CARE PRACTICES OF THE FAMILY HEALTH STRATEGY TEAM

PRÁTICAS DE CUIDADO DA EQUIPE DA ESTRATÉGIA SAÚDE DA FAMÍLIA

PRÁCTICAS DE CUIDADO DEL EQUIPO DE LA ESTRATEGIA SALUD DE LA FAMILIA

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ABSTRACT

Objective: to describe the care practices of Family Health Strategy teams from the perspective of users. **Method:** qualitative, exploratory and descriptive study with 34 users. The data were collected through a semi-structured interview and organized by the Content Analysis technique in the Categorical Analysis modality. **Results:** two thematic categories were elaborated. The care produced by the Family Health Strategy team at times is permeated by listening and welcoming and, in others, by a technician posture. The users considered that the medical and nursing consultations, the home visit and the educational activities are the care practices developed by the team. They emphasized the prescriptive-curative nature of medical consultations, the programmatic organization of consultations and the importance of educational guidelines during consultations. **Conclusion:** the care practices of the team are organized through consultations, home visits and educational activities, with the need for their re-signification, which contributes to the advancement of knowledge both for health professionals and for their training. **Descriptors:** Nursing Care; Family Health; Primary Health Care; Primary Care Nursing; Comprehensive Health Care; Unified Health System.

RESUMO

Objetivo: descrever as práticas de cuidado das equipes da Estratégia Saúde da Família sob a ótica de usuários. **Método:** estudo qualitativo, exploratório e descritivo com 34 usuários. Os dados foram coletados por meio de entrevista semiestruturada e organizados pela técnica de Análise de Conteúdo na modalidade Análise Categorical. **Resultados:** foram elaboradas duas categorias temáticas. O cuidado produzido pela equipe da Estratégia Saúde da Família em alguns momentos é permeado pela escuta e acolhimento e, em outros, por uma postura tecnicista. Os usuários consideraram que as consultas médicas e de enfermagem, a visita domiciliar e as atividades educativas são as práticas de cuidado desenvolvidas pela equipe. Destacaram o caráter prescritivo-curativo das consultas médicas, a organização programática das consultas e a importância das orientações educativas durante as consultas. **Conclusão:** as práticas de cuidado da equipe se organizaram por consultas, visitas domiciliares e atividades educativas, havendo a necessidade de sua ressignificação, fato que contribui para o avanço do conhecimento tanto para os profissionais da saúde como para a sua formação. **Descritores:** Cuidados de Enfermagem; Saúde da Família; Atenção Primária à Saúde; Enfermagem de Atenção Primária; Assistência Integral à Saúde; Sistema Único de Saúde.

RESUMEN

Objetivo: describir las prácticas de cuidado de los equipos de la Estrategia Salud de la Familia sobre la óptica de usuarios. **Método:** estudio cualitativo, exploratorio y descriptivo con 34 usuarios. Los datos fueron recogidos por medio de entrevista semi-estructurada y organizados por la técnica de Análisis de Contenido en la modalidad Análisis Categorical. **Resultados:** fueron elaboradas dos categorías temáticas. El cuidado producido por el equipo de la Estrategia Salud de la Familia en algunos momentos es permeado por la escucha y acogida y en otros, por una postura tecnicista. Los usuarios consideraron que las consultas médicas y de enfermería, la visita domiciliar y las actividades educativas son las prácticas de cuidado desarrolladas por el equipo. Destacaron el carácter prescritivo-curativo de las consultas médicas, la organización programática de las consultas y la importancia de las orientaciones educativas durante las consultas. **Conclusión:** las prácticas de cuidado del equipo se organizaron por consultas, visitas domiciliarias y actividades educativas, teniendo la necesidad de su resignificación, hecho que contribuye para el avance del conocimiento tanto para los profesionales de la salud como para su formación. **Descriptores:** Atención de Enfermería; Salud de la Familia; Atención Primaria de Salud; Enfermería de Atención Primaria; Atención Integral de Salud; Sistema Único de Salud.

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INTRODUCTION

Care is intrinsic in the field of health, and it is assumed that health professionals are sensitive to users' world in order to ensure that their practices translate into effective ways of caring for individuals and communities.¹

In the Brazilian scenario, the Family Health Strategy (FHS) has the objective of reorganizing Primary Health Care (PHC) based on a model grounded on teamwork, which enables the development of practices that foster comprehensive care through the prioritization of the family in its territory, establishment of bonding, welcoming, development of preventive and health promotion actions, treatment and rehabilitation. Thus, it is sought to articulate the other levels of care complexity with PHC in order to guarantee the comprehensiveness of the actions and the continuity of care.²

However, a study has showed that a great part of the professionals of the FHS teams still directs the care provided to the user with a biologicistic approach, centered on the disease, to the detriment of a humanized care and a qualified listening, detached from the life history and the social determinants that are inherent in the life of these subjects.³

A research carried out with FHS professionals showed that PHC has been fragmented and the teams have been restricted to the coordination of care. This is in line with other studies that also point to the fulfillment of mechanistic tasks and quantification of the consultations performed, as opposed to a strategy of organization of care directed to the health needs of the population.⁴⁻⁶

The performance in the FHS does not belittle nor invalidate the knowledge derived from biological and biomedical theories, but points out that these factors, when viewed in isolation, are insufficient to organize a comprehensive health care. In this sense, the FHS aims at the change of the current care model aimed at a reductionist approach, which excludes fundamental factors for health promotion and quality of life, such as physical environment and sociocultural inequalities, indispensable elements to ensure the comprehensive care of individuals, families and community.⁷

In turn, the Mexican health system is recognized by multiple authors for the potential reorganization of PHC; however, it depends on the resolution of the dispute between a neoliberal vision that has the purpose of universal medical insurance, with a

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basic package of services that is financed publicly; against a perspective of rights, which seeks to ensure a single, universal, comprehensive, solidary, equitable, participative and public health system.⁸

The comprehensiveness of care goes through the redefinition of health practices guided by the subjectivities inherent to health work and the valorization of users' health needs, thus impelling the possibility of building user-centered care with strengthening of the bond, acceptance and autonomy, with potential to reverse the discontinuity of care still present in the daily routine of health services.⁹

In this sense, health care contemplates skills and technical tasks, but it is not restricted to them, because it means more than treating, healing or controlling. Rather, it encompasses the construction of bonds from the life history of each family, in order to unravel the subjectivities and singularities of the subjects involved in this care, so that team and users can build joint projects.¹⁰

The relevance of this research is to contribute to improve the interaction between users and health professionals, as well as to enable these professionals to rethink their care practices, besides contributing to the reflection of technical or higher education students in the health area on the care to be provided by the Family Health team to the users.

OBJECTIVE

- To describe the care practices of ESF teams from the perspective of users.

METHOD

This is a qualitative, exploratory and descriptive study, carried out in a city in the interior of Bahia, Brazil. The municipality has 19 Family Health Units (FHU), 17 in the urban area and two in the rural area.

The inclusion criteria for the FHUs selection were having minimal complete team according to the criteria recommended by the Ministry of Health and FHU of the urban area, with two teams. Thus, seven FHUs constitute the study scenario.

The inclusion criteria established for the participants were users registered for more than one year in the referred FHU and being over 18 years of age. The exclusion criteria were users with difficulties in maintaining verbal communication or who had a health problem that made it difficult to participate in the interview, such as mental disorder, among others, totaling 34 participants.

The data collection was done through a semi-structured interview and occurred in the FHS from June to December 2014, being recorded in an audio recorder with the authorization of the participants. The interviewees were identified by the letter "P" of the participant, followed by a number corresponding to the order of interviewing, in order to ensure their anonymity.

The data were submitted to content analysis, in the thematic modality, contemplating three stages: the first consisted of pre-analysis; the second stage referred to the exploration of the material with the categorization and codification of the data; and the third step was the treatment and interpretation of these data.¹¹

This research was approved by the Research Ethics Committee of the State University of the Southwest of Bahia (Approval number 16265613.6.0000.0055).

RESULTS

There were 29 female participants, the majority being brown (13), married (15), housewives (14), income up to a minimum wage (19), not receiving social insurance (22), with an average age of 48 years, ranging from 20 to 82 years old, four children and 17 years of residence in the area covered by the FHU.

The results from the analysis of the data enabled the elaboration of two thematic categories, which address how the users perceive the care practices developed by the FHS teams. The categories are presented as follows: 1) Care produced by the FHS team; 2) Care practices developed by the FHS team.

DISCUSSION

♦ Care produced by the FHS team

The teamwork proposed by the FHS requires the strengthening of a bond between health professionals and the community, as well as the identification and appreciation of the personal, family and social context of each user, based on the sensitive listening and the welcoming posture of these professionals, providing the demonstration of trust and mutual respect among those involved in the care process.¹²⁻¹³

The study evidenced that the interviewees' speeches are based on the process of listening and welcoming as an act that corresponds to what the user wants and what the team can offer.

[They] listen well, welcome us (P9).

I see the presence of each one; one talks to me, another one talks (P19).

They listen to us. We get there, she (nurse) welcomes us well (P22).

From the speeches, it is observed that the professionals of the FHS teams use some elements such as dialogue and listening in the care provided to the users and direct their actions to meet their health needs. Thus, there must be accountability for the care to the user, which requires the professional to understand not only the needs, but also the social context of the user and their expectations achieved through the welcoming, qualified listening and professional-user relationship.¹⁴

One aspect of care is the rescue of the intersubjectivity between those providing care, those receiving care and those participating in the care in order to create a relationship of respect, empathy, help and bonding among those involved.¹⁵

The link between the health team and the users demanding health care is based on subjectivities and must be inherent to the practices undertaken by the professionals of the FHS team.^{13,16}

The results also showed that users understand that the care produced by the FHS team is translated by adequate care, that is, when the professional can identify the reason why users seek the service, whether for receiving medication, blood pressure measurement or examination scheduling.

The care provided by the nurse is good ... measuring the pressure, when we come to receive the medicine [...] any time we need (P1).

It is because when we go there at the health unit, when we need something, she (nurse) solves the problem, schedules the examinations. So we have what we need. (P16).

They serve well (nursing staff). I tell them what I need. [...] (P22).

The doctor, for me, is also a great doctor. The girls who schedule the examinations, too. [...] They serve people well (P23).

Although it is possible to identify professionals' interest in the community's problems, based on good care, this attitude does not guarantee a relation of exchange, of production of intersubjectivity, and it is not enough for care to go beyond the technical dimension.

In this sense, the FHS presupposes the realization of care practices that appreciate the biopsychosocial complexity of the human being aiming to contribute to the defragmentation of the medical-curative focus.^{3,17}

It is necessary that the FHS be configured as a space for production of knowledge, social living, invention of health and that the FHS teams take responsibility for the problems of families, which allows an approximation and trust not only in the service, but also in new conceptions of care.¹⁶

On the other hand, the users bring a reflection on how the professional-user relationship should be, which does not always provide the listening and knowledge of their health needs, since it emphasizes the biomedical aspects when prioritizing medication prescription and requesting of examinations in a FHS service.

[...] The doctor needs to listen to you, know what your day is like, know what it is like at work, how you are inside your home, because this is often missing, they stop listening to us; it is not only about prescribing a medication, an examination (P15).

[...] Last week I had a pain [...] that spread to my back. If we go there, they will give us an injection send send us home. What if I am afraid of injection? What if that injection kills us? (P11).

These findings corroborate with research that found a practice of care in the FHS still focused on the medical consultation, on the figure of the physician, in which there is often no building of welcoming and production of bonds.¹⁸⁻¹⁹

The interviewees also identified the lack of access to health services, highlighting the organization of the service, cost, accessibility, people management, among others, that interfere with the care provided to users.

We have to fight for a medical appointment. This doctor always has patients, it is always crowded (P25).

[...] I go to the health unit and they measure my pressure; I go to the public pharmacy and there is no medicine, so I go to the pharmacy and buy it. (P33).

The population faces difficulties in the search to guarantee access to services and these relations can vary from satisfactory to conflictive at the time of solvency, still insufficient, in face of the great demand of health needs of the users or due to the lack of capacity of the FHS or even the great bureaucratic demand for labor.²⁰

Thus, users experience the spontaneous demand for health services, arriving early to assure their vacancy, which evidences that programmatic actions are carried out in the FHS and the team practice is still procedure-centered, determining the access from the health problems of specific population groups²⁰. However, it is emphasized that,

through qualified care, FHS teams need to provide access to the necessary services to achieve health care.¹⁶

♦ Care practices developed by the FHS team

The users considered that the medical and nursing consultation, the home visit and the educational activities correspond to the care practices developed by the FHS team.

In the statements of the users, it was verified that the consultations carried out in the FHS are still based on the programmatic organization, that is, on the attendance of the users enrolled in the programs that are offered and, at this moment, the professional finds an opportunity to verify the health needs and try to guide/help in some way.

This new doctor is great, I have been to his office twice; he asks what we are feeling, what happened (P8).

There is the family planning, I do with the nurse, I will do the Pap smear test with her (P15).

Because they (the team) say: "You cannot stop coming here in the consultation to measure the pressure, take the pills right, do not eat food with much fat and salt, because you know that causes stroke" (P27).

The moment of the consultation allows the health professional to listen to the users' health needs, as reported below.

I have had a recent experience with the doctor I have been seen ... the doctor asked from our childhood phase until today, even examined my hair. And it was through the SUS (Unified Health System), it was not paid. So I left the room thanking God because of her; she makes the difference (P15).

In the present study, it was pointed out that the majority of users highlight the act of treating the disease. This fact seems to demonstrate that users still have the idea that the attention should be focused on the disease, rather than on the subject, by highlighting that a qualified consultation is something different.

Health care is permeated by affections and subjectivities; it goes beyond the institutional and physical aspect, raising the need for the construction of forms of care that are guided by the appreciation of the singularities of users, in order to transcend the technical aspects of care.¹³

It is evident in the users' statements that the medical consultation is very related to the prescription of medications and request for exams.

The doctor is very good [...] I had a stomach problem that I could not even eat. She gave

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me a medicine, prepared a request, and I am taking the medicine (P26).

She (physician) prescribed urine tests and even an ECHO (Echocardiogram) [...] (P33).

This study demonstrated that the medical performance has difficulties in being guided by the FHS proposals, acting based on the traditional model, prioritizing curative action, focusing on disease and clinical action.²¹

It is also possible to reflect that users seem to appreciate more those medical consultations in which the professional prescribes medicines and requests exams, assuming that the professional that does not act with like this does not satisfy the yearning of care.

The users also identified that the home visit developed by the FHS team provides a more effective interaction between the actors involved, facilitating care for the family.

The doctor used to go there and visited us a lot of times because my husband used to be sick and he always went there (P11).

Home visit [...] The community worker is always accompanying the vaccines, accompanying my exams that I need to do; she gives me the exams (P29).

The home visit is one of the activities developed by the Family Health team in the territory of coverage and the social, political, economic, cultural and geographical characteristics should be appreciated in that territory. Thus, it is possible to know the social context of the individual and the family with the direction of the educational and assistance practices before the recognition of the health needs.¹⁷

Another issue to be considered is the role of CHW in the home visit, because as users perceive it, they are responsible for screening the health needs of the population in their area. The home visit is an inherent part of the work of this professional that lives in the community and, therefore, transits in the territory with greater ease and access to the community, being a reference for family care.

A research highlighted that the users identified the home visit as the main practice performed by the CHW, outlining a vision of family involvement with this member of the team, besides highlighting the guidelines provided to the families and referrals of the users whenever there was a need.²² In this direction, the CHW facilitates the expansion of access to health services, as they perform home visit, registration, follow-up and referral of users to the professionals of the FHS team, especially to the nurse.²²

In the present study, the users reported the lack of a home visit by other members of the

FHS team, besides the performance of the home visit by the physician only when the user was in bed.

In my house, the one who is always coming is the community health worker. She comes to know how the girls are. She has always, always been there. But the nurse and the doctor, they never needed to go there, no (P8).

So I believe that when I met this health program, they said to the community that it would be a doctor who would accompany the family, who would visit [...]. When the doctor comes to visit my father who is bedridden, it is just my father. He does not ask if there is anyone else in the family who has a problem [...]. After he visits him, he leaves; it is not a detailed thing that he is going to give assistance to everybody (P15).

These reports direct reflection on the role that the FHS team plays in family care at households, showing that this responsibility is restricted to the CHW, while the other members make occasional visits, not paying attention to the needs of all family members.

Home visits should be carried out in a systematized manner by the professionals of the FHS teams, however, the CHW experiences situations similar to those of the users, which makes it possible to create a rapprochement with the residents and to understand the local reality.¹⁷

The educational activities are perceived in the users' reports as care practices in which health promotion and disease prevention actions are developed through guidelines during the individual meetings and in the consultations with the purpose of promoting a better quality of life for the users.

I believe the guidelines have helped me a lot. So with the guidance of a professional we feel safer [...] we have to change food habits; we cannot stop taking the medicine (P15).

[...] as much as we have some knowledge, if we do not have a professional guidance, it gets a little difficult (P21).

These meetings also allow users to intensify social exchanges and insertion in social interaction. This study identified the perspective of users about the practice of health education and verified that with this activity people can express their doubts and seek information on health-related issues.²³

The team's role in the care and follow-up of all the users of their area, and not only those presenting health needs, should also occur through care technologies such as health education, in addition to the resolution of health problems.²⁴

The educational activity in health refers to activities aimed at the development of individual and collective capacities aiming at the improvement of the quality of life and health. Thus, among the practices that need to be developed in the FHS, the educational activity emerges as a fundamental tool to stimulate both the self-care and the self-esteem of the users.²⁵

One of the users pointed out that in general he did not participate in the educational activities developed by members of the FHS teams, as reported below:

They do (educational activity), but I have never participated in it. They do in the church, they made a very big fair (P26).

Researches have verified the lack of adherence of users to educational activities, which requires the development of strategies by professionals to ensure the participation of users based on the reality experienced by them, as well as presents new approaches that lead to a greater understanding of users on the collective construction, valuing fundamental aspects of life.^{23,25}

It is therefore imperative that FHS professionals re-signify their care practices with users so that health work can overcome practices that focus on complaint-behavior, low resolution and dissatisfaction among users and caregivers. For this purpose, it is necessary to think of new directions of conducts based on meetings with users that appreciate reflections and practices on the know-how of health care.²⁰

The limitation presented by this study refers to the results representing the reality of a single geographical context, which requires the carrying out of further research that present the reality of other social contexts.

This study presents advances in the scientific knowledge for evidencing that the practices of the professionals working in the FHS have elements that point to the need to broaden the care produced by these professionals in a perspective that values the subjective and relational dimension of care.

CONCLUSION

The main result of the present study was that the FHS team's care practices are organized through consultations, home visits and educational activities, which are sometimes permeated by listening to users' health needs and, on the other hand, examinations and procedures, which reduces the potential of care centered on the subjectivities and singularities of users.

It was also evidenced that although there is an interaction between health professionals and users, there does not seem to be a relation of exchange and production of intersubjectivities, considering that this interaction is centered in the biological-healing dimension, pointing to the need to re-signify it through care practices that broaden listening and reconsider the human perspective, thus producing changes in this context.

In this sense, this study presents reflections that contribute to the advancement of knowledge both for health professionals and for their training, based on the users' view, so that their expectations and desires are taken into account in the planning and realization of care practices that are developed within the scope of Family Health.

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Submission: 2017/10/27

Accepted: 2017/11/26

Publishing: 2018/01/01

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