Journal of Nursing
Revista de Enfermagem
UFPE On Line
ISSN: 1981-8963

INTEGRATIVE REVIEW ARTICLE

NURSES' WORKING CONDITION IN FAMILY HEALTH STRATEGY: INTEGRATIVE REVIEW

CONDIÇÕES DE TRABALHO DOS ENFERMEIROS NA ESTRATÉGIA SAÚDE DA FAMÍLIA: REVISÃO INTEGRATIVA

CONDICIONES DE TRABAJO DE LAS ENFERMERAS EN LA ESTRATEGIA DE SALUD DE LA FAMILIA: UNA REVISIÓN INTEGRADORA

Vanessa Cristina de Almeida Viana[1], Flavia Pedro dos Anjos Santos[2], Adriana Alves Nery[3], Juliana da Silva Oliveira[3], Clara Lúcia Santos de Almeida[5]

ABSTRACT

Objective: to know the nurses' working conditions in teams of the Family Health Strategy. ***Method:*** integrative review, intending to answer the question << What are the nurses' working conditions in the Family Health Strategy? >>. The research was conducted in the databases BDENF, LILACS and ScieLO virtual library, with the keywords: working conditions, nursing, public health and community health nursing. Interpretative reading made it possible to establish the construction of two categories, with the following grouping of data: "Family Health Team: the nurse's work (in)definition?" and "Nurses' work in Family Health team". ***Results:*** the nurse experience the vulnerability of the employment and job precariousness. On the other hand, the relationship with the team, the care act and autonomy were considered favorable aspects to his/her work. ***Conclusion:*** it is necessary to seek alternatives to ensure better working conditions to nurses. ***Descriptors***: Working Conditions; Community Health Nursing; Family Health Strategy.

RESUMO

***Objetivo*:** conhecer as condições de trabalho de enfermeiros que atuam nas equipes da Estratégia Saúde da Família. ***Método*:** revisão integrativa, com vistas a responder a questão << Quais as condições de trabalho do enfermeiro que atua na Estratégia Saúde da Família? >>. Realizou-se a busca nas bases de dados LILACS, BDENF e biblioteca virtual ScieLO, com os descritores: condições de trabalho, enfermagem, saúde pública e enfermagem em saúde comunitária. A leitura interpretativa possibilitou estabelecer a construção de duas categorias, com o seguinte agrupamento dos dados: "Equipe de Saúde da Família: (in)definição do trabalho do enfermeiro?" e "Trabalho do enfermeiro na equipe de Saúde da Família". ***Resultados*:** o enfermeiro vivencia a vulnerabilidade do vínculo trabalhista e precariedade do trabalho. Por outro lado, a relação com a equipe, o ato de cuidar e autonomia apresentaram-se como aspectos favoráveis ao seu trabalho. **Conclusão:** torna-se necessário buscar alternativas para assegurar melhores condições de trabalho aos enfermeiros. ***Descritores*:** Condições de Trabalho; Enfermagem em Saúde Comunitária; Estratégia Saúde da Família.

RESUMEN

Objetivo: conocer las condiciones de trabajo de las enfermeras que trabajan en equipos de la Estrategia Salud de la Familia. ***Método:*** una revisión integradora, con el fin de responder a la pregunta << ¿Cuáles son las condiciones de trabajo de las enfermeras que participan en la Estrategia Salud de la Familia? >>. Se realizó la búsqueda en las bases de datos LILACS, BDENF y biblioteca virtual SciELO con los descriptores: las condiciones de trabajo, enfermería, salud pública y enfermería en salud comunitaria. La lectura interpretativa permitió establecer la construcción de dos categorías, la siguiente agrupación de los datos: "¿Equipo de Salud de la Familia: (in)definición de trabajo de enfermería?" y "Trabajo de las enfermeras del equipo de Salud de la Familia". ***Resultados:*** las enfermeras experimentan la vulnerabilidad del contrato de trabajo y la inseguridad laboral. Por otro lado, la relación con el equipo, el acto de cuidar y de la autonomía se presentan como aspectos favorables a su trabajo. ***Conclusión:*** es necesario buscar alternativas para garantizar mejores condiciones de trabajo para las enfermeras. ***Descriptores*:** Condiciones de Trabajo; Enfermería en Salud Comunitaria; Estrategia Salud de la Familia.

[1]Nurse, MSc Professor in Nursing and Health, Graduate Course in Nursing, State University of Southwestern Bahia/UESB. Jequié (BA), Brazil. Email: fpasantos@uesb.edu.br; [2]Nurse, Specialist in Collective Health (graduated), State University of Southwestern Bahia/UESB. Jequié (BA), Brazil. E-mail: nssa_90@hotmail.com; [3]Nurse, PhD in Nursing, Main Professor, Graduate Course in Nursing, State University of Southwestern Bahia/UESB. Jequié (BA), Brazil. Email: aanery@gmail.com; [4]Nurse, MSc Professor in Nursing and Health, Graduate Course in Nursing, State University of Southwestern Bahia/UESB. Jequié (BA), Brazil. E-mail: juli.silva.oliveira@gmail.com; [5]Physiotherapist, Specialist in Collective Health (graduated), State University of Southwestern Bahia/UESB. Jequié (BA), Brazil. E-mail: claralucya@gmail.com

INTRODUCTION

The implementation of the Unified Health System (SUS), in 1990, required a process of reorientation of health actions from the doctrinaire principles of universality, comprehensiveness and equity, as well as the organizational principles of decentralization, regionalization and hierarchy, established by the Health Organic Law Number 8,080/90. In this sense, Brazil has undergone numerous changes in the political-administrative nature, leading managers, health workers and users to witness a change in health services, regarding their organization and operation focused on the comprehensive care of users.[1-2]

With the creation of the Family Health Program (FHP) in 1994, later called Family Health Strategy (FHS), the Ministry of Health proposed a change in the healthcare model, changing the organization of services and care practices through the implementation of disease prevention and health promotion activities, bringing staff and surrounding population, reorganizing the demand and, therefore, requiring different skills of workers of this type of attention.[1-2] Therefore, the FHS teams are operationalized through the implementation of multidisciplinary teams in which the unit's professionals work together, each in their respective area, in order to produce a resolute care.

The diversity of professionals and knowledge allows the team carrying out the work shared between individuals, so that, together, they can promote effective measures to monitor the population's health situation in the unit's coverage area. The FHS team is made up of the doctor, nurse, nursing assistant or technicians and community health workers, and the oral health professionals may be part of this multidisciplinary team.[2]

There are many benefits of this multidisciplinary team, but, as it involves different professional areas, it also has conflicts related to division of labor, different degrees of professional autonomy, different characteristics and technical and social particularities of the various fields of knowledge, among others.

In this context, the nurse, as a professional of this team, can experience a working environment often conflictual, given the different interests that permeate the management, the users, as well as their own professional satisfaction.

On the one hand, there is the management that seeks the achievement of goals, delegating parallel activities and the management of the unit, which means numerous activities, and often without the necessary resources. On the other hand, there are users who do not seem to have a broader understanding of the FHS guidelines, and, therefore, do not question the causes of the weaknesses of the Family Health team, and, sometimes, blame and pressure the professional nurses, who end up overloaded when performing various activities.[3]

Even with all the importance and recognition that seems to be attributed to the nurse's work, the precariousness of employment in health is a reality still present in the FHS and this professional's working environment. The lack of public exams and the disability in recognizing the labor rights make the employment contract weaker.

The precariousness of health work has been identified as one of the obstacles to the development of the public health system, affecting the relationship between the workers and the health system and may harm the services provided by SUS, both in its quality as continuity.[4]

This study is relevant because most of the found studies emphasize the working conditions, the pathological aspects and exposure to risks in hospitals, with few studies discussing this professional's working conditions in primary health care.[5] Thus, the objective is to contribute to reflections about the nurse's work in the FHS, in order to raise strategies to reframe their work, appreciating the potential of nursing in the context of SUS and FHS.

OBJECTIVE

- To know the nurses' working conditions in FHS teams.

METHOD

Integrative review, following the six steps: preparation of the guiding question of the research, establishment of the criteria for inclusion and exclusion of studies, definition of the information to be extracted from the selected studies, assessment of the studies included in the review, interpretation and discussion of the main results and presentation of the review of synthesis.[6]

Thus, the design of this study arose from the following research question: How are the nurses' working conditions engaged in the FHS?

The following inclusion criteria were established: fully available articles, online articles available for free, national and international productions, published in Portuguese, English or Spanish. The enclosed timeline ranged from 2010 to 2014, in order to

describe the current scientific literature. Theses, dissertations, monographs and articles that, after examination, were not consistent with the purpose of the study were excluded.

The study was conducted with the consultation of scientific articles available on the following databases: Latin American and Caribbean Literature in Health Sciences (LILACS), Cochrane Library and Scientific Electronic Library Online (ScieLO) and Nursing Database (BDENF), from May to July 2014. For collecting the information, the following descriptors, standardized by the Health Sciences Descriptors associated with Boolean operator, were used: working conditions AND public health; public health AND community health nursing; nursing AND working conditions.

After reading the title and abstract of the selected studies, a validated instrument was used to assess them in relation to the identification of the original articles, methodological characteristics of the study, assessment of the methodological rigor and measured interventions, and the results of the journal, author, study and the level of evidence[7]: 1 - systematic reviews or meta-analysis of relevant clinical trials; 2 - evidence of at least one clinical trial randomized, controlled and well defined; 3 - well-designed clinical trials without randomization; 4 - cohort studies and well-designed case-control; 5 - systematic review of descriptive and qualitative studies; 6 - evidence derived from a single descriptive or qualitative study; 7 - opinion authorities or expert committees including interpretation not based on research information.

Through the content analysis technique, thematic modality, the texts were divided into units, with text cut-offs, and later regrouping.[8] The analysis consisted of reading the 18 selected articles in order to identify the meaning units that make up the study's corpus, observing the frequency of these nuclei, with similar regroupings that provided a new reading from which two categories emerged: "Family Health Team: the nurses' work (in)definition" and "The nurse's work in Health Family team".

RESULTS

Regarding the databases, nine of the studies were found in SCIELO, five, in LILACS and four, in BDENF. For the characteristics relating to the timeline of the studies, there were more from 2012 with seven (39%) findings; 2010 and 2011, each one with four (22.2%) findings; 2013 with two of the findings (11.1%); and 2014 with one article (5.5%).

Regarding the type of study, one article (5.5%) was a descriptive with quantitative and qualitative approach and 17 (94.5%), qualitative, of which four were bibliographic review articles; four descriptive; four exploratory-descriptive articles; one cross-sectional descriptive, and one case study, being classified by level of evidence, observing that 12 (66.7%) of the publications had evidence level VI, as shown in Figure 1.

Code	Title	Authors	Method	Level of evidence	Year of publication
A1	Family health strategy workers' social representations about health promotion.	Mantovani MF, Mendes FRP, Mazza VA, Marques MCMP, Balduino AFA, Campos CGP.	Qualitative, descriptive	VI	2014
A2	Worker's health in the family health strategy: the nursing team's perceptions.	Duarte MLC, Avelhaneda JC, Parcianello RR.	Exploratory-descriptive, qualitative	VI	2013
A3	Factors involved in the management of nursing care: a descriptive study.	Fernandes MC, Silva LMS, Moreira TMM, Silva MRF.	Descriptive, with qualitative approach	VI	2013
A4	Occupational risks: perception of nursing professionals of the Family's Health Strategy in Joao Pessoa, PB.	Rodrigues LMC, Silva CCS, Silva VKBA, Martiniano CS, Silva ACO, Martins MO.	Descriptive, with qualitative approach	VI	2012
A5	Work in the Basic Health Unit: implications for nurses' quality of life.	Schrader G., Palagil S, Padilha MAS, Noguez PT, Thofehrn MB, Dal Pai D.	Exploratory-descriptive, with qualitative approach	VI	2012
A6	Factors intrinsic to the work environment as contributors of the Burnout syndrome among nursing.	Cunha AP, Souza EM, Mello R.	Literature review	V	2012
A7	The working process in the Family Health Strategy and its repercussions on the health-disease process.	Shimizu HE, Carvalho Junior DA.	Cross-sectional descriptive, qualitative	III	2012
A8	The visibility of moral harassment in the work of nursing.	Azevedo AL, Araújo STC.	Literature review	V	2012
A9	Psychological violence in the nursing work.	Lima DM, Santos DF, Oliveira FN, Fonseca APLA, Passos JP.	Literature review	V	2012
A10	From pleasure to suffering in the nursing work: the speech of the workers.	Kessler AI, Krug SBF.	Exploratory-descriptive, with qualitative approach	VI	2012
A11	Work conditions and renormalization of nursing activities in family health.	Bertoncini JH, Pires DEP, Scherer MDA.	Qualitative	VI	2011
A12	Workers at a basic health unit who interface with violence.	Velloso ISC, Araújo MT, Alves M.	Qualitative	VI	2011
A13	The process of working in nursing supervision.	Santiago JLC, Medeiros JM, Castelo Branco FMF, Xavier CL, Dias IB, Monteiro CFS.	Case study, with qualitative approach	VI	2011
A14	Violence in health work: analysis of basic health units in Belo Horizonte, Minas Gerais.	Batista CB, Campos AS, Reis JC, Schall VT.	Descriptive-exploratory	VI	2011
	Work situations experienced	Pinto ESG,			

A15	by family health strategy professionals in Ceará-Mirim.	Menezes RMP, Villa TCS.	Descriptive, with quantitative approach	III	2010
A16	Overlapping of duties and technical autonomy among nurses of the Family Health Strategy.	Feliciano KVO, Kovacs MH, Sarinho SW.	Qualitative	VI	2010
A17	Occupational risks of nurses working in the family health strategy.	Bessa MEP, Almeida MI, Araújo MFM, Silva MJ.	Literature review	V	2010
A18	Occupational risks of nurses working in the family health strategy.	Nunes MBG, Robazzi MLCC, Terra FS, Mauro MYC, Zeitoune RCG, Secco IAO.	Descriptive study, with quantitative and qualitative approach	VI	2010

Figure 1. Summary of the studies related to the nurses' working conditions in ESF teams, according to the article code, title, author, method, level of evidence and year of publication. Jequié – BA, 2010-2014.

The articles analysis evidenced 18 (100%) national journals, according to what Table 1 shows.

Table 1. Distribution of the studies related to nurses' working conditions working in ESF teams, according to journals where the articles were published. Jequié – BA, 2010-2014.

Journals	n	%
Revista Brasileira de Ciências da Saúde	1	(5.5%)
Revista Trabalho, Educação e Saúde	2	(11.3%)
Revista Cogitare Enfermagem	1	(5.5%)
Revista Acta Paulista de Enfermagem	1	(5.5%)
Revista Brasileira de Enfermagem	1	(5.5%)
Revista da Escola de Enfermagem da USP	1	(5.5%)
Revista de Saúde Pública	1	(5.5%)
Revista de Pesquisa: cuidado é fundamental online	4	(22.4%)
Online Brazilian Journal of Nursing	1	(5.5%)
Revista Ciência e Saúde Coletiva	1	(5.5%)
Revista Enfermagem UERJ	2	(11.3%)
Revista Gaúcha de Enfermagem	1	(5.5%)
Revista de Enfermagem UFPE on line	1	(5.5%)
Total	18	100%

As for the objectives of the study, there was a predominance of articles with the objective of understanding and describing the occupational hazards experienced by nurses working in the ESF; and understanding the issues and the interference of social and psychological violence in the work of the Family Health teams, as shown in Table 2.

Table 2. Distribution of the studies related to nurses' working conditions in ESF teams, according to the article code and objective of publications. Jequié – BA, 2010-2014.

Code	Objective	n	%
A1	To analyze ESF workers' social representations about health promotion.	1	(5.5%)
A2	To analyze the nursing team's perceptions about the health of the ESF worker.	1	(5.5%)
A3	To investigate the factors involved in care management of the nurse in the ESF.	1	(5.5%)
A4 – A17 – A18	To investigate the understanding of nursing staff of the family health units regarding occupational risks to which they are exposed, and to identify their suggestions in order to minimize such exposure.	3	(16.5%)
A5	To know the perception of the nurses that work in the health basic units about their life quality in work.	1	(5.5%)
A6	To identify and analyze the factors of the work environment that favor the development of Burnout syndrome in nursing professionals.	1	(5.5%)
A7 – A13	To analyze and describe the working process of workers and nurses supervising ESF.	2	(11.5%)
A8	To examine bullying (AM) in nursing work	1	(5.5%)
A9 – A12 – A14	To understand in which aspects the social and psychological violences interfere in the work of Family Health teams in the perspective of health work processes.	3	(16.5%)
A10	To identify situations that cause pleasure and pain in the nursing work.	1	(5.5%)
A11 – A15	To analyze the working conditions experienced by the professionals of ESF.	2	(11.5%)
A16	To understand how ESF nurses experience the overlapping of duties and building of technical autonomy	1	(5.5%)
Total		18	100%

Regarding the participants of the analyzed studies, there was a predominance of nurses as research subjects in fifteen (82.5%) articles, as shown in Table 3.

Table 3. Distribution of the studies related to nurses' working conditions in ESF teams, according to the article code and the subjects of publications. Jequié – BA, 2010-2014.

Code	Subjects of publication	n	%
A1	Nurse, doctor, odontologist, oral health technician, nursing assistant and oral health assistant	1	(5.5%)
A2 – A4 – A10	Nurse, nursing technician and assistant	3	(16.5%)
A3 – A5 –A8 - A11 – A13 – A16 – A17 - A18	Nurse	8	(44%)
A6 - A9	Nursing professionals	2	(11%)
A7	CHA, nurse, nursing assistant and doctor	1	(5.5%)
A12 – A15	Unit workers	2	(11%)
A14	Users, workers and managers of health service	1	(5.5%)
Total		18	100%

The scenario that appeared the most was the FHS teams in 13 (71.5%) of the analyzed articles, followed by the Regional Health Coordination in one (5.5%) article. Among those studies conducted with the Family Health teams, one was also held in the Health City Department and another in a hospital simultaneously. The other analyzed articles (A6, A8, A9 and A17) were a literature review.

Regarding the Brazilian state of origin of productions, three (16.5%) articles were from Rio Grande do Sul, followed by Minas Gerais, with two (11%) articles; the states of Paraná, Ceará, Paraíba, Federal District, Piauí, Rio Grande do Norte, Pernambuco, Rio de Janeiro and one city in southern Brazil had one (5.5%) of the findings.

As for the results presented in the analyzed articles, five (28%) pointed out the poor working conditions, four (22%) revealed nurses' workload in the FHS, three (16.5%) articles showed nurses' exposure to occupational risks, three (16.5%) pointed to the violence in the workplace, followed by two (11.5%) studies discussing the difficulty of carrying out promotional activities to health and one (5.5%) described the structural difficulties of the FHS teams experienced by nurses.

Among these studies, three (16.5%) articles also showed teamwork, autonomy, the care act and interpersonal relations as favorable aspects to the nurses' work in FHS, as described in Figure 2.

Code	Summary of results
A1	Health professionals cannot operate, in their daily work, a change model that provides promotion actions to the users' health.
A2	Work overload, physical structure, financial aspect and mental and physical suffering.
A3	The resistance of users to health prevention and promotion activities was unfavorable aspects found by the study. Teamwork and autonomy were favorable aspects to the nurses' work.
A4	It points out the need for health education, improvement of working conditions and expansion of human resources in the Family Health units as strategies to minimize exposure to occupational hazards.
A5	Professional depreciation and insufficient support from managers, whereas interpersonal relationships and the act of caring were favorable aspects to job performance.
A6	Work overload, poor working conditions, interpersonal relationship conflict, lack of professional expectation, little professional autonomy, ambiguity functions and salary dissatisfaction.
A7	Division of labor between formulators and implementers, repetition of tasks, precarious working conditions and the specific requirements of care to families and community causes intense wear.
A8	Precarious work environment, relationships and the production process.
A9	Nursing workers need greater attention regarding the psychological violence.
A10	Suffering at work related to user assistance, the precarious working conditions and the difficulty of team interaction; pleasure related to the good relationship of the work team.
A11	Inadequate working conditions contradict or hinder the achievement of the health and integrity promotion goals prescribed by the FHS.
A12	Situations of violence in the community, fear, insecurity. The effectiveness of health care is challenged by violence and requires strategies to deal with it.
A13	The work overload related to the resolution of administrative problems of the Basic Health Unit.
A14	Situations of violence at the ESF. Need for strengthening the humanization and management of health work as well as improving the work conditions and environment.
A15	Large number of families, unavailability of equipment and instruments hamper the nurses' work.
A16	Excessive number of families, insufficient organizational support, work overload. Physical and mental illness, recognizing the importance of the nurse's work.
A17	Physical, chemical, biological and ergonomic occupational hazards in labor activity. Nurse's need for using biosecurity measures and promoting self-care.
A18	Identified occupational hazards: biological, mechanical, psychosocial, ergonomic, physical and accidents while going to work.

Figure 2. Summary of studies related to the nurses' working conditions in ESF teams, according to article code and summary of results. Jequié – BA, 2010-2014.

DISCUSSION

After the interpretative reading of the articles, the regrouping of the found information were established in two categories: "Health Team Family: the nurse's work (in)definition? and "The nurse's work in Health Family team". The first category intended to discuss the nurses' work in the context of FHS.

The found studies emphasize the nurse's workload in the Family Health team,[9-16] the difficulties in defining this professional's assignment[10,13-15,17-19] and also the constant fight for conquering their autonomy.[13,16,17,20]

The high rates of absenteeism and the lack of professional's hiring, in addition to the high staff turnover, causes change of function.[10-12] In this context, it is clear that the high demand for activities that nurses perform in their daily work gets worse by the lack of professionals and the great absenteeism that make up the Family Health Teams.

Therefore, the nurse's responsibilities increase, often overburdening him/her, considering that unrealized assignments often end up being directed to the nurse instead of being shared with other professionals in the team.

This situation makes the nurse to feel responsible for actions out of his/her competence and consequently decreases the time that these professionals could engage for carrying out their activities, preventing them from performing their specific activities, which can generate losses to the care produced to users.

According to the found literature, another trigger for the nurse's workload is the excessive number of followed-up families, generating great demand for consultations and various needs reported by users. In addition to the reduced number of professionals, this situation causes delays in care and hinders

solving the user's demand, creating conflicts and attacks by the population.[10,12-16]

According to Decree Number 2.488, of October 21st, 2011, which approves the Basic Care National Policy, each Family Health team should be responsible for no more than 4.000 users, being the recommended average of 3.000, respecting the fairness criteria for this setting.[2]

Even with the existence of the limit set by the Ministry of Health, the nurses' work may be overloaded, as they are responsible for a number of users far higher than stated, disregarding the fairness criteria for this definition, taking as premise that the higher the degree of vulnerability, the lowest the amount of involved people.

The high demand shows the unfavorable situation faced by this professional, as he/she has to perform a high number of consultations, which may generate a work directed by the quantity and not by the quality of the produced care.

Regarding the nurse's duties in the Family Health Team, the simultaneous attention to assistance, administrative and management activities also triggers an overload of work, representing a greater demand in the preparation and execution of the work, causing fatigue, wear and exhaustion.[10,14-15]

The nurse's duties in the Family Health teams consist of health care to the enrolled families; health education; realization of planned activities and attention to spontaneous demand; planning, management and evaluation of the actions developed by the Community Health Agents (CHA) along with other team members; contributing, participating and conducting ongoing education activities of nursing staff and other team members; and participating in the management of the necessary inputs for the proper functioning of UBS.[2]

The nurse's duties include planning, management and evaluation of the actions developed by CHA and not the management of the entire unit; managing the input is also included as duties of the doctor, dental surgeon and the nursing technician.[2]

Acting as a manager of the Family Health Unit may be related to the technical and scientific competence of nurses; however, such assignment exclusively directed to this professional should be rethought, since it has been a source of stress and work overload.

Regarding autonomy, studies reveal that even nurses exercising an effective role in the team and taking a leadership role, their autonomy is still unsatisfactory,[13,16,20] considering that, as unit manager, he/she often has the autonomy affected, due to various situations related to health management.

Although nurses assume the leading role within the Family Health team, sometimes their autonomy faces obstacles, given the interests of health management, which can cause moments of repression of this professional's autonomy.

The second category of this study, entitled "The nurse's work in Health Family team", discussed the precarious working conditions of nurses with emphasis on illness risks, vulnerability of the employment contract and motivations for their professional practice.

The precariousness of working conditions is a factor in the nurse's routine, related to physical resources and inadequate materials and the vulnerability of the employment contract,[11-2,14,17,20-1] which exposes the professional to situations that can provoke illnesses.

The nurses' illness in the FHS is related to ergonomic hazards causing musculoskeletal pain due to repetitive physical exercises and postures;[9,11,22] biological risks while in contact with contagious diseases, secretions, handling sharp objects, associated with the use, or not, of the personal protective equipment (PPE);[9,20,22-23] psychological risks due to the stress suffered in the relationship with team members, customers and management, situations of verbal and physical aggression and harassment by users, feeling fear of dissatisfaction and insecurity in executing their work.[11-3,17-8,22,24-5]

It is essential that nurses have a work environment that promotes their health, structure and suitable furniture, PPE available in satisfactory quantity and quality, harmonious interaction between staff and users, so that this professional feels encouraged to provide comprehensive care to users.

Concerning the psychological risks, stress is also very present in nursing work, being related to the pressures suffered by other professionals and users who do not seem to understand the new proposal for health care, emphasizing on preventive actions.[21]

The difficulty in breaking up with the tradition inherited from the medical model centered on disease hinders the implementation of a process of work directed to interdisciplinary practices.[18,22] Even after 20 years of the FHS implementation, an important guideline of Basic Care that prioritizes promotion activities to health and

disease prevention still needs to overcome many obstacles, considering that they are not limited to individual character, requiring the involvement of different stakeholders - users, professionals and managers - for consolidation.[1-2,26]

Sometimes, it seems that the importance of promotion and prevention actions for health are being disregarded, with a predilection to drug treatment, diseases already occurring, rather than prioritizing actions to prevent the installation of a pathological process.

In this sense, users, as well as some team members, seem to value the curative actions based on the biomedical model, which hinders the implementation of actions to promote health and disease prevention, causing the attempt to implement them to be, most often, a stressor for nurses, and may be permeated by conflicts between user-nurse and nurse-staff.

This situation can cause disinterest by some team members to perform prevention and health promotion activities, although the Ordinance of Basic Care reaffirms that the implementation of these activities are duties common to all professional teams.[2]

Regarding the instability of the employment contract, the found literature reveals predominance of temporary contracts and by services. Many professionals do not have any regulated employment contract, which forbids them from using their working rights.[14,17,22] The working conditions, often precarious, cause a staff turnover in the FHS, as the professionals search for better working conditions, both hired as permanent professionals in demand for more dignified wages, autonomy gain and professional affirmation.[12,14-15,17]

The Ministry of Health provides for the common responsibilities of the three levels of government, which should ensure the infrastructure necessary for the functioning of basic health units, according to their responsibilities, ensuring the labor and social security rights, the qualification of employment contracts, and the implementation of careers involving employee development with qualification of the services offered to users.[2]

Due to the failure of fulfilling these responsibilities, the nurse's reality seems unfavorable, with constant turnover of hired and permanent professionals, who, despite having stability, as well as the hired ones, are also looking for better working conditions, making it difficult to create bonds with the community and the continuity of health actions.

Entering the labor market by public exams could enable equal opportunities for remaining in the labor market and also the construction of the bond, but the health management (un)paths seem to forbid it from happening.

The adoption of implementing strategies of a worker's valuation policy, labor improvement and SUS consolidation began to be implemented by the Ministry of Health, through the creation of the Inter-institutional National Committee for Labor Improvement in SUS[4], with the objective of formulating policies and guidelines for fighting precariousness. However, it is important to move forward in the discussions and actions because of the magnitude of the problems caused by job insecurity.

Some found studies showed favorable aspects in the work of nurses in the FHS regarding the relationship with the team and their support;[13,17, 25] feelings of satisfaction in the care act;[13,25] and autonomy.[17]

Therefore, these alternatives can improve the nurse's appreciation as a professional and encourage him/her to fight for more decent working conditions.

CONCLUSION

The study met the proposed objective as it enabled a better understanding of the nurse's working conditions in the FHS.

The nurse is in a precarious working situation, and experiences the vulnerability of the employment contract and its consequent uncertainty.

Even being important for the FHS, with a significant role for SUS consolidation, the nurse seems to be underrated, there are still many challenges to be overcome, especially concerning the lack of decent working conditions and recognized and hired labor rights.

The search for better working conditions is a reality for both hired nurses as for the ones who entered the job by public exam, that, even with recognized labor rights and stability of employment also experience the precariousness of work and are looking for better working conditions. However, even in a professional routine permeated by difficulties, with much unfavorable evidence in relation to working conditions, the study showed that nurses still find reasons for the exercise of work, such as the satisfaction of the produced care and team's support.

The working conditions, work management in health and the frailty of the labor rights of nurses are issues that have been raised by this research and can potentially contribute to further researches about the subject.

REFERENCES

1. Magnago C, Pierantoni CR, França T, Garcia AC, Ney MS, Matsumoto K. A influência da estratégia saúde da família sobre indicadores de saúde em municípios do Rio de Janeiro, Brasil. Online braz j nurs [Internet]. 2011 [cited 2014 Dec 01];10(1):1-15. Available from: http://www.objnursing.uff.br/index.php/nursing/article/view/j.1676-4285.2011.3211.1

2. Brasil. Ministério da Saúde. Portaria nº 2.488 de 21 de outubro de 2011: Política Nacional de Atenção Básica. Brasília: Ministério da Saúde; 2011.

3. Albuquerque FJB, Melo CF, Araújo Neto JL. Avaliação da Síndrome de Burnout em profissionais da estratégia saúde da família da capital paraibana. Psicol reflex crit [Internet]. 2012[cited2014 Oct 08];25(3):542-9. Available from: http://dx.doi.org/10.1590/S0102-79722012000300014

4. Brasil. Ministério da Saúde. Secretaria de Gestão do Trabalho e da Educação na Saúde. Departamento de Gestão e da Regulação do Trabalho em Saúde. Departamento de Gestão e da Regulação do Trabalho em Saúde. Comitê Nacional Interinstitucional de desprecarização do trabalho no SUS. Programa Nacional de Desprecarização do trabalho do SUS – DesprecarizaSUS: perguntas & respostas. Brasília: Ministério da Saúde; 2006.

5. Daubermann DC, Tonete VLP. Qualidade de vida no trabalho do enfermeiro da atenção básica à saúde. Acta Paul Enferm [Internet]. 2012 [cited 2014 June 11];25(2):277-83. Available from: http://dx.doi.org/10.1590/S0103-21002012000200019

6. Mendes KDS, Silveira RCCP, Galvão CM. Revisão integrativa: método de pesquisa para a incorporação de evidências na saúde e na enfermagem. Texto & contexto enferm [Internet]. 2008 [cited 2016 Apr 21];17(4):758-64. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-07072008000400018

7. Melnyk BM, Fineout-Overholt E. Making the case for evidence-based practice. In: Melnyk BM, Fineout-Overholt E. Evidence-based practice in nursing & healthcare: a guide to best practice. Philadelphia: Lippincot Williams & Wilkins; 2005 [Internet]. 2006 [cited 2016 Apr 21];3-24. Available from: http://download.lww.com/wolterskluwer_vitalstream_com/PermaLink/NCNJ/A/NCNJ_546_156_2010_08_23_SADFJO_165_SDC216.pdf

8. Minayo MCS. O desafio do conhecimento: Pesquisa qualitativa em saúde. 14 th ed. São Paulo: Hucitec, 2014.

9. Rodrigues LMC, Silva CCS, Silva VKBA, Martiniano CS, Silva ACO, Martins MO. Riscos ocupacionais: percepção de profissionais de enfermagem da Estratégia Saúde da Família em João Pessoa – PB. Rev bras ciênc saúde [Internet]. 2012 [cited 2014 June 11];16(3):325-32. Available from: file:///C:/Users/Usuario/Downloads/12660-22260-1-PB%20(1).pdf

10. Bertoncini JH, Pires DEP, Scherer MDA. Condições de trabalho e renormalizações nas atividades das enfermeiras na saúde da família. Trabalho Educ e Saúde [Internet]. 2011[cited 2014 Dez 15]; 9(Suppl 1): 157-73. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1981-77462011000400008&lng=pt&nrm=iso&tlng=pt

11. Duarte MLC, Avelhaneda JC, Parcianello RR. A saúde do trabalhador na estratégia de saúde da família: percepções da equipe de enfermagem. Cogitare Enferm [Internet]. 2013 [cited 2014 Oct 28];18(2):323-30. Available from: http://ojs.c3sl.ufpr.br/ojs/index.php/cogitare/article/view/32582/20697

12. Velloso ISC, Araújo MT, Alves M. Trabalhadores de uma unidade básica de saúde na interface com a violência. Acta Paul Enferm [Internet]. 2011[cited 2014 May 13];24(4):466-71. Available from: http://www.scielo.br/pdf/ape/v24n4/a04v24n4.pdf

13. Schrader G., Palagil S, Padilha MAS, Noguez PT, Thofehrn MB, Dal Pai D. Trabalho na unidade básica de saúde: implicações para a qualidade de vida dos enfermeiros. Rev bras enferm [Internet]. 2012 [cited 2014 Nov 30];65(2):222-8. Available from: http://www.scielo.br/pdf/reben/v65n2/v65n2a04.pdf

14. Pinto ESG, Menezes RMP, Villa TCS. Situação de trabalho dos profissionais da estratégia saúde da família em Ceará-Mirim. Rev esc enferm USP [Intenet]. 2010 [cited 2014 May 13];44(3):657-64. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0080-62342010000300015&lng=pt&nrm=iso&tlng=pt

15. Feliciano KVO, Kovacs MH, Sarinho SW. Superposição de atribuições e autonomia técnica entre enfermeiras da Estratégia Saúde da Família. Rev saúde pública [Internet].2010

[cited 2014 Out 28];44(3):1-11. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-89102010000300016&lng=pt&nrm=iso&tlng=pt

16. Cunha AP, Souza EM, Mello R. Os fatores intrínsecos ao ambiente de trabalho como contribuintes da síndrome de burnout em profissionais de enfermagem. Revista de Pesquisa: Cuidado é Fundamental Online [Internet]. 2012 [cited 2014 Dec 02];4(Suppl 1):29-32. Available from: http://www.seer.unirio.br/index.php/cuidadofundamental/article/view/1716/pdf_507

17. Fernandes MC, Silva LMS, Moreira TMM, Silva MRF. Fatores intervenientes na gerência do cuidado do enfermeiro: estudo descritivo. Online braz j nurs [Internet]. 2013 [cited 2014 Dez 01];12(3):1-12. Available from: http://www.objnursing.uff.br/index.php/nursing/article/view/4081/pdf_1

18. Santiago JLC, Medeiros JM, Castelo Branco FMF, Xavier CL, Dias5 IB, Monteiro CFS. O processo de trabalho da enfermagem na supervisão. Revista de Pesquisa: Cuidado é Fundamental Online [Internet]. 2011 [cited 2014 Dez 02];3(Suppl 1):217-22. Available from: http://www.seer.unirio.br/index.php/cuidadofundamental/article/view/1983/pdf_548

19. Shimizu HE, Carvalho Junior DA. O processo de trabalho na Estratégia Saúde da Família e suas repercussões no processo saúde-doença. Ciên Saúde Colet [Internet]. 2012 [cited 2014 Nov 30]; 17(9): 2405-14. Available from: http://dx.doi.org/10.1590/S1413-81232012000900021

20. Azevedo AL, Araújo STC. A visibilidade do assédio moral no trabalho de enfermagem. Revista de Pesquisa: Cuidado é Fundamental Online [Internet]. 2012 [cited 2014 Dec 02];4(3):2578-84. Available from: http://www.seer.unirio.br/index.php/cuidadofundamental/article/view/1427/pdf_595

21. Batista CB, Campos AS, Reis JC, Schall VT. Violência no trabalho em saúde: análise em unidades básicas de saúde de Belo Horizonte, Minas Gerais. Trabalho Educ e Saúde [Internet]. 2011[cited 2014 Dez 15];9(2):295-317. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1981-77462011000200008&lng=pt&nrm=iso&tlng=pt

22. Bessa MEP, Almeida MI, Araújo MFM, Silva MJ. Riscos ocupacionais do enfermeiro atuante na estratégia saúde da família. Rev enferm UERJ [Internet] 2010[cited 2014 Oct 22];18(4):644-9. Available from: http://www.facenf.uerj.br/v18n4/v18n4a24.pdf

23. Nunes MBG, Robazzi MLCC, Terra FS, Mauro MYC, Zeitoune RCG, Secco IAO. Riscos ocupacionais dos enfermeiros atuantes na atenção à saúde da família. Rev enferm UERJ [Internet] 2010 [cited 2014 Oct 22];18(2):204-9. Available from: http://www.facenf.uerj.br/v18n2/v18n2a07.pdf

24. Lima DM, Santos DF, Oliveira FN, Fonseca APLA, Passos JP. Violência psicológica institucional no trabalho da enfermagem. Revista de Pesquisa: Cuidado é Fundamental Online [Internet]. 2012 [cited 2014 Dec 03];(Suppl.):17-20. Available from: http://www.seer.unirio.br/index.php/cuidadofundamental/article/view/1651/pdf_502

25. Kessler AI, Krug SBF. Do prazer ao sofrimento no trabalho da enfermagem: o discurso dos trabalhadores. Rev Gaúcha enferm [Internet]. 2012 [cited 2014 Nov 28];33(1):49-55. Available from: http://www.scielo.br/pdf/rgenf/v33n1/a07v33n1.pdf

26. Mantovani MF, Mendes FRP, Mazza VA, Marques MCMP, Balduino AFA, Campos CGP. Representações Sociais dos trabalhadores da Estratégia Saúde da Família sobre promoção da saúde. J Nurs UFPE on line [Internet]. 2014 [cited 2014 Dec 14];8(12):4292-9. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/5900

Submission: 2015/04/03
Accepted: 2016/05/12
Publishing: 2016/07/01

Corresponding Address

Flavia Pedro dos Anjos Santos
Rua José Moreira Sobrinho, s/n
Bairro Jequiezinho
CEP 45200-000 –Jequié (BA), Brasil