

The production of care in the routine of Family Health Teams

A produção do cuidado no cotidiano das Equipes de Saúde da Família
La producción del cuidado en el cotidiano de los Equipos de Salud de la Familia

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ABSTRACT

Objective: To identify the factors interfering in the production of care in the daily work of health professionals from the Primary Health Care. **Method:** Qualitative research carried out with Family Health Strategy (FHS) teams, in the health units of Rocinha (Rocinha is a favela located in the South Zone of the city of Rio de Janeiro, Brazil). To analyze the data, the thematic network proposed by Attride-Stirling was used. **Results:** The routine of Teams in the Production of Care was the denomination of the network formed by the following themes: *scales of services of the teams; structural problems of Family Health Units; standardization of protocols; challenges for the production of care; and collections of micro and macro management.* **Final considerations:** The production of care by Family Health Teams is challenged when they take care beyond what is imposed in the organizational protocols of the FHS, reflecting the complexity of working and caring in territories with social disparities. **Descriptors:** Nursing; Primary Health Care; Focal Groups; Public Health; Qualitative Research.

RESUMO

Objetivo: Identificar os fatores que interferem na produção do cuidado no cotidiano de trabalho dos profissionais de saúde que atuam na Atenção Primária à Saúde. **Método:** Pesquisa qualitativa realizada com as equipes da Estratégia Saúde da Família (ESF), nas unidades de saúde da Rocinha/RJ. Para análise dos dados, utilizou-se a rede temática, proposta por Attride-Stirling. **Resultados:** O cotidiano das Equipes na Produção do Cuidado foi a denominação da rede formada pelos seguintes temas: *escalas de atendimento das equipes; problemas estruturais das Unidades de Saúde da Família; padronização dos protocolos; desafios para a produção do cuidado; e cobranças da gestão micro e macro.* **Considerações finais:** A produção do cuidado pelas Equipes de Saúde da Família é desafiada quando essas cuidam para além do que está imposto nos protocolos organizacionais da ESF, reflexo da complexidade para a atuação e para o cuidar em territórios com disparidades sociais. **Descritores:** Enfermagem; Atenção Primária à Saúde; Grupos Focais; Saúde Pública; Pesquisa Qualitativa.

RESUMEN

Objetivo: Identificar los factores que interfieren en la producción del cuidado en el cotidiano de trabajo de los profesionales de salud que actúan en la Atención Primaria de Salud. **Método:** Investigación cualitativa realizada con los equipos de la Estrategia Salud de la Familia (ESF), en las unidades de salud de la Rocinha, estado del Rio de Janeiro. Para el análisis de los datos se utilizó la red temática, propuesta por Attride-Stirling. **Resultados:** El Cotidiano de los Equipos en la Producción del Cuidado fue la denominación de la red formada por los siguientes temas: *escalas de atención de los equipos, problemas estructurales de las unidades de salud de la familia, estandarización de los protocolos, desafíos para la producción del cuidado y cobranzas de la gestión micro y macro.* **Consideraciones finales:** La producción del cuidado por los Equipos de Salud de la Familia es desafiada cuando éstas cuidan más allá de lo que está impuesto en los protocolos organizacionales de la ESF, reflejo de la complejidad para la actuación y para cuidarlo en territorios con disparidades sociales. **Descritores:** Enfermería; Atención Primaria a la Salud; Grupos Focales; Salud Pública; Investigación Cualitativa.

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INTRODUCTION

Care plan production has the user as a central component and is constructed from various meetings between users and health workers. These meetings aim to empower this user and enable their shared decision-making with health workers. Living work in the act is developed by workers either in the form of reception, accountability or resoluteness⁽¹⁾.

The user looking for a health service brings with him/her his/her history, social and cultural relations. Therefore, the citizen is part of his/her own care, because there is an interaction between workers and users in the search for solutions to their health needs⁽²⁾.

Health work process must be based on relationships that occur from the encounter and act, in other words, being produced and consumed at the same time. As consequence, we have freedom that leads to processes of innovation and changes in the production of care in the daily life of health teams, allowing the worker self-government about his/her work process. The micropolitics of the health work process is a dynamic production, developed in the social environment that individuals find themselves, in the daily relations established by the workers, and between these and the users⁽³⁾.

In this sense, micropolitics occurs from the daily action of each person in their work environment, leading to changes and redefinitions that can transform singular therapeutic projects from small daily acts, which are not fixed and immutable, such as the act of welcoming. The worker has the possibility to change his/her work process, because the act of caring is always unique, made from a meeting that will never be the same⁽⁴⁾.

Caregiver acts can be produced by all workers in a health service, such as welcoming, listening, and bonding. Each one brings a differentiated look that contributes to the understanding and communication with the users, enabling them to occupy a place as an active agent in the production of their health⁽⁵⁾.

Producing unrelated care of the prescriptive and homogenizing references in the field of health becomes necessary for all health professionals, since it can only be constructed from a singular therapeutic project with the user of the service. It is only from their demands that care can be traced, intervening in their needs to reach a resolution action.

Hard and soft and hard technologies, such as the use of protocols and indicator management, are important for health actions, but they cannot stifle the professionals and guide care. Health indicators and the production of teams demonstrate quantitative results that reflect a reality of the caring setting, and should be consonant with a care plan that considers the needs of the users and the specifics of the territory in which they are inserted, not impeding the power of the living work in the act.

Family Health Teams in their daily lives produce acts that can be identified as an "improvisation", avoiding pre-established protocols and standardized routines, in order to redefine the needs that the user presents in the health service. Unusual acts that are not standardized can arise from the encounter between the user and the worker, to face the obstacles to the referral of a singular therapeutic project⁽⁴⁾.

OBJECTIVE

This study aims to identify the factors, which interfere in the production of care in the daily work of Family Health Teams. The concepts and discussions of production of care in the micropolitics of living work in the act were used as a theoretical framework, which searches the health services user for their deepest meaning⁽¹⁾.

METHOD

Ethical aspects

This study is a part of the master's thesis of the Graduate Program in Nursing of the *Universidade Federal do Estado do Rio de Janeiro* (PPGENF/UNIRIO). The research was approved by the Ethics Committee of the *Universidade Federal do Rio de Janeiro* and by the Ethics Committee of the Municipal Office Health of the Rio de Janeiro state.

Type of study

Qualitative research that was based on inherent specificities of social research, compatible with the work process theme of the Family Health Teams as a complex social phenomenon⁽⁶⁾.

Study setting

The study was carried out in the three Family Health Units of the community of Rocinha/RJ, territory characterized by numerous social contrasts. Within the same health unit, which is divided into areas and microareas, there are distinct social differences. Some areas include commerce, basic sanitation, good masonry houses and in others there are houses built with remnants of building materials, with a risk of collapse and without any infrastructure.

Among the main services offered by Basic Health Units, we have the collection of laboratory tests, pregnancy and sputum examination, dressings, vaccines, administration of medication, vital signs measurement, reception, medical and nursing appointments.

Data source

The components of the focus groups were the health professionals who work in the Family Health Strategy of the units of Rocinha/RJ.

Data collection

The data were produced through focus group that aims to plan health interventions and discuss reality, aiming to collect information on a specific topic, through the discussion among the participants, and it is important that there is an interaction between the researcher and the participants, leading to the exchange of experiences, concepts and opinions⁽⁷⁾.

Focus groups were held during team meetings that took place on different days of the week and had an average duration of fifty minutes. The teams were chosen by lot drawing which occurred the week before the team meetings. The draw had the participation of the units managers and a representative of each team. It was established by the author the quantitative of two teams per unit, making a total of six Family Health Teams of the three health units of Rocinha, which has 100% coverage by the FHS.

The results of this study were produced through the performance of the six focus groups that took place in February and

March 2017. The total number of participants was forty-five professionals from the six different teams drawn.

Participants were twenty-six CHA (Community Health Agents), six Family Health Strategy nurses, two nursing technicians, four family health physicians, three nursing residents, three medical residents and one pharmacist. In each group, an average of eight health professionals participated.

CHA hold a dialogue between the members of the Family Health Team and the community, as they are part of this territory, leading to the creation of bonding and welcoming of users. FHS nurses are the leaders of teams and articulate the various actors for the production of care, conduct appointments, examinations, collective activities. Family health practitioners act directly in the health care of the population, and it is not compulsory to be specialists in Family Health.

Organization and data analysis

In order to create discussions in the focus groups, a script was made up of thematic issues about the care production of the Family Health Team professionals. The questions posed for each meeting were: *What do you understand as health care?; How does the team work? How are actions planned and organized by the team?; Do you think that the social/economic conditions influence the population health served by the team? In what way?; What are the potentialities and/or weaknesses for comprehensive family health care/actions to be undertaken?.*

These questions were used to guide the discussions, so that everyone could give their contribution and opinion about the care, the organization of the work process in the unit and the daily life of the team.

The Attride-Stirling proposal, specified as the thematic network, was used to analyze the data. The application of thematic networks is a way of organizing the qualitative data in order to facilitate the structuring and representation of the information that appears in the focus groups. The coding of the collected data allows reducing them as an abstract based on the research questions, using specific words that are applied to dissect segments of the text, allowing the identification of standards. After this process, you need to refine this information to encapsulate a set of ideas. Each theme must be specific enough to belong to an idea, but broad enough to find expressions in different segments of the text. The identified themes provide the source for thematic networks. Similar themes are grouped according to similarity and coherence⁽⁸⁾.

The data were organized according to the themes that emerged in the focus groups and followed six steps. First the encoding of the material occurred to reveal the passages of the most significant texts. After this step, the themes were identified and transcribed into a new document. In the third moment, the thematic networks were constructed and identification of the macro categories. In this step, all the themes that have similarity were grouped, later described for later exploration of the thematic networks, seeking a deep understanding of the information. In the fifth step a summary of the themes is organized and finally the data are interpreted⁽⁹⁾.

Thus, the research data were coded according to the common themes, thus forming the themes, as an example, to raise the theme structural problems, the specific words identified in the focus group discussions were: infrastructure, physical space and resources, which led to the identification of a common standard serving as the source of analysis. All the themes come before the thematic network. These are the themes that lead to the creation of a thematic network.

RESULTS

The analysis of the focus groups provided the following topics: *scales of services of the teams; structural problems of Family Health Units; standardization of protocols; challenges for the production of care; performance of teams in the territory; and collections of micro and macro management.* The thematic network that emerged from these themes was: routine of the teams in the production of care. This categorization allowed us to identify the factors that interfere in the production of care, bringing the reflection about the work process that sometimes becomes distant from the users' needs. The names of the teams have been replaced by numbers from 1 to 6 to ensure the confidentiality of information.

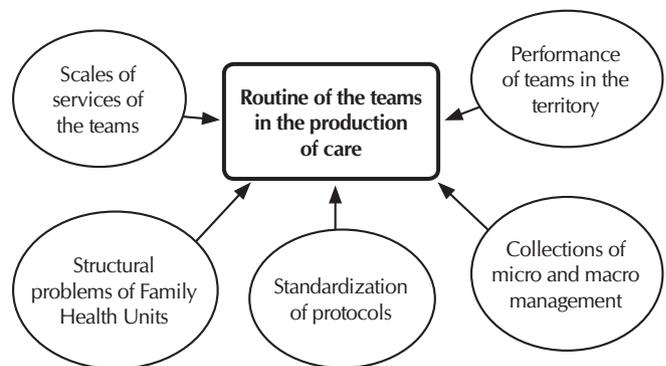


Figure 1 – Themes network

Chart 1 – Routine of the teams in the production of care

Themes	Speeches
Scales of services of the teams (2.1)	<p><i>The most distressing are these permanent scales in our work, permanent in the clinic it wears out. (Group 1)</i></p> <p><i>The scales take a lot of our time, we would need to be careful with more time, so we go over everything, we even do, but sometimes don't even conclude things because of this, because of the time, the scale is done by the administrative unit. (Group 5)</i></p> <p><i>In some situations the routine of the unit disrupts the care and sometimes we don't have the Nursing technician near. (Group 4)</i></p> <p><i>The flows make it difficult especially when you impose groups, you are not in the mood to participate but you are obliged, because this will disrupt a DOTS [Directly Observed Treatment], a HV [home visit], is not planned, arrives and has to do, has to go in other bodies, go to day care to do the weighing and measure, do the brushing, cycle debates. (Group 6)</i></p>

To be continued

Chart 1 (concluded)

Themes	Speeches
Structural problems of Family Health Units (2.2)	<p><i>The infrastructure is also the one that disturbs more, until the communication itself, there is lack of organization. (Group 4)</i></p> <p><i>The very quick test that is done at the end of the hall, with a screen, doesn't have a room, privacy for the patient, the screen is there, but there are people who go there face to face. (Group 5)</i></p> <p><i>We had our room, which was our space, right, but because of the residences that arrived, we were kicked, kicked, nobody asked, just kicked, they took this room to perform the care. (Group 1)</i></p> <p><i>I like to arrive early here because I know that if I don't arrive early I won't find a computer... (Group 2)</i></p> <p><i>So, this release of us, the material for us to work on, which is the computer we don't have, and has no answer, it was already several times spoken at a general meeting request, begged, that we need a decent space, to we at least have ours, one computer per team. (Group 1)</i></p> <p><i>For example, you have to go to the area to make the file and today we have the otics that makes the job easier, if you had a tablet would also facilitate. (Group 3)</i></p> <p><i>Should be made available more resources for us to do this follow up here and register the way they want, a computer only I think is not enough, for me I wanted that palm-top I was already going to the area, I sit in the patient's door and I would not miss it. (Group 5)</i></p>
Standardization of protocols (2.3)	<p><i>We end up having no time, we waste a lot of time, we won't standardize a visit in thirty minutes, there is no way, one house is 20 in the other is one hour, there are houses that we stay four hours, because people don't stop and you don't want to be rude and walk away, and you have to listen. (Group 5)</i></p> <p><i>The Health Family already comes with a line, right, it already gives you a worksheet, it forces you to work with that line there, and this beautiful variable, at first it gives you even a basic numbering, symbolic, which for the amount of people there is, a quantity of disease, it already gives you this, and not necessarily, it is so, so we have a daily fight, in our daily lives, it is not normal. (Group 3)</i></p> <p><i>It is you wanting the person to have a standardized business for everyone, the guy doesn't want to and there, doesn't want, you have no way to compel, sometimes it's just the time that will make him approach here, sometimes know the space to see what another has already achieved, do you understand? (Group 1)</i></p> <p><i>Not to mention that not always, for appointment is only 30 minutes, right, there is a query that we will see, it is in more than an hour. (Group 3)</i></p> <p><i>So we're going to be with him 24 hours, you know, it's a lot of racing, there's no way you can time it, you don't work accordingly, I cannot do a care, if Family Health tells you, to 12 people marked, but you cannot do that, you answer from 12 to 20, and does it have to be done in how many minutes? Thirty? In thirty minutes you will have to fill all those fields, how do you put it? (Group 3)</i></p>
Performance of teams in the territory (2.4)	<p><i>At the same time that we have no difficulty, we have the difficulty, to enter, no matter how much you say you don't have. Everyone will have. (Group 3)</i></p> <p><i>Then I did not go because I was going through "war", but there was no one talking about war, no war appeared on television, there was nothing saying, it was red, green, yellow, wait, but it was not like that. (Group 3)</i></p> <p><i>So there are some cases that would be Emergency Care, we know it would not be a family clinic, it would be UPA (Emergency Care), but it ends up coming here, and ends up overloading the family clinic. (Group 4)</i></p> <p><i>We walk over the sewers, we walk in the alleys, stamping our feet on the ground so that we can escape, otherwise it bites, and so people. We have to walk with our feet on the ground, which is for the rat not to bite us, and so we go, so you end up finding that you do it in the usual way, you already do. (Group 3)</i></p> <p><i>Spontaneous demand, too large number of people to meet, then it is tricky to serve well, knowing that one morning has thirty people to meet you. (Group 6)</i></p>
Collections of micro and macro management (2.5)	<p><i>I think we're charged, because of lots of things, we're charged for numbers, enough numbers, we're charged. (Group 3)</i></p> <p><i>It is a charge of all levels, not only local management, I have a CAP [coordination of the programmatic area], I have a call center, that keeps sending email, at all times, so I have charges that not only the patient's care, because if this were our biggest problem, serving 3 thousand patients, it would be easy busy, but it is not, because those annoying things or things that don't work and we have to think about solutions, in alternatives. (Group 3)</i></p>

DISCUSSION

The themes that emerged in this thematic network demonstrated the complexity of the work process of the Family Health Strategy Teams to produce care. The micropolitics of the work process that happens in the daily practice of these workers is perceptible when they bring their daily practice and their experiences that lead them to produce care according to what they experience in their social environment.

At first, the professionals seemed afraid about the issue, but the discussion led to an enriching debate about the daily work of these teams in the health units. Focus groups occurred at team meetings that are scheduled and are part of the daily work, so there was no damage to the activities of the health units.

The most participatory professionals in all focus groups were nurses and Community Health Agents. This aspect reflects the work process of these workers, since they establish a greater bond with the population and with each other. The nurse as

team leader is an expressive actor in the process of caring for the team. The Community Health Agents, because they are residents of the area they work, experience and relate to the population of the territory in an intense way.

Therefore, it is emphasized that the micropolitics of the health work process reflects an individualized production of care generated by the relationships within the teams that are created from lines of contact between the social agents and the social environment where each one is inserted, which constitute a source of reality production with multiple connections and flows⁽⁴⁾.

2.1 Scales of services of the teams

The scales refer to the places that professionals are distributed to work daily in the health units. These locations are: the booth where the CHA welcomes the users; rapid test (HIV, syphilis) performed by nurses. In many scenarios, these requests come from unit management and not from the team nurses. This has a negative impact on teams that lose the reference of leadership, since the nurse is the coordinator of their team, and can organize it in a way that does not compromise the bond with the users and the activities that the team must develop in your area.

The need for health for the user may be seen as a problem, but not always, due to the many attributions that professionals have, can be the basis for building a relationship between health services and users. In this way, work is seen only as an operational practice and there is no reciprocal production process⁽¹⁾.

The teams demonstrated concern to produce comprehensive care for the population. Despite numerous assignments, teams seek to tailor their routine according to the needs of their users. They recognized that many of these individuals' needs will not be solved only by performing procedures or by pre-established procedures. In order to achieve effective care it is necessary to welcome and listen to the user.

It is emphasized that there is a routine in the work with the organization of scales. But it is important to highlight that the nurses of the Family Health Teams have the autonomy to perform the scales, since they have mastery over the work process of their team and the need of their area that differs according to each microarea.

2.2 Structural problems of Family Health Units

The professionals pointed out that the structural problems existing in the health units make difficult the daily work of the teams. The units are small and do not support the contingent of professionals, which affects their work and performance.

Another item mentioned was the shortage/insufficiency of some equipment, such as computers, which are used to record the information in the electronic medical record. In spite of this, the collections of updating and feeding this information are frequent, which precarizes even more the work of the teams.

In this way, health workers are discouraged from carrying out their activities. In addition, there is a precariousness of work links that lead to a high turnover of professionals, especially nurses and doctors, reinforced by a poor working condition⁽¹⁰⁾.

Another fact evidenced by the teams was the failure to carry out home visits and health groups due to bureaucratic activities, which are delegated to the nurses and CHA by the administration and management of the health units.

2.3 Standardization of protocols

Standardization is relevant and pointed out in the speeches as something that does not allow the realization of care in a comprehensive way, since the user is not seen in an individualized way, but as a pre-established standard of actions that must be fulfilled and executed, according to the goals requirements.

Management believes that in order to achieve good practice in health services it is necessary to dictate rules, work according to protocols and establish what good practices are for professionals. Management should consider that the project for care should also be a project of the worker himself⁽¹¹⁾.

The mandatory registration of users also follows a standard where all must be registered. In areas with violence, this register becomes a major challenge for health agents, since they must create a link in the area and gain the trust of the population of the territory to become facilitators of the team's work process.

Another item discussed was the standardized duration time for appointments. The meeting between users and professionals, which is individual, becomes mechanical. The determination of service/time goals for the appointments, especially those of Nursing, harms the reception of the needs of this user in its entirety.

The health act should not be reduced to the execution of procedures, with determined protocols and number of visits per hour. In this way, the user is divided into a variety of technical acts that do not always have resolution, where the product related to care is reduced to corporative practices that aim at generating the achievement of results through the production of mechanized and standardized procedures⁽¹²⁾.

Thus, the meeting between the professional and the user is distanced by the excessive use of hard, and soft and hard technologies rather than soft technologies, which allows living work in the act to be developed in a unique way, being a product of listening and accountability that is articulated to build commitment bonds in intervention projects. This process can be carried out by any health worker, leading to the possibility of creating micropolitics of the user-centered work process⁽¹³⁾.

The concept of equity must also be considered and is defined as the way to recognize differences between individuals with the production of care appropriate to each individual need in order to reduce existing inequalities. In health, equity is the right time everyone has to reach their health potential, considering the context in which they live⁽¹⁴⁾.

The professionals of the teams also showed disappointment, because their freedom in producing care is impaired with the obligations that arise in the daily life. It is necessary autonomy for the worker in the management of this care so that they can happen at the moment of their meeting with the user, where their work process will be determined. Freedom will provide for the reception and establishment of bonds⁽¹¹⁾.

2.4 Performance of teams in the territory

The large number of appointments was pointed out by the teams as an obstacle to reach the goals proposed by the FHS, due to the workload and responsibilities of these professionals. The users are "sliced" in the health services that end up concentrating their care in the use of a hegemonic science instead of being served in an individualized way taking into

consideration the therapeutic process that must be traced from the bond with whom it is served⁽¹⁵⁾.

The question related to the length of service for the number of users became constant in the focus groups, the professionals showed great wear and discouragement when referring the weaknesses of the services rendered to the population, since they have little time to perform services by shift.

In Rocinha, the water and sewage system is still a major challenge and constitutes a major public health problem. There are ditches that converge to an old Walloon that has not yet been modified and receives most of the sewage from the favela and when it rains the same overflows. These difficulties for the implementation of basic sanitation in favela areas are historical data, as is access to water on a regular basis⁽¹⁶⁾.

In the territory, due to the marked social problems/inequalities, home visits are complex, and are always carried out on foot, because the alleys are extremely narrow where only one person can pass by. There is no pavement in certain areas and sewage is apparent with the presence of numerous rodents. In the speeches this difficulty was explicit when they affirm that they need to hit the feet so that the rats can move away.

The violence in the territory is relevant and is part of the routine of the health teams of Rocinha, since there is the presence of drug trafficking. The professionals said that this fact is not an impediment to the accomplishment of the home visits, but the registration of the users becomes difficult due to the necessity of presentation of documents.

The collection by goal of production of home visits is also portrayed in the lines, not always the teams have an opening with the management of the unit to point out the places of access difficulty due to the violence. Rocinha is a very large neighborhood, not always the clashes that occur in a certain area affect the neighborhood as a whole, with that the issue of violence must be treated in a judicious way so as not to put at risk neither users nor professionals.

Another relevant theme that was discussed in the groups was the importance of acting/articulating the other levels of attention, for the realization and effectiveness of a comprehensive health care network. Mehry says that family doctors are treated as if they were a panacea, they can solve all health issues as if they were miracle workers, leaving aside the importance of multidisciplinary teams⁽¹⁷⁾.

2.5 Collections of micro and macro management

Professionals of the teams showed that they feel very collected, as already mentioned in other topics, since they must meet the goals established by the municipality's management contract, which is divided into variables that evaluate service access, surveillance and quality. In addition, there are other internal demands common to the service that originates from different hierarchical levels.

The precarious employment relationship and the reduced number of professionals are factors that can be used as instruments of political control over Family Health Teams, by those who consider health as the disease industry. The absence of workforce planning, and excessive collections, mean that these workers are held hostage in this context⁽¹⁰⁾.

In this sense, the professionals of the teams cannot see if there is an importance for the goals and standardization of the procedures, since they do not reflect the capacity to exercise the comprehensiveness of care and to have a critical look on the health situation of its territory. They refer to collections as having no bearing on care.

It is evident in the lines of the teams that the professionals are not heard by the management of the unit and the coordination of the area. There is a gap between what is collected by management and what is and can be executed in practice. Merhy states that it is necessary to listen to be a manager to build an understanding and willingness to cooperate in order to achieve institutional commitment⁽¹⁾.

Study limitations

Considering that the focus groups were scheduled in the days of the team meetings, it was necessary to respect the dynamics of the teams in order to reschedule the groups, because the agenda of the meeting was already extensive, which made it impossible for the teams to participate in the focus group. Another limitation was the innumerable activities, such as vaccination campaigns, which prevented some team members from participating in the meetings, which led to a lack of participation in the focus group.

Contributions to Health

The contribution of this study is to contribute to a reflection on the challenges that the professionals of the teams face to produce care in addition to protocols and goals established in territories with social disparities.

FINAL CONSIDERATIONS

The teams' performance in the FHS can be characterized as highly complex, due to the social dynamics of the territories in which they are inserted, considering that the care process goes beyond the treatment and cure of diseases. The meeting between professionals and users is an event and expression of the production of care that happens not only in the physical structure of the health unit, but in the territory where this user is inserted, with all its historicity and multiplicities of concepts.

It was possible to detect several elements that provoke tension in the relations that permeate the production of care. It was noted that the collection in relation to the accomplishment of goals and protocols does not take into account the territory of the teams, since these are the same for any territory of action within the municipality of Rio de Janeiro.

The importance of protocols as guides for professional practices in the field of health is emphasized, but it is also known that professionals and management need to be sensitized and made aware of the fact that care must go far beyond protocol proposals.

The results of this study show that in the micropolitics of the work process, the effort of the teams to carry out their production of care based on the needs of the users of their territory is notorious despite the various difficulties and crossings in the organization of daily work, including violence as a factor that interferes with the care plan.

Implanted and overly standardized practices affect the professional-user relationship that ceases to be singular, subjective and comprehensive. Understanding and producing care from a micropolitical point of view requires applying the multiple dimensions present in public health policies, which bring to the real the uniqueness of the many points of view (managers, professionals, users) without harm and distortions of health.

Therefore, the protocols and goals should be adaptable and be feasible according to the characteristics of each territory, so that they could assist the teams in the production of comprehensive

and equitable care. In this way, health actions can go beyond the mechanized and bureaucratic biomedical model, thus being able to serve the foundations of Primary Health Care and promote the production of healthy policies.

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