THEORETICAL STUDIES

Challenges for nursing at the reach of Primary Health Care goals*

DESAFIOS PARA A ENFERMAGEM NO ALCANCE DAS METAS DA ATENÇÃO PRIMÁRIA

DESAFÍOS PARA LA ENFERMERÍA EN EL ALCANCE DE LAS METAS DE LA ATENCIÓN BÁSICA

Marcia Regina Cubas[1]

ABSTRACT

The debate is based on the contextualization of the goals presented by the National Primary Health Care Plan (*Plano Nacional de Atenção Básica*), which despite having improved the quality and attempted to solve inequities and vulnerabilities, still has contradictions to overcome. The plan discusses that nursing, in this setting, is included as a member of the family health team and in the coordination of community health agents. The analysis of the challenges to be overcome was divided into three blocks: undergraduate teaching, the working process, and continuous training. The first block presents a panorama of undergraduates studies in Brazil and how the primary health care issues are addressed in the curricula and understood by faculty and students; the second examines the views that primary health care nurses have about their working process and the guidelines of the Brazilian National Health System; finally, the third block points to the challenges related to the different knowledge and practices that must be developed in nursing, in this specific area of practice.

DESCRIPTORS

Primary Health Care
Primary Care Nursing
Organizational objectives

RESUMO

O debate parte da contextualização das metas apresentadas pelo Plano Nacional de Atenção Básica, que embora tenha agregado qualidade e tentado resolver iniquidades e vulnerabilidades, possui contradições a serem superadas. Discute que a Enfermagem se insere neste cenário como membro da equipe saúde da família e na coordenação de agentes comunitários. A análise dos desafios a serem superados foi recortada em três blocos: o ensino na graduação, o processo de trabalho e a capacitação continuada. No primeiro se oferece um panorama da graduação no Brasil e de como o conteúdo da atenção primária é abordado nos currículos e entendido por docentes e alunos; no segundo, apreciam-se os olhares que os enfermeiros da atenção básica possuem sobre seu processo de trabalho e sobre as diretrizes do SUS; no terceiro, apontam-se os desafios relacionados aos diferentes saberes e práticas que devem ser desenvolvidos pela enfermagem neste âmbito de atuação.

DESCRITORES

Atenção Primária à Saúde
Enfermagem de Atenção Primária
Objetivos organizacionais

RESUMEN

El debate parte de la contextualización de las metas presentadas por el Plan Nacional de Atención Básica, que aunque haya agregado calidad e intentado resolver inequidades y vulnerabilidades, posee contradicciones a superar. Discute que la Enfermería se inserta aquí como miembro del equipo salud de la familia y en la coordinación de agentes comunitarios. El análisis de desafíos a superar se partió en tres bloques: enseñanza en el curso, proceso de trabajo y capacitación permanente. En el primero se ofrece un panorama de la graduación en Brasil y de cómo el contenido de atención básica es abordado en los currículos y entendido por docentes y alumnos; en el segundo se aprecian las visiones de enfermeros de atención básica respecto del proceso de trabajo y directivas del SUS; y el tercero determina los desafíos relativos a diferentes conocimientos y prácticas a desarrollarse por la enfermería en este ámbito de actuación.

DESCRIPTORES

Atención Primaria de Salud
Enfermería de Atención Primaria
Objetivos organizacionales

* Work presented at the Round Table "Avaliando o SUS em seus princípios, processos e produtos", 2º Simpósio Internacional de Políticas e Praticas em Saúde Coletiva na perspectiva da Enfermagem - SINPESC, São Paulo, University of São Paulo School of Nursing, October 2011. [1]Registered Nurse. PhD in Nursing. Adjunct Professor of the Undergraduate Nursing Program and of the Postgraduate Program in Health Technology at the Pontifícia Universidade Católica of Paraná. Curitiba, PR, Brazil. m.cubas@pucpr.br

Received: 10/25/2011
Approved: 11/13/2011

OnLine Português / Inglês www.scielo.br/reeusp

In addressing the challenges that nursing is subjected to in order to achieve the goals of primary healthcare, first, allow me a little contextualization in order to understand what goals we are talking about. I will outline the National Policy of Primary Healthcare[1]. This policy establishes goals to be met, updating and overcoming the three major agreements related to the national policy of 2006[2], namely: the defense of the Brazilian National Health Service (SUS), of the Management and of the Life. It should be noted here that the policy conceptualized primary healthcare as a set of actions of individual and collective context being developed in a defined area, supported by democratic and participative management/health practice, and by teamwork. The policy revises the guidelines and standards of Primary Health Care, of the Family Health Strategy and of the Community Health Agent Program - PACS, regarding their principles, responsibilities, skills, specificities and attributes; establishes strategic areas; and redefines the responsibilities of the spheres of government.

Regardless of whether an unquestionable scenario is constructed of overcoming the regional inequalities and of reducing the vulnerabilities of groups, such as indigenous, adolescents in conflict with the law and the prison population, the policy presents a great contradiction when establishing Family Healthcare as a model of care and Primary Healthcare as the originator center of the care networks, while simultaneously presenting the strategic areas by ranges of life cycle and conditions of morbidity and mortality, these being the goals established in these domains.

When searching material that anchors this theme, I came across another curious situation, the fact that, even today, the SUS is visualized by different authors as an alternative healthcare model. Although it was evaluated that in the United Kingdom it took more than 50 years for the principles presented in the health policies to be incorporated into the practice, the Brazilian reality shows that in the lifetime of the SUS this system has had to cope with a neoliberal discourse of budget constraints; managers with the interests of fulfilling the primary healthcare requirements only to receive federal funds; and the need to answer what the real impact of the actions of the family health strategy is regarding the health of the population[3]. Obstacles such as the bureaucratic structure of the state apparatus; the corporatism; the difficulties of the training institutions; and the prejudices toward the simplified technology required for the actions of primary healthcare can be added to the coping[3]. Therefore. I think that the lifetime of the SUS, at least with regard to primary healthcare, has yet to produce significant effects to construct its principles in order to become hegemonic. Among other challenges, the decentralization and the equity were faced with a fragmented and immensely diverse scenario; the universality, with the precarious and deficient public provision; the social control, with low levels of civic culture and participation; and the integrality, with the presence of informality and the absence of a network[4-5].

> ... the lifetime of the SUS, at least with regard to primary healthcare, has yet to produce significant effects to construct its principles in order to become hegemonic.

It is in this contradictory space of health and management practices that the nurse is inserted in the singular dimension, as a member of the family health team or as the coordination of the PACS. Not unlike other practices that develop the social area, our practice is also contradictory, as it seeks to transform the hegemonic healthcare model, however confirms or maintains it in its own actions[6]. Aware that I will have a partial view of the necessary overcoming process, I will address three elements that I consider fundamental: education, the world of work and the processes of continuous/permanent training.

Within the teaching space I begin my discussion with the disorderly expansion of graduate courses in Brazil. The 2010 Higher Education Census recorded 752 nursing courses, a number that is still growing. In the last publication accessed that condensed and discussed the issue, there is a worrying condition: from 1996 to 2004, there was an expansion of 286.79%, with strong inclusion of the private initiative, which presented the percentage of 837.77%. This scenario could be considered positive, given the need for the professional in Brazil, however, the National Examination of Student Performance - ENADE, concludes that the profile of the nursing student demands broader skills to act in support of the sustenance of a model with the principles and guidelines of the SUS[7].

This profile is constructed by educational processes that cover generalist knowledge, however, emphasize specialities and disconnect the teaching and service. Another situation presented is that regardless of the formation institution (public or private) there is an inadequate preparation for primary healthcare, however, there is a tendency toward some adaptation of the teaching-learning process to work in primary healthcare in the public institutions, by the different strategies that they present, among them, the rural strategies, inclusion in research groups and university extension activities[8].

This situation could be more chaotic if it was not for a comprehensive discussion of the Brazilian Nursing Association - ABEn, which, through the National Seminar on Guidelines for Nursing Education - SENADEn, raised serious questions about the teaching, problematizing its determinants and proposing ways to overcome this. Among the items approved in the minutes of the 12th SENADEn, there was an application to the Ministry of Education and Culture requesting that the amendment of Decree 5,773 of 2006 be performed speedily, so that the requests for the creation of Graduate Courses in Nursing could be for-

warded for the consideration of the National Health Council, as was already happening with the courses in medicine, odontology and psychology. Thus, making a concrete approach to social control effective.

The advances in the construction of pedagogic projects from the Guidelines and Framework Law - LDB cannot be denied, however, what is seen in practice is that formation in the healthcare area is the co-responsibility of the health and education sector, which are intersectoral, in order to form a professional with the ability to visualize the healthcare needs of the population based on the principles of the SUS, furthermore this formation is structured in a context which privileges the ideology that the national system itself is counter-hegemonic[9-10].

In the singular dimension of education, overcoming the challenges in the formation process can be anchored in the pillars of contemporary education, namely: the student should be seen as a subject of their formation; the training must be based on skills, affording the student experiences and opportunities; the theory should be linked with the practice; and the educator-educated interaction must be constant. All of this is in parallel with the use of pedagogic strategies, which enable the comprehension of the health determinants, and with the diversification of learning scenarios[11]. This is a complex task, however, with no possibility of being denied.

The challenges related to the world of work start with a potential factor: the generalist formation of the nurse promotes their insertion into the labor market. However, by entering into the work, the graduate must exercise the quality of the relationship with the user, which should be considered in its *singularity, complexity, integrality and socio-cultural insertion*, with acceptance of the diversity originating from the Brazilian heterogeneity[12-13]. This requires the inclusion of technological devices, which relate to light technologies[14], not always given preference in the formation process, nor the subject of discussion in the spaces of the practice.

Regarding the clinical practice of the nurse, which is established in the goals related to nursing consultations included in the strategic areas of care, it is still centered on the individual. When the family is the subject of the practical action it is related to the physical environment (housing) and with a focus on helping the individual (family member) that requires care[15]. Faced with individuals in society, the collective face of these individuals and its insertion in the social space are demonstrated. Thus, by the successive approximations with the social, nurses incorporate into their practice the need to include the collective face, or at least to accept it in their care processes. In this context, in the pursuit of their professional practice nurses become the conflictions representative of the clinical knowledge as they are capable of organizing clinical knowledge and relate it to the social needs triggered by the epidemiological profile, even being those limited to the public policies[15].

It can be seen that the programmed actions allow construction of new technologies, practices and knowledge[6]; and that integrality expands the vision of human beings by treating them as beings with needs, feelings and afflictions[16]. Therefore, the nurse, when assuming direct attention, needs to move between the two poles: the clinical and social[6]. Added to all this is the fact that nurses develop hospitable attitudes and use of the dialogue, of the personal interaction and of the techniques, however, are still a *do everything* in various practice cenarios[16]. In primary healthcare this is no different. These same nurses that address the clinical knowledge of the form mentioned in the primary healthcare space can focus their work on the disease, as well as organize their work process in order to dominate the team through technical division and sometimes distance themselves from direct care, recommending administrative actions, relegating to the auxiliaries, among other activities, the well-being of the patient[6]. Therefore, the challenge is in the difficult balance of being operationalized.

Finally, within this world of work, when the focus is on continuing or permanent educational activities, it can be verified that intersectorality is confused in its concept and operationality, with interdisciplinarity, which reflects the great difficulty in the training and articulation of the subjects[5]. The education processes are based on the need for the intergration of education, service and community and on the development of critical and creative abilities. Although health workers who participate in education activities realize that they posses quality as a result, they still have their training focused on the need for the resolution of identified problems or on the inclusion of new equipment, most of which are external to the service, i.e. derived from individual needs or from the central and regional level[17-19]. These are individualized or institutional movements, which are modified or transformed at every appearance of a new urgency in the service. In this sense, awakening to the critical reflection requires a permanent health education that prepares nurses to act from the principles of intergrality and interdisciplinarity, which reflect the best quality of work and healthcare actions[20].

Another point to be highlighted as a challenge is the lack of thematic suitability to the work environment, which gradually results in the discontinuation of the educational process, which in principle should be operationalized with participation and partnership. The overcoming of which would result in the creation of spaces of: pedagology of education, interactive of team meetings and collective reflection of the practices. This is an exercise of an institutional culture, which requires extensive democratization of the management as well as membership of the community[21-22]. In this case, the targets should be agreed at the local level, which at first would have greater knowledge of the reality of its area, of its instaled capacity and of its needs to be overcome to effectively organize its practices in a democratic and participatory way, thereby

constructing the agreement of the goals in accordance to the concept of Primary Healthcare. However, what can be verified in reality is that this movement of agreement is still far from being democratic and participatory. The team, has no space for listening or discussion and is sometimes regarded as a mere executor of the plan, not being aware of the real impact of their actions.

It can be concluded that the outline offered in a theme as dense as the one presented in this debate, will serve as a stimulus to reflection regarding the goals established for nursing in the agreements presented by the National Primary Healthcare Policy. These goals require a deep understanding of the principles of the SUS, which will not be operationalized if there are not education, work and continuous learning processes adherent to them.

If this process took 50 years in the United Kingdom and if this experience can be related to us, it seems that we still have 29 years to go and many hurdles to overcome. Or, from a more optimistic perspective, we have already completed 21 years and we have many success stories to relate!!!

REFERENCES

1. Brasil. Ministério da Saúde. Portaria n. 2.488, de 21 de outubro de 2011. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica, para a Estratégia Saúde da Família (ESF) e o Programa de Agentes Comunitários de Saúde (PACS) [Internet]. Brasília; 2011 [citado 2011 nov. 28]. Disponível em: http://www.editoramagister.com/legislacao_ler.php?id=17944

2. Brasil. Ministério da Saúde. Portaria n. 648, de 28 de março de 2006. Aprova a Política Nacional de Atenção Básica estabelecendo a revisão das diretrizes e normas para a organização da Atenção Básica para o Programa Saúde da Família (PSF) e Programa Agentes Comunitários de Saúde (PACS) [Internet]. Brasília; 2006 [citado 2011 jul. 15]. Disponível em: http://dtr2001.saude.gov.br/sas/PORTARIAS/Port2006/GM/GM-648.htm

3. Conill EM. Ensaio histórico-conceitual sobre a atenção primária à saúde: desafios para organização de serviços básicos e da estratégia saúde da família em centros urbanos no Brasil. Cad Saúde Pública. 2008;24 Sup1:S7-16.

4. Bodstein R. Atenção básica na agenda da saúde. Ciênc Saúde Coletiva. 2002; 7(3):401-12.

5. Paula KA, Palha PF, Protti ST. Intersetorialidade: uma vivência prática ou desafio a ser conquistado? O discurso do sujeito coletivo dos enfermeiros nos núcleos de saúde da família do Distrito Oeste – Ribeirão Preto. Interface Comunic Saúde Educ. 2004; 8(15):331-48.

6. Lucena AF, Paskulin LMG, Souza MF, Gutiérrez MGR. Construção do conhecimento e do fazer enfermagem e os modelos assistenciais. Rev Esc Enferm USP. 2006; 40(2):292-8.

7. Teixeira E, Vale EG, Fernandes JD, De Sordi MRL. Trajetória e tendências dos cursos de enfermagem no Brasil. Rev Bras Enferm. 2006;59(4):479-87.

8. Montenegro LC, Brito MJM. Aspectos que facilitam ou dificultam a formação do enfermeiro em atendimento primário à saúde. Invest Educ Enferm. 2011;29(2):238-47.

9. Lucchese R, Vera I, Pereira WR. As políticas de saúde – SUS – como referência para o processo ensino-aprendizagem do enfermeiro. Rev Eletr Enferm [Internet]. 2010 [citado 2011 jul. 13]; 12(3):562-6. Disponível em: http://www.fen.ufg.br/revista/v12/n3/v12n3a21.htm

10. Silva MJ, Souza EM, Freitas CL. Formação em enfermagem: interface entre as diretrizes curriculares e os conteúdos de atenção básica. Rev Bras Enferm. 2011; 64(2):315-21.

11. Silva MG, Fernandes JD, Teixeira GAS, Silva RMO. Processo de formação da(o) enfermeira(o) na contemporaneidade: desafios e perpectivas. Texto Contexto Enferm. 2010;19(1):176-84.

12. Coberllini VL, Santos BRL, Ojeda BS, Gerhart LM, Eidt OR, Stein SC, et al. Nexos e desafios na formação profissional do enfermeiro. Rev Bras Enferm. 2010;63(4):555-60.

13. Haddad JGV, Zoboli ELC. O sistema único de saúde e o giro ético necessário na formação do enfermeiro. Mundo Saúde. 2010;34(1):86-91.

14. Merhy EE. Saúde: a cartografia do trabalho vivo. São Paulo: Hucitec; 2002.

15. Cezar-Vaz MR, Cardoso LS, Bonow CA, Sant´Anna CF, Sena J. Conhecimento clínico do enfermeiro na atenção primária à saúde: aplicação de uma matriz filosófica de análise. Texto Contexto Enferm. 2010;19(1):17-24.

16. Ferreira VA, Acioli S. Prática de cuidado desenvolvida por enfermeiros na atenção primária em saúde: uma abordagem hermenêutica-dialética. Rev Enferm UERJ. 2010; 18(4):530-5.

17. Rodrigues ACS, Vieira GLC, Torres HC. A proposal of continuing health education to update health team professionals in diabetes mellitus. Rev Esc Enferm USP [Internet]. 2010 [cited 2011 July 12];44(2):531-7. Available from: http://www.scielo.br/pdf/reeusp/v44n2/en_41.pdf

18. Peduzzi M, Del Guerra DA, Braga CP, Lucena FS, Silva JAM. Atividades educativas de trabalhadores na atenção primária: concepções de educação permanente e de educação continuada em saúde presentes no cotidiano de unidades de saúde em São Paulo. Interface Comunic Saúde Educ. 2009;13(30):121-34.

19. Montanha D, Peduzzi M. Permanent education in nursing: survey to identify the necessities and the expected results based on the workers conception. Rev Esc Enferm USP [Internet]. 2010 [cited 2011 July 12];44(3):597-604. Available from: http://www.scielo.br/pdf/reeusp/v44n3/en_07.pdf

20. Silva LAA, Ferraz F, Lino MM, Backes VMS, Schmidt SMS. Educação permanente em saúde e no trabalho de enfermagem: perspectiva de uma práxis transformadora. Rev Gaúcha Enferm. 2010;31(3):557-61.

21. Costa V, Cezar-Vaz MR, Cardoso L, Soarez JF. Educação permanente no Programa Saúde da Família: um estudo qualitativo. Invest Educ Enferm. 2010;28(3):336-44.

22. Lima JVC, Turini B, Carvalho BG, Nunes EFPA, Lepre RL, Mainardes P, et al. A educação permanente em saúde como estratégia pedagógica de transformação das práticas: possibilidades e limites. Trab Educ Saúde. 2010;8(2):207-27.

Correspondence addressed to: Marcia Regina Cubas
Rua Imaculada Conceição, 1155 CCBS/PPGTS
CEP 80215-901 Curitiba, PR, Brazil