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THE WORLD OF WORK IN THE FAMILY HEALTH STRATEGY FROM THE NURSES' PERSPECTIVE

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ABSTRACT

We aim to analyze how the world of work in the Family Health Strategy was configured in the first decade of the 2000s from the nurses' perspective, especially with regard to permanent and continuing health education; selection and recruitment of professionals; and the guarantee of sufficient material resources, equipment and supplies for the operation of the health units and teams. It is a qualitative study, with a critical analytical approach, developed in a Brazilian city in the state of Bahia. The participants included six nurses who participated in the Family Health Strategy in the first decade of the 2000s. In-depth interview and documentary analysis were used to collect data and triangulation and Bardin's content analysis were used to analyze the data. We realize that continuing health education is presented as training; the selection and recruitment of professionals were similar to the process of work precariousness, strengthened by the lack of guarantee of material resources, equipment and supplies. As a result, we highlight that a greater focus on the conflicts and contradictions between the development of health work and the process of precariousness of work is important.

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INTRODUCTION

From the perspective of Ciavatta (2012), the world of work can be understood as the world involving both the material and productive activities as well as intangible cultural creation activities that emerge from the reproduction of life giving it meaning.It is a complex category since it groups concepts such as work and its relations, market, employment relationship and salaries, organization, among other concepts that reveal their conflicts and contradictions, and translate it (FIGARO, 2008).In view of this perception, the Family Health Strategy (FHS) can be seen as a field in which work and its relationships happen, thus translating material and productive activities, as well as immaterial activities when it focuses on the development of health work – the act of taking care of life. The FHS was conceived from the current Brazilian National Health Policy, in the nineties, presenting itself initially as a Family Health Program. Yet, this program has evaded the logic of the other programs designed and implemented by the Ministry of Health (MH) as it presents itself as a strategy for the reorganization of health work, fromprimary care to coping and solving problems, within a delimited territory, with the purpose of guaranteeing the principles of the Unified Health System (*Sistema Único de Saúde*, SUS). In this perspective, it promotes the establishment of a relationship and the creation of bonds of commitment and co-responsibility between the health team and the assisted community (BRASIL, 1997). In this context, the health institutions (Ministry of Health and State Health Secretaries) encouraged the municipalities to disseminate this proposal through the Family Health Expansion and Consolidation Project (*Projeto de Expansão e Consolidação da Saúde da Família*, PROESF), offering a financial incentive for expanding the implementation of teams that make up the FHS, and consequently enhance the work opportunities for healthcare professionals, such as nurses, doctors, oral health team (Surgeon dentist and Dental Hygiene Technician), Community Health Agents, to enter the world of labor. The PROESF proposes the expansion and restructuration of different initiatives for the development of human resources in the FHS, as well as to increase other resources, support the implementation of the ongoing process of professional qualification as well as the setting of human resources in these health units (BRASIL, 2003).Herewith, we realize that the PROESF has an idea of how the world of work

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must be directed in the FHS. This idea is also present in the National Primary Care Policy (*Política Nacional de Atenção Básica*, PNAB) of the Ministry of Health, which requires that each level of government (union, state and municipality) will have its own powers to compose the process of implantation and implementation of the FHS.

Thus, in view of the above, we aimed to analyze how the world of work was configured, from the perspective of professional nurses, in the Family Health Strategy in the first decade of the 2000s, particularly with regard to the development of permanent and continuous educational actions; the selection and hiring of the professionals who make up the teams of the FHS; and the guarantee of sufficient material resources, equipment and supplies for the operation of the health units and teams.

MATERIALS AND METHODS

It is a study with a qualitative approach, in a critical analytical perspective for unveiling the universe of social meanings. It was developed in a municipality in the state of Bahia, located in the south-central region of Bahia, approximately 365 km from the state capital, with an estimated population of 155.800 inhabitants (IBGE, 2018). We chose the nurses who worked in the first decade of the year 2000, the period between 2000 and 2009, as participants of our study. This choice was made because these professionals are responsible for the management of the health units, thus constituting a direct link with the municipal management and the community. We counted on the participation of 06 nurses who signed the Term of Free and Informed Consent, which guarantees anonymity, and the participants were identified with the name of a flower.

Regarding the chosen period, we can list some justifications, such as: period of effervescence of productive restructuring and its implications in the world of work in the Brazilian scenario; effervescence and expansion of the FHS in the Brazilian context; implantation and expansion of the family health teams in the surveyed city; and, the forms of management and organization of health work in the said municipality, especially with regard to nurses.

As for the data collection technique, we developed an in-depth interview as from Minayo's perspective (2010), for providing the nurses with the freedom to freely discuss the subject, and documentary analysis. The period of data collection comprised the months of May to August 2015, since we needed to find those professionals who were no longer working at the municipality's FHS at the time of the study.

Regarding the analyzed documents, we listed the Municipal Health Management Reports of the study period, 2000 to 2009, for which our sample was composed by the reports of the years 2000, 2003, 2004, 2006, 2007 and 2008, which when mentioned in the text will be identified by the term Doc. 01, Doc. 02, etc. The collected data were analyzed according to the triangulation technique, since it provides the researcher with an expanded view on the description, explanation and understanding of the studied problem. At the same time, it develops the first aspect based on the perceptions of the subjects of the study, followed by the analysis of documents, and, finally, it makes a relation with the socioeconomic and cultural structures of the study context (TRIVIÑOS, 1987). We emphasize that with regard to the content of the interviews we performed an approximation with the technique of content analysis as proposed by Bardin (2009).We also emphasize that we sought to guarantee the ethical aspects that involve research with human beings, and that the project was registered in the *Plataforma Brasil* under CAAE: 41883615.2.0000.0055, that sent it to the Ethics in Research Committee of the State University of Southwest Bahia, UESB, which consubstantiated and authorized the beginning of the data collection through Favorable Opinion number 1,067,808/2015.

RESULTS

The study participants are female; mostly middle-aged adults with a training time ranging from 16 to 20 years. Most are graduates in Collective Health; and worked at the FHS for less than 5 years, as can be seen in Table 1.

Table 1. Sociodemographic characterization of the nurses who participated in the study, Jequié, 2015

Variables	%
Age	
Up to 40 years	01
Between 41 and 50 years	03
Did not want to inform	02
Sex	
Female	06
Male	00
Training time	
Up to 15 years	01
Between 16 and 20 years	03
More than 21 years	02
Postgraduate studies	
Yes	04
No	-
Did not inform	02
Time of action in the Family Health Strategy	03
Up to 5 years	02
Between 6 and 10 years	01
More than 11 years	

Source: Field study database.

With regard to the contents of the interviews, three thematic categories, which will be presented below, emerged as a result: Permanent and continuing education actions in the context of the Family Health Strategy, Selection and hiring of the professionals who make up the multiprofessional teams of the Family Health Strategy, and Guarantee of sufficient material resources, equipment and supplies for the functioning of the health units and teams.

Permanent and continuing educationactionsin the context of the Family Health Strategy.

In accordance with the PNAB, which governs the Family Health Strategy, it is part of the municipal competences "to develop actions, articulate institutions and promote access to workers, for training and guarantee of permanent and continuing education for health professionals of all the implanted teams that work in Primary Care" (BRASIL, 2006, 2011, 2017).The narratives and the documents converge to this concern of the municipal management with the actions of continued education in the perspective of capacitation, as well as for the establishment of partnerships for the accomplishment of these actions. However, there are no mentions of permanent education actions.

Initially there was still some training, [...]. It was not the Municipal Secretary itself, the State Secretary came with more resources, more training came. There was the Mais Saúde Program, the Introductory itself in which the municipality also gave its counterpart, some events for the area of women's health. (Nurse Iris)

Concerned with the quality of the assistance given to users and the training of their Human Resources, the Municipal Health Department has made major investments in training and capacitation, either through the promotion of events with its own resources, viability of the necessary conditions for the displacement of its technicians or participating in partnerships with other bodies and institutions (Doc. 0 1).

Theselectionandhiringofthe professionals who make up themultiprofessionalteamsofthe Family Health Strategy.

It is a competence of the municipality to "select, hire and remunerate professionals that make up the multidisciplinary primary care teams in accordance with current legislation" (BRASIL, 2006; 2011; 2017).The narratives present the selective process with its stages (Interview and curriculum analysis), nonetheless the documents do not mention how this process happened. The narratives also show that hirings were made in different ways: through various Associations and/or outsourcing, commissioned position, by political indication, which corroborates the documents when they mention the types of bond of these professionals, who were mostly hired, Doc 01, without mentioning by whom; and the commissioned positions, Doc. 05.

This situation enables us to realize the existence of a weakness in the construction of the employment relationship, which could give rise to an approach of this context with the process of precarious work, especially when they there is a certain turnover of these contracts and/or when mentioning labor rights and loss of the worker when needing to get paid for times of service.

This admission into the Strategy was done through a selection. [...] who did an interview; it was a resumé and an interview. [...] . And then we started to work [...]. (Nurse Rosa)

Because we were hired via associations. Each day it was a neighborhood association that signed, which was responsible. As to this day I have not been able to verify these contraction counts yet because I cannot prove this relationship of those times, because every day it was an association that was responsible. (Nurse Ixia)

Through outsourcing, it was a contract made through outsourcing. We were hired by the Association of Community Agents; and ... Then we were hired by the Cansanção Residents' Association. Only after a couple of years - 99, 2000 - two to three years, that bond shifted to a commissioned position. [...]. Then, the FHS nurses began to be hired as an appointed position, as a political one, with appointment by a politician, appointment by city councilors, this changed that question completely. (Nurse Rosa)

[...] 02 nurses of the FHS have an effective bond; 08 were contracted and 01 assigned, totaling 11 nurses of the FHS (Doc. 0 1).

[...] the existence of 11 nurses of the FHS but does not specify the type of bonding/contracting. (Doc. 0 2).

[...] a total of 24 nurses from the FHS, called Nurses Managers of the Family Health Program, in which 3 have the post of Commissioned Position and 21 are statutory in a Commissioned Position. (Doc. 0 5)

Guaranteeofmaterial resources, sufficient equipment and supplies for the operation of thehealthunits andteams.

In accordance with the PNAB, it is also a municipal competence to assure physical structure, material resources, equipment and supplies necessary for the operation of the Basic Health Units. From this context, the narrative evidences positive and negative points. As negative points there are the lack of material and human resources (materials, medications, exams), lack of management support; which diverges from Doc. 01 when it mentions that the allocation of material resources for the structuring of the FHS was a management priority in the year 2000. However, it acknowledges the weaknesses experienced in 2006, when it addresses the difficulties faced by the teams that make up the FHS, Doc. 04.

Positive points are mentioned even in the face of the adversities presented in the narrative and in the document and refer to the interpersonal relationship of the team in a harmonious perspective of work, which motivates, stimulates and encourages the professional, creating in this context a certain defense of the work and/or naturalization of the context.

As a negative point, there is often the lack of materials; lack of medication; lack of support, because the Family Health Strategy needs to be intertwined with issues other than just local. But also other types of examinations; difficulty in marking exams, laboratory tests; sometimes lack of staff to work, to mark the appointments. So then, lack of support, often from other segments. In relation to working conditions the positive points are at the local level. In relation to the staff. ***The positive points I managed to experience, thank God, were in relation to the team, that same dedication, dedication to work, harmony at work.So, we are happy to go to the unit, to work, to look for new strategies to be working****. (Nurse Rosa, emphasis added)*

In the year 2000, the SMS ***acquired a range of materials*** *for the instrumentalization of its network, being a great variety directed to the structuring of the Family Health Unit. (Doc. 01, emphasis added).*

- Difficulties Found: Insufficient number of basic drugs; Excess of families in the coverage areas of some family health teams; Delays in the acquisition of permanent material; Delays in the release of consumer material; Delay in the repair of equipment [...](Doc 04).

DISCUSSION

In the context of the actions of permanent and continuing education for professionals in the Family Health Strategy, it was clear that the actions of continuing education were present both in the nurses' narratives and the analyzed documents, attesting that the municipality was in line with what the PNAB

advocates. However, we emphasize the importance of not confusing Continuing Education with Permanent Education, since the second is designed for the Brazilian Unified Health System (SUS), in the Brazilian context, as a strategy in which professionals and the communities together construct a health model which transforms reality, not restricting itself to contents that translate knowledge on a specific pathology and/or punctual contents (LOPES; ANDRADE; WISNESKY, 2011; SAMPAIO, SOUZA; PIRES; CARVALHO, 2018). This proviso is consubstantial because we perceive the use of terms such as capacities. This in turn may mask control and manipulation processes of the professionals, leading them to purely technical practices, politically, ideologically and culturally influenced, distancing health work from the local reality, i.e. disarticulated from a change in strategy of the health services (DAVINI, 2009; SAMPAIO, SOUZA; PIRES; CARVALHO, 2018).

With regard to the selection and hiring process of the professionals who make up the multiprofessional teams of the Family Health Strategy, it was possible to perceive that the nurses went through a selective process composed of interview and curriculum analysis. However, the hiring process appeared to be outsourcing in several ways (Associations of Community Health Agents, Residents), commissioned and effective positions.We noted inconsistencies between the narratives and the analyzed documents, since the latter mention effective nurses, hired, assigned, in a commissioned position, or do not mention the form of hiring. However, comparing the information from the two sources, we noticed that the process of contracting of the FHS of the municipality studied in the defined historical period approached the process of precarious work. This is characteristic of a capitalist society, which expresses different modalities of work organization: temporary, partial, subcontracted; a trend that recovers the economic, political and ideological forms of labor and employment control (ANTUNES, 2008). As regards the guarantee of the material resources, sufficient equipment and supplies for the operation of the health units and teams, we identified compliance with the PNAB, which is also a municipal responsibility. Nevertheless, we also perceived in the narrative and the documents the existence of difficulties in the implementation of this competence, which reflects the working conditions developed by these professionals. Thus, it strengthens furthermore the approximation to the process of precariousness of work mentioned above.However, the narrative shows that even in the face of these difficulties it is possible to find positive points for the development of their work in healthcare. Given this context, Dejours (2007) emphasizes the importance of discussing issues related to the aspects that pervade the suffering and the defense experienced in the world of work by these professionals, which can be understood as a process of naturalizing suffering/difficulties. However, this same author points out that this naturalness can be interpreted as the result of a composition between suffering and the struggle (individual and collective) against suffering at work, that is, defense at work, characterizing what he calls "suffering normality" in workers fighting hard against the forces that can destabilize them psychically and come from the pressures at work (DEJOURS, 2007).

Final Considerations

The development of this study enabled us to analyze how the professional world of work in the FHS in the first decade of the year 2000 is configured, in the perspective of the professional nurse. As regards the material and productive activities, these are approximate to the precarious process of work characteristic of a capitalist society with its conflicts and contradictions that influence, and will also influence, the production of immaterial activities, especially when we identified the existence of "suffering normality" in the process of reproduction of life.

This "suffering normality" can cause damages both in the life of the professional and in the development of their work. What makes us think about the need of creating strategies that impact less on the worker's life and on the development of their professional practice, especially in the health field, where health work brings repercussions both for the lives of those who care, and those who require care.

Regarding the actions of permanent education in health, we realize that we need to better understand it, and consequently implement it as a requirement for the transformation of the scenario. For we believe that through it we can think of strategies of change both in the construction of a model of care, and in the construction of a world of work that translates the reality that we want.

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