practices and the traditional basic care service network should be replaced with a view to its consolidation, so as to influence the qualification of the care model based on the work of multiprofessional teams[11].

However, family health teams face difficulties to identify the population's health needs and systemize care actions based on these needs. The pilot study of the instruments evidenced that the interviewed family health teams used no specific instruments to recognize the population's health needs.

It should be highlighted that the instruments consisted of open questions, which were adapted to closed questionnaires in the attempt to homogenize answers with a view to data processing. Thus, they can better picture the health needs profiles in the collective health dimension, and not just in the singularity of users presenting those needs. Answers of judges who suggested that some questions should be open will be considered in another instrument.

CONCLUSION

The *expert* analysis method demonstrated its usefulness to elaborate and improve the instruments aimed at getting to know health services' characteristics, practices and tools health professionals use to recognize the population's health needs, strengthening the findings of different other studies[12-16] .

The instrument was intended to be practicable in the care practice of Collective Health professionals, as health services do not have a technological apparatus to contribute to the recognition of the population's health needs. The incorporation of specific instruments to recognize the population's health needs in the activity area of family health demands efforts and awareness from health professionals and should be articulated between the community and health teams. This is so because a tool to read the population's health needs demands a reflection on the work logic that approximates the health team to the users, permitting listening that is qualified by the understanding of the health needs the population presents.

To broaden the understanding of the health-disease process as a social and historical product, as the base for the understanding, recognition and satisfaction of health needs – in line with fundamental conceptions of collective health – a technological apparatus is needed that systemizes pieces of information and establishes relations so as to recompose knowledge about the objective reality of services and of the territory they aim to cover. Instruments as such are fundamental for the work process to be guided by the goal of truly satisfying needs. If the intentionality present in the work processes is not individual but social, so that work is directed at the social needs that justify it[17], the use of instruments also permits knowing and transforming the social reality. The fact is that the elaboration and application of these instruments do not guarantee their success. They need to be presented and exposed to criticism with a view to their improvement according to their goal.

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Funded by São Paulo Research Foundation (*Fundação de Amparo à Pesquisa do Estado de São Paulo*) - FAPESP

Appendixes

ASSESSMENT A - INSTRUMENTO PARA CARACTERIZAÇÃO DA UBS

I) Identificação e caracterização da UBS

1. Identificação do participante
1.1 gerente da unidade
1.2 outro ☐ Quem?_____

2. Profissão do participante

_____

3. Tempo que atua na unidade _____ anos

4. Coleta de dados realizada em: ___/___/___

5. Responsável pela coleta de dados

_____

6. Identificação da UBS (nome)

_____

7. Distrito Administrativo

_____

8. Horário de funcionamento: das _____ às _____

9. nº equipes de saúde da família na unidade de saúde

_____

10. nº famílias atendidas pela ESF da unidade_____

11. População da área de abrangência da unidade

_____

12. Subvenção e vinculação às demais instâncias do Sistema de Saúde
12.1 exclusivamente público (SUS, SMS, coordenadoria) ☐
12.2 público/privado (parceira/OS) ☐
12.3 privado (parceira/OS) ☐
12.4 não sabe ☐
12.5 outro ☐ _____

13. Tipo de parceiro
13.1 filantrópica:_____
13.2 fundação (de direito privado ou público):

_____

13.3 privado: _____
13.4 público: _____
13.5 outro: _____

14. Finalidade e objetivo (resposta múltipla)
14.1 atender necessidades de saúde ☐
14.2 intervir no processo saúde-doença da população ☐
14.3 realizar prevenção de doenças, promoção e recuperação da saúde ☐
14.4 oferecer atenção básica e/ou atenção primária ☐
14.5 prestar bom atendimento ☐
14.6 seguir os princípios do SUS ☐
14.7 não sabe ☐
14.8 outro ☐ _____

II) Atividades de infra-estrutura e organização

15. Esta UBS é referência
15.1 para o Distrito ☐
15.2 para o município ☐
15.3 não é referência ☐

16. Para onde encaminha
16.1 AMA ☐
16.2 CAPS ☐
16.3 especialidades ☐
16.4 hospital ☐
16.5 Núcleo de Apoio à Saúde da Família (NASF) ☐
16.6 Pronto Socorro (PS) ☐
16.7 Serviço de urgência ou emergência ☐
16.8 não se aplica ☐
16.9 outro ☐ _____

17. Motivo do encaminhamento
17.1 encaminhamento médico ☐
17.2 internação ☐
17.3 urgência/ emergência ☐
17.4 solicitação de exames ☐
17.5 não sabe ☐
17.6 não respondeu ☐
17.7 outro ☐ _____

18. Existe contra-referência?
18.1 sim ☐
18.2 não ☐

19.Sistemas de informação que utiliza
19.1 CNES ☐
19.2 Hiperdia ☐
19.3 Mãe Paulistana ☐
19.4 Medic ☐
19.5 SIAB ☐
19.6 SIASUS ☐
19.7 SINASC ☐
19.8 SIS pré-natal ☐
19.9 Sisvam ☐
19.10 outro ☐_____

20.Critérios para matrícula do usuário/família
20.1 morar na área ☐
20.2 ser cadastrado ☐
20.3 não sabe ☐
20.4 não se aplica ☐
20.5 outro ☐ _____

21. Documentos para matrícula
21.1 cartão SUS ☐
21.2 comprovante de residência ☐
21.3 CPF ☐
21.4 protocolo de VD (ACS) ☐
21.5 RG ☐
21.6 não sabe ☐
21.7 não se aplica ☐
21.8 outro ☐ _____

22. Freqüência da matrícula
22.1 diária ☐
22.2 semanal ☐
22.3 não sabe ☐
22.4 não se aplica ☐
22.5 outro ☐ _____

23. Período da matrícula
23.1 manhã ☐
23.2 tarde ☐
23.3 manhã e tarde ☐
23.4 não sabe ☐
23.5 outro ☐ _____

24. Formas de participação da comunidade na UBS
24.1 associações/ instituições da comunidade ☐
24.2 através do ACS ☐
24.3 Conselho Gestor ☐
24.4 Fórum sub-prefeitura ☐
24.5 ouvidoria ☐
24.6 não sabe ☐
24.7 outro ☐ _____

25. Entrada no serviço (organização do acolhimento)
25.1 demanda espontânea ☐
25.2 por horário (agenda). Qual é o horário ☐ _____
25.3 por escala ☐
25.4 por equipo ☐
25.5 pela VD ☐
25.6 outro ☐ _____

26. Responsável pelo acolhimento
26.1 Auxiliar de Enfermagem ☐
26.2 Enfermeiro da equipe ☐
26.3 Enfermeiro Responsável Técnico ☐
26.4 revezamento dos membros da equipe (rodízio) ☐
26.5 não sabe ☐
26.6 outro ☐ _____

27. Realiza capacitação para o acolhimento
27.1 sim ☐
27.2 não ☐

28. Quem faz a supervisão do acolhimento
28.1 Gerente da UBS ☐
28.2 Enfermeiro da equipe ☐
28.3 Enfermeiro Responsável Técnico ☐
28.4 não sabe ☐
28.5 outro ☐ _____

continua...

...continuação

29. Exames coletados na unidade	30. Freqüência da coleta	31. Período da coleta	32. Tempo médio de espera entre a solicitação e a coleta	33. Qual é o laboratório que faz o exame?	34. Tempo médio de espera do resultado após a coleta
29.1 fezes ☐	_____	_____	32.1 ____ (dias)	_____	34.1 _____ (dias)
29.2 papanicolau ☐	_____	_____	32.2 ____ (dias)	_____	34.2 não sabe ☐
29. sangue ☐	_____	_____	32.3 ____ (dias)	_____	34.3 _____ (dias)
29.4 urina ☐	_____	_____	32.4 ____ (dias)	_____	34.4 não sabe ☐
29.5 escarro ☐	_____	_____		_____	34.5 _____ (dias)
29.6 ECG ☐	_____	_____		_____	34.6 não sabe ☐
29.7 outro ☐ _____	_____	_____		_____	34.7 _____ (dias)
	1. todos os dias 2. uma vez/ semana 3. duas vezes/semana 4. não sabe 5. outro_____	1. manhã 2. tarde 3. manhã e tarde 4. não sabe			34.8 não sabe ☐

35. Exames realizados na UBS (referidos pelo entrevistado)

35.1 colposcopia ☐

35.2 dextro ☐

35.3 pregnosticon ☐

35.4 outro ☐ _____

36. Tempo médio de espera do resultado após a coleta

36.1 _____ (dias)

36.2 não sabe ☐

36.3 _____ (dias)

36.4 não sabe ☐

36.5 _____ (dias)

36.6 não sabe ☐

36.7 _____ (dias)

36.8 não sabe ☐

37. Profissionais da equipe	38. Número	39. Atividades que desenvolve
37.1 ACS ☐	38.1 _____	39.1 _____
37.2 Auxiliar de cirurgião dentista (ACD) ☐	38.2 _____	39.2 _____
37.3 Assistente Social	38.3 _____	39.3 _____
37.4 Auxiliar de Enfermagem ☐	38.4 _____	39.4 _____
37.5 Auxiliar Técnico Administrativo (ATA) ☐	38.5 _____	39.5 _____
37.6 Cirurgião dentista ☐	38.6 _____	39.6 _____
37.7 Educador físico ☐	38.7 _____	39.7 _____
37.8 Enfermeiro ☐	38.8 _____	39.8 _____
37.9 Farmacêutico ☐	38.9 _____	39.9 _____
37.10 Fisioterapeuta ☐	38.10 _____	39.10 _____
37.11 Fonoaudiólogo ☐	38.11 _____	39.11 _____
37.12 Médico ☐	38.12 _____	39.12 _____
37.13 Psicólogo ☐	38.13 _____	39.13 _____
37.14 Técnico de Enfermagem ☐	38.14 _____	39.14 _____
37.15 Técnico Higiene Dental (THD) ☐	38.15 _____	39.15 _____
37.16 outro ☐ _____	38.16 _____	39.16 _____

Atividades:

1. acolhimento
2. administração
3. agendamento
4. assistência/consulta
5. coleta exames
6. curativos
7. direção
8. educação continuada
9. farmácia
10. inalação
11. matrícula
12. medicação
13. orientação/palestras
14. recepção
15. supervisão
16. vacinação
17. Vigilância Epidemiológica
18. VD
19. outra_____

continua...

...continuação

40. Documentos para acesso aos medicamentos distribuídos	41. Faltam medicamentos na farmácia?	42. Medicamentos que faltam	43. Com que freqüência?
40.1 cartão SUS ☐ 40.2 receita ☐ 40.3 receita com xerox ☐ 40.4 matrícula ☐ 40.5 não sabe ☐ 40.6 outro ☐ _____	41.1 sim ☐ 41.2 não ☐	42.1 _____ 42.2 _____ 42.3 _____ 42.4 _____ 42.5 _____ 42.6 _____	43.1 _____ 43.2 _____ 43.3 _____ 43.4 _____ 43.5 _____ 43.6 _____ 1. às vezes 2. sempre 3. quase sempre 4. nunca 5. quase nunca

44. Tipo de orientação ao usuário na falta do medicamento	45. Há capacitação do funcionário da farmácia?	46. Responsável pela supervisão da farmácia
44.1 encaminha para outra UBS ☐ 44.2 ir à Farmácia Popular ☐ 44.3 não há orientação ☐ 44.4 não sabe ☐ 44.5 procurar gestor para viabilizar ☐ 44.6 outro ☐ _____	45.1 sim ☐ 45.2 não ☐ 45.3 não sabe ☐	46.1 Auxiliar Técnico Administrativo ☐ 46.2 Gerente UBS ☐ 46.3 Enfermeiro da equipe ☐ 46.4 Enfermeiro Responsável Técnico ☐ 46.5 Farmacêutico ☐ 46.6 Médico ☐ 46.7 outro ☐ _____ 46.8 não há supervisão ☐ 46.9 não sabe ☐

III) Enfermagem

47.Há instrumento específico para Sistematização da Assistência de Enfermagem (SAE)?	48. Qual a base teórica da SAE adotada na UBS?	49. Locais de Registro das ações de enfermagem
47.1 sim ☐ Qual _____ 47.2 não ☐ 47.3 não sabe ☐		49.1 Carteira de vacina ☐ 49.2 Formulários/Fichas ☐ 49.3 Hiperdia ☐ 49.4 Prontuário da família ☐ 49.5 SIAB ☐ 49.6 SIS pré-natal ☐ 49.7 não sabe ☐ 49.8 não se aplica ☐ 49.9 outro ☐ _____

IV) Necessidades de Saúde

50. Na sua visão, quais atividades o serviço desenvolve para identificar e atender as necessidades dos usuários?

_____

_____

_____

ASSESSMENT B - Instrumento para identificação dos instrumentos de reconhecimento das necessidades de saúde e vulnerabilidades da população e processo de trabalho das EQUIPES da ESF

Obs.: O respondente prioritário do questionário deve ser o enfermeiro(a), caso não seja possível, outro profissional da equipe poderá respondê-lo.

I) Identificação

1.Coleta de dados realizada em:

____/____/____

2. Responsável pela coleta de dados

_____

3. Identificação do participante

3.1 ACS ☐
3.2 auxiliar de enfermagem ☐
3.3 enfermeiro ☐
3.4 médico ☐

4. Tempo que atua na unidade

_____ anos

5. Identificação (nome da unidade)

_____

6. Distrito Administrativo

6.1 ☐ _____

7. Número ou nome da equipe (equipe rosa, verde...)

_____
_____
_____

II) Caracterização da população e área de abrangência

8. Escolaridade (de acordo com registro no SIAB mais recente)

8.1. 7 a 14 anos na escola_____%
8.2. 15 anos e + alfabetizado___%

9. Situação de renda e trabalho predominante dos moradores da área de abrangência (resposta múltipla)

9.1 aposentados ☐
9.2 comércio ☐
9.3 construção civil ☐
9.4 desemprego ☐
9.5 do lar ☐
9.6 domésticas ☐
9.7 trabalho informal ☐
9.8 auxílio doença - INSS ☐
9.9 outro ☐ _____

10. Moradia (considerar o que é mais predominante na sua área)

10.1 Casa (resposta múltipla)

10.1.1 casa salubre (com boas condições de ventilação, umidade, luminosidade) ☐
10.1.2 casa insalubre ☐
10.1.3 casa com condições boas de conservação ☐
10.1.4 casa com condições ruins de conservação ☐
10.1.5 casa de alvenaria e inacabada ☐
10.1.6 casa de alvenaria e com acabamentos ☐
10.1.7 casa feita com outros materiais ☐
10.1.8 casa com quintal comum ☐
10.1.9 casa com mais de três pessoas/cômodo ☐
10.1.10 casa com menos de três pessoas/cômodo ☐
10.1.11 condições precárias ☐
10.1.12 apartamento de conjunto habitacional (COHAB) ☐
10.1.13 rua do tipo viela ☐
10.1.14 outros ☐ _____

10.2 Entorno da casa (resposta múltipla)

10.2.1 córrego ☐
10.2.2 esgoto a céu aberto ☐
10.2.3 lixo ☐
10.2.4 mato ☐
10.2.5 ratos, baratas ☐
10.2.6 risco para alagamento ☐
10.2.7 risco para atropelamento ☐
10.2.8 risco para desmoronamento ☐
10.2.9 sem área verde, praças, área de lazer ☐
10.2.10 outro ☐
_____

11. Morbidade nos últimos 12 meses na família (residentes na casa) (resposta múltipla)

*considerar o que é mais predominante na sua área

11.1 álcool e drogas ☐
11.2 Acidente Vascular Cerebral ☐
11.3 deficiência física ☐
11.4 desnutrição ☐
11.5 Diabetes Mellitus ☐
11.6 doenças respiratórias ☐
11.7 gravidez na adolescência ☐
11.8 Hipertensão Arterial ☐
11.9 HIV/AIDS ☐
11.10 neoplasia ☐
11.11 obesidade ☐
11.12 problemas mentais/ saúde mental ☐
11.13 tuberculose ☐
11.14 verminose ☐
11.15 violência doméstica ☐
11.16 outras violências ☐
11.17 outra ☐ _____

III) Atividades de infra-estrutura e organização para o atendimento da população

27. Periodicidade das reuniões realizadas com a equipe 27.1 diária ☐ 27.2 semanal ☐ 27.3 quinzenal ☐ 27.4 mensal ☐ 27.5 outro ☐ _____	**28. Finalidades** 28.1 avaliação de resultados ☐ 28.2 discussão casos ☐ 28.3 encaminhamento para VD ou grupos ☐ 28.4 planejamento de atividades ☐ 28.5 outro ☐ _____	**29. Supervisor da equipe** 29.1 enfermeiro da equipe ☐ 29.2 enfermeiro Responsável Técnico ☐ 29.3 gerente ☐ 29.4 médico ☐ 29.5 não sabe ☐ 29.6 outro ☐ _____	**30. Instrumentos de supervisão** 30.1 auditoria ☐ 30.2 discussão dos casos atendidos pela equipe ☐ 30.3 ficha de atividades ☐ 30.4 metas de produção ☐ 30.5 observação das atividades ☐ 30.6 reuniões ☐ 30.7 SIAB ☐ 30.8 não sabe ☐ 30.9 outro ☐ _____
31. Programas 31.1 Álcool e drogas ☐ 31.2 Dengue ☐ 31.3 Diabetes/ HA ☐ 31.4 Hanseníase ☐ 31.5 Hiv/Aids ☐ 31.6 Imunizações ☐ 31.7 Mãe Paulistana ☐ 31.8 Saúde do adolescente ☐ 31.9 Saúde do adulto ☐ 31.10 Saúde da criança ☐ 31.11 Saúde do idoso ☐ 31.12 Saúde da mulher ☐ 31.13 Saúde do Trabalhador ☐ 31.14 Tuberculose ☐ 31.15 Violência doméstica ☐ 31.16 outro ☐ _____	**32. Atividades** 1. campanhas 2. consulta de enf. 3. consulta médica 4. grupos 5. VD	**33. Freqüência** 1. diário 2. semanal 3. quinzenal 4. mensal	**34. Responsável** 1. ACS 2. aux. enfermagem 3. enfermeiro da equipe 4. enfermeiro Responsável Técnico 5. médico 6. outro _____
35. Ações na comunidade 35.1 Atividades físicas (Lian Gong/ Tai chi chuan, relaxamento, caminhada, entre outros) ☐ 35.2 Grupos ☐ Quais_____ 35. Lazer (artesanato, filmes, passeios...) ☐ 35.4 Mutirão ☐ 35.5 Palestras/orientações/cursos ☐ 35.6 Terapeuta Ocupacional ☐ 35.7 Vacinação ☐ 35.8 não sabe ☐ 35.9 outro ☐ _____	**36. Responsável** 1. ACS 2. aux enfermagem 3. enfermeiro da equipe 4. enfermeiro Responsável Técnico 5. médico 6. outro _____	**37. A equipe relaciona as atividades na comunidade com mudanças no perfil de saúde-doença** 37.1 sim ☐ Explique:_____ 37.2 não ☐ Explique:_____ 37.3 não sabe ☐	**38. Formas de inserção da população no serviço de saúde** 38.1 busca ativa ☐ 38.2 demanda espontânea ☐ 38.3 folders/cartazes ☐ 38.4 VD ☐ 38.5 não sabe ☐ 38.6 outro ☐ _____

continua...

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39. Instituição ou serviço que encaminha	40. Finalidade do encaminhamento	41. Impressos utilizados para encaminhamento	42. Tem contra-referência
39.1 AMA ☐ 39.2 CAPS ☐ 39.3 Centro de Referência DST/Aids ☐ 39.4 Delegacia ☐ 39.5 Especialidades ☐ 39.6 Hospital ☐ 39.7 Núcleo de Apoio à Saúde da Família (NASF) ☐ 39.8 ONG ☐ 39.9 outra UBS ☐ 39.10 Pronto Socorro ☐ 39.11 serviço de urgência/emergência ☐ 39.12 não sabe ☐ 39.13 outro ☐ _____	1. alcoolismo 2. exames 3. especialistas 4. HIV/AIDS 5. saúde mental 6. violência doméstica 7. violência sexual 8. urgência/emergência 9. outro_____	41.1 guia de referência ☐ 41.2 impresso próprio ☐ 41.3 receita ☐ 41.4 não sabe ☐ 41.5 não se aplica ☐ 41.6 outro ☐ _____	42.1 sim ☐ 42.2 não ☐ 42.3 não sabe ☐
		43. Desenvolve atividades de prevenção de HIV / AIDS 43.1 sim ☐ 43.2 não ☐	**44. População alvo** 44.1 gestantes ☐ 44.2 homossexuais ☐ 44.3 jovens ☐ 44.4 profissionais do sexo ☐ 44.5 pessoa com mais de um parceiro(a) ☐ 44.6 não se aplica ☐ 44.7 outro ☐ _____

IV) Necessidades de saúde

45. O que você considera como necessidade de saúde dos usuários deste serviço de saúde?

46. Instrumento de identificação de necessidades de saúde	47. O que é observado	48. Quem identifica	49. Onde identifica as necessidades de saúde?
46.1 Cartão da família ☐ 46.2 Carteira de saúde (criança, pré-natal, vacinação...) ☐ 46.3 Consultas ☐ 46.4 Dados epidemiológicos ☐ 46.5 Registro de atendimentos ☐ 46.6 SIAB ☐ 46.7 Triagem/acolhimento ☐ 46.8 VD ☐ 46.9 outro ☐ _____		1. ACS 2. aux. enfermagem 3. enfermeiro 4. equipe 5. médico 6. outro _____	49.1 casa ☐ 49.2 consulta ☐ 49.3 contatos com outras instituições da comunidade, com lideranças locais ☐ 49.4 dados epidemiológicos ☐ 49.5 entrevistas ☐ 49.6 registro de atendimentos ☐ 49.7 reuniões de equipe ☐ 49.8 SIAB ☐ 49.9 supervisão do especialista ☐ 49.10 VD ☐ 49.11 não sabe ☐ 49.12 outro ☐ _____

50. Como as necessidades de saúde são enfrentadas?	51. Onde identifica as vulnerabilidades em saúde?*	52. Capacitação dos profissionais para identificação de necessidades
50.1 encaminhamento para PS ☐ 50.2 consulta médica ☐ 50.3 consulta de enfermagem ☐ 50.4 grupos ☐ 50.5 relação com outros dentro e fora da área da saúde ☐ 50.6 VD ☐ 50.7 não sabe ☐ 50.8 outro ☐ _____	51.1 casa 51.2 consulta 51.3 dados epidemiológicos ☐ 51.4 dados populacionais oficiais (IBGE...) ☐ 51.5 entrevistas ☐ 51.6 registro de atendimentos ☐ 51.7 SIAB ☐ 51.8 VD ☐ 51.9 não sabe ☐ 51.10 outro ☐ _____	52.1 sim ☐ 52.2 não ☐

*A vulnerabilidade quer expressar os potenciais existentes nos processos saúde e doença relacionados à indivíduos e grupos que vivem em um certo conjunto de condições históricas e sociais. Enquanto os fatores de risco indicam probabilidades, a vulnerabilidade é um indicador da iniqüidade e da desigualdade social. Nesse sentido, a vulnerabilidade antecede ao risco e determina processos diferenciados de saúde e doença e as possibilidades para o seu enfrentamento.

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