PROFESSIONALS' PERCEPTION OF THE FAMILY HEALTH STRATEGY IN AN INLAND CITY IN THE STATE OF CEARÁ

Percepção dos profissionais sobre a Estratégia Saúde da Família em um município do interior do Ceará

Percepción de los profesionales sobre la Estrategia de Salud de la Familia de un municipio del interior de Ceará

Original Article

Tiago Freire Martins[1]
Márcia Vannusa Vieira[1]
Taianne Michelle Silva de Souza[1]
Daniel Moura de Sousa[1]
Katiana Diógenes Saldanha[1]
Emília Soares Chaves Rouberte[1]
Cristianne Soares Chaves[2]
Révia Ribeiro Castro[3]

1) University for International Integration of the Afro-Brazilian Lusophony (*Universidade da Integração Internacional da Lusofonia Afro-Brasileira - UNILAB*) - Redenção (CE) - Brazil

2) Ceará State Health Secretariat (*Secretaria de Saúde do Estado do Ceará - SESA*) - Fortaleza (CE) - Brazil

3) State University of Rio Grande do Norte (*Universidade Estadual do Rio Grande do Norte - UERN*) Natal (RN) - Brazil

ABSTRACT

Objective: To assess the professionals' perception of the Family Health Strategy in an inland city of the state of Ceará. **Methods:** Descriptive study of qualitative approach, conducted from February to April 2015 with health professionals from seven Primary Health Units of Limoeiro do Norte, Ceará, and a municipal primary care coordinator. The interviews were recorded in a private place on a previously scheduled date. The information was analyzed through content analysis. The following categories were identified: "Implementation of the Strategy"; "Characterization of the actions of the Strategy"; "Perception of the Strategy by the actors"; and "Difficulties encountered in the Strategy implementation". The research was approved by the Research Ethics Committee of the University for International Integration of the Afro-Brazilian Lusophony (UNILAB), according to Resolution 466/12. **Results:** The coordinator had not a clear knowledge of the Strategy implementation process in the city. He highlighted the necessary trusting relationship between professionals and the population for the team to be well accepted in the community, and the importance of a stream of attention in the public health service. Professionals reported satisfaction with the teamwork and good communication between the team members, and they believe they have the necessary training to work in primary care. Additionally, they highlighted the population's recognition of the work performed, but complained about the lack of support from the municipal management on the provision of inputs for the activities. **Conclusion:** The participants believe in the importance of teamwork to minimize the Strategy problems, but presented themselves discouraged with the current health situation of the municipality.

Descriptors: Family Health Strategy; Qualitative Research; Interview; Health Personnel.

RESUMO

Objetivo: *Conhecer a percepção dos profissionais sobre a Estratégia Saúde da Família (ESF) em um município do interior do Ceará.* **Métodos:** *Estudo descritivo, de natureza qualitativa, realizado de fevereiro a abril de 2015 com profissionais de saúde de sete Unidades Básicas de Saúde de Limoeiro do Norte, Ceará e um gestor coordenador da atenção básica do município. As entrevistas foram gravadas em local reservado e data agendada previamente. A análise das informações ocorreu através da análise de conteúdo. Identificaram-se as seguintes categorias: "Implementação da ESF", "Caracterização das ações da ESF", "Percepção sobre a ESF pelos atores" e "Dificuldades encontradas para implementação da ESF". A pesquisa teve aprovação do Comitê de Ética em Pesquisa da Universidade da Integração Internacional da Lusofonia Afro-Brasileira (UNILAB), de acordo com a Resolução 466/12.* **Resultados:** *O gestor não tinha clareza do processo de implementação da Estratégia no município. Destacou a relação de confiança entre profissionais e população para que a equipe seja bem aceita na comunidade e a importância de um fluxo de atenção no serviço público de saúde. Os profissionais relataram a satisfação do trabalho em equipe, a boa comunicação entre os membros e acreditam que têm formação necessária para trabalhar na atenção básica. Ressaltaram, ainda, o reconhecimento da população pelo trabalho executado, mas reclamaram da falta de apoio da gestão do município em*

Received on: *07/07/2015*
Revised on: *10/28/2015*
Accepted on: *11/28/2015*

fornecer insumos para o trabalho. **Conclusão:** *Os participantes acreditam na importância do trabalho em equipe para minimizar os problemas da estratégia, mas apresentaram-se desestimulados com a atual situação da saúde do município.*

Descritores: *Estratégia Saúde da Família; Pesquisa Qualitativa; Entrevista; Profissional da Saúde.*

RESUMEN

Objetivo: *Conocer la percepción de los profesionales sobre la Estrategia de Salud de la Familia (ESF) de un municipio del interior de Ceará.* **Métodos:** *Estudio descriptivo, de abordaje cualitativo realizado entre febrero y abril de 2015 con profesionales de la salud de siete Unidades Básicas de Salud de Limoeiro do Norte, Ceará y un gestor coordinador de la atención básica del municipio. Las entrevistas fueron grabadas en un sitio reservado y fecha definida con antelación. El análisis de las informaciones se dio a través del análisis de contenido. Se identificaron las siguientes categorías: "Implementación de la ESF", "Caracterización de las acciones de la ESF", "Percepción de la ESF en la opinión de los actores" y "Dificultades encontradas para la implementación de la ESF". La investigación fue aprobada por el Comité de Ética en Investigación de la Universidad de la Integración Internacional de la Lusofonia Afro-Brasileña (UNILAB) según la Resolución 466/12.* **Resultados:** *El gestor no estaba seguro del proceso de implementación de la Estrategia del municipio. Se destaca la relación de confianza entre los profesionales y la población para que el equipo sea bien recibido por la comunidad y la importancia de un flujo de atención en el servicio público de salud. Los profesionales relataron la satisfacción del trabajo en equipo, la buena comunicación de los miembros y creen tener la formación necesaria para el trabajo en la atención básica. Resaltaron aún el reconocimiento de la población por el trabajo realizado pero reclamaron de la falta de apoyo de la gestión del municipio en ofrecer insumos para el trabajo.* **Conclusión:** *Los participantes creen en la importancia del trabajo en equipo para disminuir los problemas de la estrategia pero se presentaron sin estimulo delante la situación actual de la salud del municipio.*

Descriptores: *Estrategia de Salud Familiar; Investigación Cualitativa; Entrevista; Personal de la Salud.*

INTRODUCTION

The Ministry of Health has proposed the idealization of the Family Health Strategy (FHS), aiming at reorganizing the health care model from the primary care. Its purpose is to organize the services and guide professional practices directed at health promotion and disease prevention[1].

In the economic reality of the Brazilian income distribution, the majority of the FHS users is nowadays formed by low-income people. The emerging classes, due to disbelieving the public health effectiveness, are increasingly seeking alternatives in health care, such as health insurance and health plans[2].

The main reasons for the user evasion are the difficult access to the system, the delay in providing assistance and performing procedures, and the lack of humanized care, which prompt the population to distance from the service and have complaints about it[3,4].

The FHS professionals are recognized as the operators of the service, responsible for the flow chart developed and holders of technical knowledge used in outpatient assistance practices. Thus, they are a valuable source of information about the system because, in addition to experiencing the daily activities in the unit, they are also able to modify it to better serve the users, favoring the expansion of actions related to health promotion and disease prevention[5].

It is noteworthy, however, that one of the major difficulties posed to the implementation of the FHS is the lack of professionals trained for a generalist approach, to work effectively on the complex demands of primary care[6]. It is up to the managers of the Brazilian Unified Health System (*Sistema Único de Saúde – SUS*) to develop strategies to minimize the problems faced by these professionals[7].

Nevertheless, an excessive turnover of local health managers, commonly observed in inland municipalities, jeopardizes the continuity of care and the actions taken by the previous manager. Health managers of smaller municipalities find themselves increasingly charged due to the high demand for specialized consultations, procedures and surgeries, by the users and health professionals as well, mainly the doctors[8].

Concern for the guarantee of health care quality has been increasingly discussed among professionals. The demand for quality, whether by the management or the users, is perceived in the daily work process and makes the improvement of practices more and more important[9].

This study is justified because the quality of the assistance provided to the user is the main objective of all the actions performed. There are few studies addressing the perceptions of health professionals and municipal managers within the FHS, and an evaluation of this strategy, using these two actors of SUS, has not been performed yet in the state of Ceará. Thus, it is extremely important to know the local politics reality, in order to help managers define strategies directed at the possible problems occuring in this region.

The aim of the study was to know the professionals' perception of the Family Health Strategy (FHS) in an inland city in the state of Ceará.

METHODS

Descriptive study of qualitative approach, conducted from February to April 2015 with health professionals (doctors, nurses and nursing technicians) who work in the seven Primary Health Care Units (PHU) located within the urban area of Limoeiro do Norte, Ceará, and the manager responsible for coordinating the primary care of the municipality.

Being a health professional, working in the PHUs of the municipality and agreeing to participate were the inclusion criteria. Being a professional with schedule incompatibility, being on vacation or ill during the period of data collection, or refusing to participate in the study composed the exclusion criteria. The source of data collection was primary, directly with the professionals and the health manager, following the established inclusion and exclusion criteria.

Initially, 26 professionals participated in the study. Eight were excluded, thus totaling 18 participants.

Two adapted interview scripts[10] were adopted – one for health assistance professionals and other for the manager. For the assistance professionals, the script included identification data (sex, training, and length of time working in the PHU) and questions addressing the following issues: previous experiences in other workplaces, belief in having proper credentials for the work, reasons that led them to work in the FHS, assignments of the position they hold, their evaluation of the work performed in the community, their work team and coleagues in the FHS, criteria that define a good Family Health Team, the way decisions are taken, degree of satisfaction with the work they do, good and bad points of the work, main difficulties of the work, and their perception of the valuation of their work.

The script for the manager contained identification data (sex, academic credentials, and length of time working in the position) and questions addressing the propositions of the FHS, the manager's assignments; criteria that define a good Family Health Team; selection criteria for FHS professionals; acceptance of the FHS by the community; benefits and difficulties of the FHS in the municipality studied.

The investigated subjects received information about the objectives and methodology of the study, and anonymity on the research findings was guaranteed to them. Professionals who agreed to participate signed the Informed Consent form (IC), and the manager signed both the Informed Consent form and the letter of agreement, thus giving permission for the research to take place within municipal public offices. The respondents' identity was kept confidential.

The basic data sources consisted of the statements generated from the recorded interviews. Those participants who did not allow the use of the recorder had their answers written down in full by the researchers. The interview took place in the workplace, in a private place, free from the traffic of people or noise, on a date previously scheduled with the study subjects.

After data collection, the speeches of the research subjects were organized. A free-floating reading of the most relevant topics of the interviews was performed.

The statements were organized by using the content analysis, specifically the categorization phase[11]. With this methodological option, one is allowed to enter the world of meanings of the human actions and relations, an aspect that is not perceptible nor liable to convey through means, graphs and statistical measures[12]. The analysis and aggregation of converging responses were conducted by using the theme as a recording unit. Next, the elements comprised in each thematic unit were classified and grouped. The extraction from the participants' statements was achieved through the interpretation of the data collected, by analogy and by organizing them into categories, i.e., through the common part in the existing data[11]. The results were compared to the literature available at the national level on the issues present in the scientific inquiry.

The following categories were identified: "Implementation of the FHS", "Characterization of the FHS actions", "Perception of the FHS by the actors" and "Difficulties encountered in the Strategy implementation".

The research was approved by the Research Ethics Committee of the University for International Integration of the Afro-Brazilian Lusophony (UNILAB), under opinion no. 901251, in compliance with Resolution 466/12 of the National Health Council/Ministry of Health, referring to studies involving human subjects. In the data presentation, participants were referred to as professional 1, 2, and so on, as a means of preserving anonymity.

RESULTS AND DISCUSSION

Characterization of study participants is shown in Table I. Most of the professionals interviewed were women, graduate in Nursing, with length of time over 10 years of professional experience and working in the FHS, but working at the PHU for less than five years, at the time of the study. The majority of the graduate professionals had a post-graduate degree, and no nursing technician had iniciated a higher education program.

From the results, it was possible to expose some characteristics of the FHS in the municipality studied.

Table I - Characterization of the health professionals participating in the study. Limoeiro do Norte, Ceará, 2015.

Variables	n (n=17)	%
Sex		
Male	01	5.88
Female	16	94.12
Academic credentials		
Nurse	08	47.06
Nursing technician	06	35.29
Doctor	03	17.65
Length of time in professional practice		
< 5 years	03	17.65
5 to 10 years	01	5.88
> 10 years	13	76.47
Length of time working in the FHS		
< 5 years	06	35.29
5 to 10 years	03	17.65
> 10 years	08	47.06
Length of time working at the PHU		
< 5 years	11	64.71
5 to 10 years	02	11.76
> 10 years	04	23.53
Postgraduate (for nurses and doctors) (n=11)		
Yes	10	90.91
No	01	9.09
Education level (for Nursing technicians) (n=6)		
Complete High School	06	100
Incomplete Higher Education	-	-
Complete Higher Education	-	-

n: number of the corresponding sample; %: percentage of the corresponding sample; FHS: Family Health Strategy; PHU: Primary Health Care Unit.

There is a predominance of women within the FHS services, which demonstrates the feminization in the public health workforce in Brazil. Similar data was found in other researches addressing the theme[13]. In some professions, such process of feminization is more recent and has a stronger impact, such as among the doctors: in the 1970s, female physicians represented only 11%; in the next decade, this percentage had already increased to 22%, reaching 33% in 1990. It is estimated that this percentage should reach 50% in coming decades[14].

In a study that addressed the same target audience, most of the professionals interviewed had also been working for less than five years at the PHU[10]. Those professionals with longer length of time serving in primary care demonstrate greater companionship, bonds formation, communication, confidence and, consequently, greater capability of resolving cases within the territory[15].

Another aspect observed in that same survey was that most graduate professionals also had a post-graduate degree[10]. Study found that health professionals have become increasingly specialized over the years, and that occurs not only among the professionals who work in the FHS, but is also true for other new professions that have been inserted in the health team[16]. It is extremely important that primary care professionals become specialized in their area of occupation, for this is a very dynamic service, in constant renewal, thus requiring frequent training and encouragement to continuing education[13].

As concerns the municipal government managers, it was only possible to carry out the study with a woman

who was the coordinator of the primary care services of the municipality. She was graduate in nursing (without postgraduate degree) and had little experience in the management area (only four months). The length of time working as a health manager is relevant to the performance of their work, as the experience with the daily activities of the service will provide better execution in planning, organization, direction and control of the work[14].

Health professionals who do not specialize in the management area to hold a position of such consequence eventually do not develop the administrative activities properly[17]. Specialization in the management area is conducive to the development of specific activities, taking into account that training in planning or in public health ensures more quality to the activity, since planning is a basic area of knowledge for the academic qualification of professionals in these areas[18].

The information was organized according to the following categories: “Implementation of the FHS”, “Characterization of the FHS actions”, “Perception of the FHS by the actors”, and “Difficulties encountered in the FHS implementation”.

Implementation of the FHS

The professional responsible for health managing in the municipality demonstrated no clarity about the implementation process of the FHS locally. This shows a lack of knowledge about the historical events related to health in the city under her responsibility. This data can be connected to the short length of time working in a management position (only 4 months), as well as to a restrict professional experience (2 years from graduation).

Regarding the reason why this strategy had been created, the manager identified the FHS as a bond that allows the public health service to be closer to the population, in order to meet the existing demands even in the places that are most deprived of attention. When asked about the purpose of the FHS, she answered:

“To provide comprehensive assistance to the population, seeking to satisfy its needs. To structure the health services for the relationship with the community and for the different levels of care, as well (...).” (MANAGER)

Similar report was found in a study in which the managers interviewed cited as the FHS most important features the health education, assistance and health promotion for the population, which reveals a perspective of the program proposal[10].

As regards the implementation of the FHS, it is of utmost importance the development of health policies and actions that have increased likelihood of becoming effective and bring greater benefits to the health of the population[19].

The manager emphasized the importance given to the professionals– community bonds for the endurance of strong ties and firmed roots, so that the FHS can be well accepted and the population attendance to the service can be continuous and lasting. She also spoke about the establishment of friendly ties, favoring a close bond between the parties. Questioned about the most important feature in the FHS, she answered:

“The bond and trust (...) that should exist between the community and the unit staff.” (MANAGER)

This speech corroborates what was shown in a study in which the respondents stressed the importance of commitment on the part of the professionals to the service provided, as well as being accessible and attentive to the needs of the population[10].

In another statement, the manager placed much emphasis on the response capacity of the primary health care, thus avoiding that certain cases be sent improperly to another service without a real necessity. About the benefits of the FHS for the population, the manager said:

“The gateway for a patient should be the Family Health Program (FHP), possibly finding the solution, and not going to a hospital to solve (...) a simple thing.” (MANAGER)

Managers interviewed in Minas Gerais also pointed out that the biggest benefit that the FHS provides to the population is bringing the intervention much closer and next to the families[10].

The ability of health services to solve the problems is limited both due to its nature, which requires interventions of various kinds, and to its ineffectiveness, as evidenced by the available scientific assessments[20].

One may note that, for the manager, the flow of patients through the public health service provided is something to be taken into account, since comings of the patient to undue sectors may lead to increased costs to the public coffers. When asked about the FHS organization and referrals to other levels of care, she said:

“By means of a referral form, which contains the patient’s personal data, reason for referral, exam results, and type of specialized care he is being sent to.” (MANAGER)

Decentralization of SUS has made it possible for municipalities to assume responsibility for organizing flows, structures and management processes, in order to improve, organize and expand the health care. The creation of the

referral form may be seen as one of those instruments. It was materialized from the need to regulate the population's access between the health care sectors[21].

Managers need autonomy to adjust the services to the users' needs and thus, reach the highest quality in every service for the population, at the best cost-benefit ratio for the management[18].

Health professionals

The health professionals' trajectories were presented in this category, as they are believed to exert a direct influence on the implementation of the FHS.

When asked about appropriate training for the work developed in the FHP, most health professionals reported having a specific training directed at the work in the program, as well as previous experience in other areas.

> *"Fortunately, my college was very focused on public health, very focused on primary care, on the FHP." (NURSE 7)*
>
> *"Yes. I have worked in Cuba and in Venezuela with general practice and family medicine." (DOCTOR 1)*

On the assessment of the main reasons for working in the FHP, most of the interviewees replied that it was because they like to work directly with the patients and also stressed the love of working with the community.

> *"I like this relationship; I like the bond, knowing the patient, having that bond, though it demands more efforts (...). I really like this relation with the population. I think it is better than that kind of practice that you go there, take your shift, then turn your back and have no link with the patient. Not me, I like it this way, in day-to-day activities. That makes me feel so good, in a way, so I think the main reason was that." (NURSE 4)*
>
> *"Vocation. I like the work and family care." (DOCTOR 1)*

This information does not corroborate a survey conducted in Minas Gerais, in which the authors observed that the main reason why health professionals were in the FHS was the largest supply of labor[10]. One can perceive the importance of this result, since the relationship between the teams and the families is the central focus of family health, as the family health professionals must, first of all, be committed to the users. Studies demonstrate that the primary care organized by means of the FHS, when well trained and integrated into the community, is able to solve 85% of the health needs of the population[22].

With regard to what is necessary for a good performance in their functions, most responded that study and specialization are essential.

> *"Having good academic credentials and taking courses that qualify us; having availability to develop a good work and having subsidies (...)." (NURSING TECHNICIAN 4)*
>
> *"Good credentials, enjoying it, the pleasure, feeling good for serving the population. And, in a general way, being also properly paid, because this contributes to your pleasure, right?" (DOCTOR 2)*

The FHS should appropriate and reformulate the health knowledge, so that its goals and guidelines can be met satisfactorily. Therefore, it is of fundamental importance to their qualification, the implementation of continuing education programs, courses, case discussions and clinical advice that make it possible to conclude that path satisfactorily[10].

There are serious problems with the personnel policy, going from the precarious system of recruitment to the almost total lack of opportunity for both specialized training and access to continuous education processes. The majority of doctors and nurses do not have specialized training in family health, public health, or directed at a clinical assistance operated with enlarged generalist approach, nor can they reckon upon technical or institutional support[23].

The FHS is seen as a new workspace in many ways, especially with regard to the previous experiences of members of the current team, so it presents itself as a technical challenge, because it represents an operational logic that differs from what the health professionals were used to, until then[24], as mentioned by one of the interviewees:

> *"At the time I graduated, the FHP didn't exist, so I learned with time and with the specialization program." (NURSE 1)*

Still exploring that same subject, despite the importance of the clinical work, a health professional, when asked about how their work process, highligthed more strongly the importance of the preventive practice as one of the guiding pillars of primary care:

> *"I believe it is continuous and for prevention, as we work in the primary care area." (NURSE 3)*

This same perspective was found in the study conducted in Minas Gerais[10]. Nonetheless, the way such prevention is being carried out by these teams should be evaluated, since it represents only one of the FHS assumptions, meaning that, given the fact it is comprised in a comprehensive strategy, it must associate assistance, prevention and health promotion[25].

Another point under analysis involved the work processes in teams and interpersonal relationships. In the

evaluation of teamwork, most regarded the relations as good or excellent. One of the interviewees used the National Program for Access and Quality Improvement of Primary Care (*Programa Nacional de Melhoria ao Acesso e da Qualidade da Atenção Básica -- PMAQ*) in her evaluation:

> *"In PMAQ, we were ranked as 'excellent'. Our talk about it may seem suspect, but PMAQ gave us that answer. This was one of the teams that got an 'excellent', and the user has been interviewed, then it is the user who should give us that answer. The whole team presents itself well in front of the population, although sometimes some flaws occur, but in general I think it is very well positioned, very well developed in what it does." (NURSE 4)*

The federal government, in view of improving the quality standard of care in the PHUs, has created the PMAQ. For this, the professionals who comprise a health care team (doctors, nurses, dentists, nursing technicians, dental health workers, and community health workers) are monitored and evaluated. This assessment takes into account the PHU infrastructure, the equipment, provision of medicines, and citizen satisfaction. Teams that offer improvements in quality of care receive more funds from the federal government. That is, the better their performance, more financial incentives will be repassed[26].

When asked about what defines a good family health team, the opinions were very divergent. Some highlighted the union and being an active team, others highlighted the presence of a complete team:

> *"First, the interrelationship between all of us. Communication is very important." (DOCTOR 1)*
>
> *"For having a good team (...), it would be nice to have all the professionals in the FHP. (...) However, as I told you, we lack some more availability, another person in the team to help me. (...) It's missing (...) also an oral health technician, which we still don't have." (NURSING TECHNICIAN 4)*

In this dimension, one study showed that issues related to insufficient number of professionals and work overload leads to a fragmentation of the teamwork processes, collective moments, professional profile, and their accountability[27]. Other study shows that the insufficient number of professionals in health teams has hampered the access to services and the user embracement[28]. Thus, with a significant demand for assistance, there is a work overload, which hinders relations between the team and the users[29].

On the evaluation of the work developed by the doctor in the team, most regarded it as a good work. In the evaluated teams, the majority of the doctors were Cuban. Cuban doctors came to Brazil in 2013 through the "More Doctors Program", created by the federal government. The project put forward proposals whose aims would be the improvement of quality in the public health policy and SUS. This initiative raises issues that deserve support but, at the same time, there are several others aspects that should not be supported by those interested in the welfare of the Brazilian people[30]. Studies assessing the performance of these doctors in the FHS are not available yet, which highlights the need for researches that can verify what has changed in these scenarios of practice.

Characterization of the FHS actions

A nurse's report demonstrates that the activities are quite diverse and dynamic:

> *"We do several activities in the unit, we work as a manager, monitor the CHA (Community Health Agents), perform nursing consultation in programs directed at the women's health, child health, hypertension and diabetes, tuberculosis, leprosy, and conduct cervical and breast cancer (CA) prevention. We do home visits to bedridden clients and postpartum women, vaccination, SHP (School Health Program), we take stitches out, apply wound dressings, and perform educational activities. After all, a lot of bureaucratic work." (NURSE 1)*

Some guidelines or functions that primary care must meet have been established. Among them is the user embracement, active search with vulnerability assessment, comprehensive and shared clinical care, public health, participation in management and co-management[31]. The nurse's report evidence that the actions are far more focused on the outpatient clinical care, failing to meet many recommended actions. Among other factors, this can be explained by the lack of professional and financial resources in the primary care network, a reality that was also observed in the study performed in Minas Gerais[10].

Perception of the FHS by the actors

As for the professionals's perception of the FHS, most reported that the organization is not conducive to work, as stated by the professionals:

> *"It is far from being what one might wish, not only here in this city. I believe it is a nationwide situation in Brazil, regarding the lack of medicines, supplies. We need to perform certain tasks, and we fail to do them because some material is missing. We try to work on what we have, and the little that is available is not satisfactory." (NURSE 4)*
>
> *"The inclusion of some teams for a new territorial approach and more even division of families for the PSF is still missing." (NURSE 1)*

Even with the FHS expansion in some regions, it is important to recognize that we are far from having a primary care network with wide coverage and adequate effectiveness. Some problems are still observed, such as insufficient funding, lack of personnel policy, and a consistent project for training of specialists[23].

Difficulties encountered for the FHS implementation

Some difficulties in the implementation of the FHS were cited by the manager. Some of them were related to the infrastructure, others related to the lack of employees to perform some functions or to the lack of financial resources. When the manager was asked about the main difficulties faced by the service, she replied:

> *"Lack of human resources and supplies, units undergoing structural reform, cars and drivers that are not specifically assigned to the units (...)." (MANAGER)*

Managers of municipalities in the state of Minas Gerais said that the main constraints that hinder the development of the FHS in the municipalities are: incomprehension on the part of the population of the FHS objectives, professionals' poor qualification, and the users' dependence on the Community agent[10].

Poor-quality health services can cause serious harm to the population. Therefore, these services need to respect quality standards, but should not be too formalized, though[32].

Generally, limited financial resources are available to the public health sector. This eventually disposes the public manager to associate the poor quality of services provided with the shortage of financial investment in these services. In many cases, however, they can be improved without generating considerable costs, just by using some organization and vision of the future[33].

The demand for health status improvement refers to the issue of efficient use of available resources, for the health services to be effectively offered. This challenge is greater in developing countries like Brazil, due to the lack of financial, physical and human resources[20].

The professionals described the level of satisfaction and the main difficulties at work. Most reported feeling valued in their scenario of practice. This, however, also pointed out some important weaknesses, such as work overload caused by the lack of professionals, low wage, lack of infrastructure and shortage of labor supplies, as observed in the following statements:

> *"The main difficulties are the lack of supplies and administrative materials, hindering the implementation of programs." (NURSING TECHNICIAN 1)*

> *"(...) Lack of physical and structural conditions, materials and medicines." (NURSE 2)*

The structural difficulties are indeed a perceptible reality in the states. A study that evaluated the nurses' perception of the primary care in Fortaleza pointed out that these difficulties mainly refer to the very physical structure of health facilities, as some of them lack medicines, materials such as prescription pads, or transportation. Additionally, the bad condition of the roads is seen as hindrance to the visitations and, in many places during the rainy season, only off-road cars manage to make the route, but these are not available for all teams[34].

Some dilemmas should be considered when reflecting on the scenario of practice, such as reordering of the care model in traditional PHUs; the minimum composition that the FHS teams are required to reach; the expansion of multiprofessionality, within the logic of matrix support; the clientele expected to be served by a family health team; the relationship between people, their families, and the community; the incorporation of embracement without transforming the FHS in emergency care assistance. Therefore, it would be necessary to investigate the most important clinical and managerial difficulties posed to the improvement of the FHS and, from this research, contribute to the development of training proposals and to co-management of professionals able to provide a more comprehensive clinical assistance[23].

FINAL CONSIDERATIONS

There is a need to strengthen primary care locally, since the health manager acting in the municipality demonstrated no clarity about the FHS implementation process. As for the activities developed, the nurse is found in the leading role in the health units, being responsible for managing the services offered and supervising the other professionals as well.

The professionals' perception of the Strategy reflects that good ties existing between the professionals and the community were directly related to the users' assiduous attendance to the service. They classified as good the relationship between members of the healthcare team and emphasized the union as its strong feature. They also reported a scenario of uncertainty about the future, linked to a lack of some team members, or even the lack of complete teams to meet the service demands, as well as limitations on the shortage of medicine and supplies to perform consultations and procedures. The lack of human and financial resources was pointed out, including, as a difficulty that prevents the full implementation of the service. Even though some professions feel valued, they still complain about the exhaustive workload and low wages.

REFERENCES

1. Ministério da Saúde (BR). Saúde da família: uma estratégia para a reorganização do modelo assistencial. Brasília: Ministério da Saúde; 1998.

2. Azevedo ALM, Costa AM. A estreita porta de entrada do Sistema Único de Saúde (SUS): uma avaliação do acesso na Estratégia de Saúde da Família. Interface Comun Saúde Educ. 2010;14(35):797-810.

3. Elias PE, Ferreira CW, Alves MCG, Cohn A, Kishima V, Escrivão A Júnior et al. Atenção básica em saúde: comparação entre PSF e UBS por estrato de exclusão social no município de São Paulo. Ciênc Saúde Coletiva. 2006;11(3):633-41.

4. Moimaz SAS, Marques JAM, Saliba O, Garbin CAS, Zina LG, Saliba NA. Satisfação e percepção do usuário do SUS sobre o serviço público de saúde. Physis (Rio J.). 2010;20(4):1419-40.

5. Albuquerque FJB, Melo CF, Souza FE Filho, Araújo JL Neto. Avaliação da estratégia saúde da família a partir das crenças dos profissionais. Estud Psicol (Campinas). 2011;28(3):363-70.

6. Campos FE, Belisário SA. O Programa de Saúde da Família e os desafios para a formação profissional e a educação continuada. Interface Comun *S*aúde Educ. 2001;5(9):133-41.

7. Ministério da Saúde (BR). Carta dos direitos dos usuários da saúde. Brasília: Ministério da Saúde; 2006.

8. Cecílio LCO, Andreazza R, Souza ALM, Lima MR, Mercadante CEB, Pinto NRS, et al. O gestor municipal na atual etapa de implantação do SUS: características e desafios. Reciis. 2007;1(2):1-8.

9. Albanes HC, Lobo E, Bernardini IS. O Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica (PMAQ-AB) e sua relação com a qualidade dos serviços prestados nos centros de saúde. Coleção Gest Saúde Públ*.* 2013;1(4):83-102.

10. Ronzani TM, Silva CM. O Programa Saúde da Família segundo profissionais de saúde, gestores e usuários. Ciênc Saúde Coletiva. 2008;13(1):23-34.

11. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2011.

12. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 11ª ed. São Paulo: Hucitec Editora; 2014.

13. Trajman A, Assunção N, Venturi M, Tobias D, Toschi W, Brant V. A preceptoria na rede básica da Secretaria Municipal de Saúde do Rio de Janeiro: opinião dos profissionais de Saúde. Rev Bras Educ Med. 2009;33(1):24-32.

14. Machado MH, Oliveira ES, Moyses NMN. Tendências do mercado de trabalho em saúde do Brasil. In: Celia P, Mario RDP, Tania F. O trabalho em saúde: abordagens quantitativas e qualitativas. Rio de Janeiro: CEPESC/UERJ; 2011. p. 103-16.

15. Lima MCCS, Costa COM, Bigras M, Santana MAO, Alves TDB, Nascimento OC, et al. Atuação profissional da atenção básica de saúde face à identificação e notificação da violência infanto-juvenil. Rev Baiana Saúde Pública. 2011;35(1):118-37.

16. Falcão SMR, Sousa MNA. Gerenciamento da atenção primária à saúde: estudo nas unidades básicas. Rev Enferm UFPE. 2011;5(6):1510-7.

17. Santos NR, Amarante PDC. Gestão pública e relação público privado na saúde. Rio de Janeiro: Cebes; 2010.

18. Berretta IQ, Lacerda JT, Calvo MCM. Modelo de avaliação da gestão municipal para o planejamento em saúde. Cad Saúde Pública. 2011;27(11):2143-54.

19. Barreto ML. O conhecimento científico e tecnológico como evidência para políticas e atividades regulatórias em saúde. Ciênc Saúde Coletiva. 2004;9(2):329-38.

20. Erdmann AL, Andrade SR, Mello ALSF, Meirelles BHS. Gestão das práticas de saúde na perspectiva do cuidado complexo. Texto & Contexto Enferm. 2006;15(3):483-91.

21. Ministério da Saúde (BR). Gestão municipal de saúde: textos básicos. Brasília: Ministério da Saúde, 2001. 344p.

22. Ministério da Saúde (BR). Saúde da família: panorama, avaliação e desafios. 1ª ed. Brasília: Ministério da Saúde; 2005.

23. Campos GWS, Gutiérrez AC, Guerrero A, Cunha GT. Reflexões sobre atenção básica e a Estratégia de Saúde da Família. In: Campos GWS, Guerrero AVP. Manual de práticas de atenção básica: saúde ampliada e compartilhada. 2ª ed. São Paulo: Hucitec Editora; 2010. p. 132-53.

24. Oliveira EM, Spiri WC. Programa Saúde da Família: a experiência de equipe multiprofissional. Rev Saúde Pública. 2006;40(4):727-33.

25. Alves VS. Um modelo de educação em saúde para o Programa Saúde da Família: pela integralidade da atenção e reorientação do modelo assistencial. Interface Comun Saúde Educ. 2005;9(16):39-52.

26. Ministério da Saúde (BR). Portaria Nº 648 de 28 de março de 2006. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da atenção básica para o Programa Saúde da Família (PSF) e o Programa Agentes Comunitários de Saúde (PACS). Brasília: Ministério da Saúde; 2006.
27. Nora CRD, Junges JR. Política de humanização na atenção básica: revisão sistemática. Rev Saúde Pública. 2013;47(6):1186-200.
28. Marin MJS, Storniolo LV, Moravcik MY. A humanização do cuidado na ótica das equipes da Estratégia de Saúde da Família de um município do interior paulista, Brasil. Rev Latinoam Enferm. 2010;18(4):763-9.
29. Camelo SHH, Pinheiro A, Campos D, Oliveira TL. Auditoria de enfermagem e a qualidade da assistência à saúde: uma revisão da literatura. Rev Eletrônica Enferm. 2009;11(4):1018-25.
30. Campos GWS. A saúde, o SUS e o Programa Mais Médicos. Rev Méd Resid (Online). 2013;15(2):1-4.
31. Campos CEA. O desafio da integralidade segundo as perspectivas da vigilância da saúde e da saúde da família. Ciênc Saúde Coletiva. 2003;8(2):569-84.
32. Shinyashiki GT, Trevisan MA, Mendes IAC. Sobre a criação e a gestão do conhecimento organizacional. Rev Latinoam Enferm. 2003;11(4):499-506.
33. Albarello CB. O papel do administrador na gestão pública. Rev Adm. 2006;5(9):49-71.
34. Medeiros RLR, Andrade AMBA, Fernandes AFC, Almeida NMGS, Lessa MGG. O enfermeiro no Programa Saúde da Família: percepções, possibilidades de atuação, fronteiras profissionais e espaços de negociação. Fortaleza: CETREDE/UFC/UECE, 2007.

Mailing address:
Tiago Freire Martins
Rua José Hamilton de Oliveira, 160
Bairro: Centro
CEP: 62930-000 - Limoeiro do Norte - CE - Brasil
E-mail: tiagofreire@yahoo.com.br