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Study of the work and of working in Family Health Care Support Center

ABSTRACT

OBJECTIVE: To understand the organization of and the working conditions in family health care support centers, as well as subjective experiences related to work in two of these centers.

METHODS: This was a case study carried out during 2011 and 2012 in two family health care support centers in Sao Paulo, Southeastern Brazil. Data were collected and analyzed using two theoretical-methodological references from ergonomics and work psychodynamics influenced, respectively, by ergonomic work analysis, developed based on open observations of a variety of tasks and on interviews and in practice in work psychodynamics, carried out using think tanks about the work.

RESULTS: The work of the Family Health Care Support Centers in question is constituted on the bases of complex, diversified actions to be shared among the various professionals and teams involved. Innovative technological tools, which are not often adopted by primary health care professionals, are used and the parameters and productivity measures do not encompass the specificity and the complexity of the work performed. These situations require constant organizational rearrangement, especially between the Family Health Care Support Centers and the Family Health Care Teams, causing difficulties in carrying out the work as well as in constituting the identity of the professionals studied.

CONCLUSIONS: The study attempts to lend greater visibility to the work processes at the Family Health Care Support Centers in order to contribute to advances in public policy on primary healthcare. It is important to stress that introducing changes at work, which affect both its organization and work conditions, is above all a commitment, which to be effective, must be permanent and must involve the different levels of hierarchy.

DESCRIPTORS: Primary Health Care; Ergonomics, Family Health Program. Qualitative Research, Work.

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INTRODUCTION

The principles and directives that guide the *Sistema Único de Saúde* (SUS – Brazilian Unified Health System), such as universal access to health care services, integrated care and social control, drove changes in the area of preventative, care and rehabilitation activities. Within this context, the *Estratégia de Saúde da Família* (ESF – Family Health Care Strategy) has become fundamental in the reorganization of the SUS care model, since 1994, increasing problem solving in primary health care, based on implementing of generalist and multi-professional health care teams in health care units, responsible for a set number of families in a specific geographic territory.^{1,a}

The *Núcleos de Apoio à Saúde da Família*^b (NASF – Family Health Care Support Centers) were created in 2008 to support and complement the work performed by the ESF teams (EqSF). These team are made up of health care professionals from different areas, among them: psychology, physiotherapy, speech therapy, nutrition, occupational therapy and other medical specialties, which support between eight and 15 EqSF.^a

The national directives and other documents that guide the NASF^{c,d} recommend that their activities be developed in partnership with the EqSF and care carried out primarily in groups. Their principal tools are matrix support, broadened clinic and individual and collective therapeutic projects.² It is a recent change in the area of public policy and that has innovative tools and ways of organizing the work, with work processes that are not yet totally defined and systemized.

Organization of work represents aspects concerned with content and prescription, as well as how, why and when the work is carried out. The conditions of the working environment correspond to material aspects, to the physical space, among others. Each worker, when doing their work, can proceed in a different way, depending on the time available, the tools and instruments used, on the environmental conditions to which they are exposed, on their past and present professional experience and on health care conditions, among other variables.^{4,6,7}

In this context, implementing health care policies, models and programs of intervention transforms the

work of the professionals involved. Thus, this study aimed to understand the characteristics of the organization of the work, the conditions and the subjective experiences related to working in two family health care support centers. Another objective was to identify the interfaces between NASF and EqSF work processes.

METHODS

This study presents some of the results of the “Work Processes in Family Health Care Support Centers and their Effects on the Workers’ Mental Health – *O Processo de Trabalho nos Núcleos de Apoio à Saúde da Família e seus Efeitos na Saúde Mental dos Trabalhadores*” study.^e

It is a case study conducted in two NASF in a specific region of Sao Paulo, SP, Southeastern Brazil, between 2011 and 2012. The theoretical-methodological references from ergonomics^{5,6} and work psychodynamics (WPD)³ were used in collecting the data. The approaches differ in the way they approach the object of the study, in the methods used (respectively, ergonomic work analysis – EWA and in practice in WPD), in the ways of observing and/or listening to the worker and in the expected objectives.

Both disciplines understand that prescribed work and actual work are out of sync due to variability in the tasks, the subjects and the respective work situations. Prescribed work includes, for example, the objectives, procedures and technical means for the task to be completed which, in the case in question, based on the directives drawn up by public policy. Actual work refers to how the workers use their body and their skills to carry out what was prescribed. For WPD, the subjects develop their own intelligence and know-how, using subjective logic to deal with things that are still not given by prescribed organization of the work. In this discipline, such subjective mobilization, named strategy of dealing with reality, becomes the focus of study.^{3,5,6}

There are two NASF – Alfa and Beta – in the region studied.^f It was decided to begin the various stages and procedures for each theoretical – methodological

^a Ministério da Saúde. Portaria no 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). *Diário Oficial Uniao*. 24 out 2011;Seção1:48. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt2488_21_10_2011.html

^b Ministério da Saúde. Portaria nº 154, de 24 de janeiro de 2008. Cria os Núcleos de Apoio à Saúde da Família – NASF. Brasília (DF); 2008 [cited 20 Jun 2010]. *Diário Oficial Uniao*. 4 mar 2008;Seção1:35-7. Available from: <http://www3.dataprev.gov.br/sislex/paginas/66/MPS/2>

^c Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Diretrizes do NASF – Núcleo de Apoio à Saúde da Família. Brasília (DF); 2009. (Série B. Textos Básicos de Saúde - Cadernos de Atenção Básica, 27).

^d Prefeitura do Município de São Paulo. Coordenação da Atenção Básica. Estratégia Saúde da Família. Diretrizes e parâmetros norteadores das ações dos Núcleos de Apoio à Saúde da Família (NASF). São Paulo; 2009.

^e Lancman S; Barros JO; Uchida S; Silva MT; Gonçalves RMA; Daldon MTB, et al. O Processo de Trabalho nos Núcleos de Apoio à Saúde da Família (NASF) e seus Efeitos na Saúde Mental dos Trabalhadores. Pesquisa subvencionada pelo Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPq) Relatório Final. Processo CNPq 480319/2010-3.

^f Alfa and Beta are fictitious names used for protecting the identity of the teams studied.

reference in the Alfa NASF, the first to be established in the context in question. The data collected were complemented and validated in the Beta NASF at the end of the process.

The researchers organized meetings with the coordinator of the teams studied and then with the workers in NASF Alfa to present the research and clear up any doubts.

There was a managing group, composed of the researchers and NASF workers, aiming to create conditions to conduct the research, present the principles of EWA and WPD, as well as identifying volunteers to take part in the other stages. The researchers had some hypotheses on the difficulties of work in the NASF. They sought to present these to the workers, aiming to understand the questions they themselves had about their work and their expectations concerning the research proposal. The initial hypotheses were reframed and reformulated. Both for EWA and for WPD, this stage was named Analysis and Reconfiguration of Demand.

The EWZ and the Action in WPD took place simultaneously. The data from the two methodologies were mutually compared in order to identify contributions, convergences and divergences between them. This dialogue aimed to enrich and qualify the results and discussions of the study.

In addition to the analysis and reconfiguration of demand, the EWA is constituted of stages such as: survey and analysis of data on the company and the workers; analysis of the task and the activity; diagnosis, validation and recommendations.⁵ In this study, three of these stages were carried out, due to the specificity of the work of the NASF: 1) survey and analysis of the NASF guiding documents; survey of the organizational structure, profile of the workers and the population cared for in the two NASF; survey and analysis of data on the productivity of the NASF and the *Unidades Básicas de Saúde* (UBS – Basic Care Units) in question; 2) meetings and individual and group interviews with the NASF coordinators and with the managing groups; observing some tasks (meetings, user groups, and others); 3) validating the results.

The WPD in practice was also constructed in stages.³ After reconfiguring demand, the survey itself took place. It was in the form of a group task, which aimed to encourage discussion process on work so that, on sharing individual perceptions, each worker was able to transform them into collective reflections. The field work took place over three months, with fortnightly sessions, totaling 12 hours.

The researchers were alert to the content of the dialogue, to consensus, to contradictions, to what emerged spontaneously, or not, and to what was not said or omitted concerning the topics discussed. After this stage, there was a month long break for the researchers to formulate

a report with a synthesis of the topics approached, seeking to give them meaning through using WPD concepts and categories, such as suffering and pleasure at work, mechanisms of recognition, cooperation and defence strategies.

In order to create a qualified hearing, avoiding abusive disruptions or distortions and to encourage neutrality in the researchers during the clinical listening part, the content of each session was shared with an external researcher who acted as a supervisor and aided in the process of reflection on each of them.

A provisional report was presented and discussed with a group in validation sessions, totaling ten hours, in order for adjustments to be made and support given in producing the final version. This process took place in an interactive way to encourage the workers involved in the study to re-appropriate the material.

A process of presenting the research and clearing up and doubts was initiated with the workers in the NASF Beta. Volunteers completed a questionnaire to obtain information on actual work and validate the results of the EWA and the WPD in practice, developed in the NASF Alpha.

The research project was approved by the Research Ethics Committee of the Faculty of Medicine of the *Universidade de São Paulo* (Protocol no. 160/11) and by the Research Ethics Committee of the *Prefeitura Municipal de São Paulo* (Protocol no. 239.0.162.000-10). All of the participants signed a consent form.

RESULTS

The most relevant results of the two methodologies used are organized into two broad categories, which are shown after a general characterization of the two NASF teams studied.

Profile of the teams studied

Both of the teams were established in 2010: one in the first semester and the other at the end of the second. The health care professionals, 15 in each of the NASF teams, worked Monday to Friday between 07.00 and 17.00; 62.5% had a weekly workload of 20 hours, while the rest worked a 40-hour-week. Each team was multi-disciplinary and, despite being made up of young workers, the majority had experience working in primary health care (Table).

Contributions of Ergonomics: Characteristics of the Organization and Working Conditions

There was a lot of variation in the tasks carried out by each team, many of which were described in the guiding documents, although with few specifics and aimed primarily at shared activities. The work was outlined

based on practice, on the characteristics of the region and of the population, on the demands which appeared in the EqSF and in agreements reached while the teams (NASF and EqSF) were working.

In this context, work was organized based on meetings with the different protagonists. Some meetings involved the whole team, some involved representatives and others simply the group of three individuals in question. Activities developed by representation were a strategy created to optimize the workers' time and ensure that the work fronts in the Centers became reality.

The meetings took up a large part of the health care professionals' day; of these, two were considered essential in enabling the development of the actions: 1) between the trios of references from the NASF and EqSF – spaces in which organizing the affiliate takes place, based on discussion of the more complex cases, agreements of intervention strategies, decisions on the professional(s) who would be responsible for the case and making necessary appointments were initiated; 2) between the NASF professionals – a space essential in discussing cases, exchanging information and solutions on administrative issues, as well as planning the centers activities and work flow.

There were deficiencies relating to material resources, characterized by the lack of rooms for individual and group consultations and meetings, both in the UBS (cupboards, chairs and materials necessary for carrying out appointments, for example) and in the community area. Most workers used their own cell phones and computers and their own means or transport when making community visits.

The NASF, being a support team, depends on partnerships developed with the health care professionals which make up the EqSF for its work to be carried out, so the quality of relationships are, therefore, important. However, differences between the teams can complicate this process. One of them, when talking about service user demand, for example, said that whereas the EqSF had direct contact with the population and

had to provide care to the families in the area for which it is responsible, the NASF was only involved in more complicated cases, shared with the EqSF. Other significant differences concern the composition of the two teams, their training and their health care professionals' experience, the work dynamics, productivity required and the facility and/or difficulty each health care professional has in sharing the work.

As an example, due to the resistance of some health care professionals in the EqSF in agreeing activities with the NASF and sharing user treatment projects, together with the different forms in which work is organized in the teams, many groups that should have been developed together peter out and end up being carried out solely by health care professionals from the Centers.

Another issue concerns the limitations and the precariousness of the network of services at the various level of health care in following up care started in primary care before the establishment of the NASF. Despite the expectation that the NASF would be able to meet part of the demand, the scarce services and resources in the region complicate the possibilities of this team solving problems. Transforming the directives in the documents into practical actions is the main daily challenge for health care professionals in the NASF.

As mentioned above, aspects related to productivity are the main obstacles in developing cooperation between the NASF and ESF teams, as the parameters for each of them differ significantly. It was expected that the doctors from the EqSF would carry out around 400 appointments per month, while in the NASF the productivity parameters prioritize collective activities and have a more qualitative character. This interferes in the teams' rhythm of work, in the time available to share and in resolving the cases, among other aspects.

With regards the NASF teams, although of a more qualitative character, the instruments used to guide production do not include the complexity and specificity of the work they do.

Table. General data on the two family health care support centers studied. Sao Paulo, SP, Southeastern Brazil, 2012.

Technical composition of the teams	15 health care professionals in each NASF (doctors of various specialties such as geriatrics, psychiatry, gynecology, pediatrics, general medicine, occupational therapists, physiotherapists, psychologists, speech therapists, physical trainers and nutritionists)
Gender of the health care professionals	69.0% female
Age groups of the health care professionals	44.0% and 56.0% between 31 and 40 years old: NASF, Alfa and Beta, respectively
EqSF in question	9 NASF Alfa; 10 NASF Beta
Mean number of families for whom each EqSF is responsible	850 families and 4,500 individuals per EqSF team

NASF: *Núcleo de Apoio à Saúde da Família* – Family Health Care Support Center; EqSF: *Equipe de Saúde da Família* – Family Health Care Team

Contributions of WPD: Working to Construct a New Practice and a New Identity

The NASF teams need to build partnerships, share practices and their workspace and, simultaneously, create an identity.

“We’re changing the tire while the car is moving”

Doubts, ambiguities and difficulties pervade the implementation of this pioneering proposal. The scene of the workplace is something to be invented on a day-to-day basis, to enable the creation of spaces in which it is possible to work and construct new practices in primary care. As the work of the NASF depends directly on that of the EqSF, each initiative becomes a process of constant reaffirmation of the partnership.

The resistance found in adherence to the proposals and to developing shared actions produces two sensations: impotence and the feeling of being underused/idle, as seen in the quotes below:

“...I’m left with a feeling of impotence, of having my hands tied, of not being able to reach the cases where I am most needed...”

“...what distresses me most is having skills and not being called upon to use them.”

“...I feel underused.”

“The biggest frustration is when I offer something and there is no take up. When the EqSF want something, then we work.”

There are situations in which the experiences of distress pervade these workers and they are intrinsically connected with the lack of place in the organization, the feeling of being invisible in the eyes of those who should be their peers and even with the lack of clarity of who these peers are: the EqSfs? The partner institution who contracted them? The population or the other colleagues on the team?

This ambiguity with regards relationships, the invisibility of their work, the feeling of not having a place and not belonging, due to difficulty in their actions and contributions being recognized. Such conditions make it difficult to construct an identity.

In general, everyone tries to define a practice which sets them apart from the other health care professionals who share the same stage in the UBS. Concepts such as organizing an affiliate, supervision and coordination become confused in talking, in the role, in the professional carrying out their duty and in relation to the other professionals with whom they interact.

“(...) organizing an affiliate is seen as supervision; that’s the logic of the medical residency. The role

of the NASF would be to show other possibilities of organizing an affiliate.”

“We’re not supervisors; we’re a support center.”

The NASF health care professionals sought to establish collective strategies to face the difficulties, such as searching for cohesion among members of the team, mutual support in the day-to-day work. They thought, coordinated, promoted activities reflecting on their practice, shared among themselves the difficulties they faced with the EqSFs, with the territory, with the lack of resources.

“I feel well supported by the team, we think the same...”

However. The main strategies used by NASF teams to carry out their work and face up to the abovementioned difficulties were principally individual. Each health care professional found a way to make themselves part of the organization and carry out their work. They sought to take part in groups organized by the EqSF, “we ran after information” and to follow up shared cases, ending up working with cases which should have been referred to the secondary level, using contacts in their personal network in order to facilitate appointments with other services, etc. These solutions, although contributing to work taking place, did not constitute strategies which would advance the work of the NASF as a whole.

The challenge of “becoming” was a daily struggle for these workers. They knew what they didn’t want to be, and felt ready to contribute and fulfill their role, but they did not always achieve the necessary agreements for this to happen. They made an effort to get work, to find loopholes, establish partnership strategies, but felt frustrated as they could not achieve and contribute all that they were able to and would have liked to.

The strategies established enabled small steps to be taken, some success to be achieved, but did not always turn into possibilities to transform practice within spaces which encouraged the exercise of working smart, of using the expertise they possessed and ensuring that they occupied the space that was their due.

FINAL CONSIDERATIONS

In harmony with the public health policies in force in the country, the establishment of the NASF contributes to increasing the number and diversity of human resources available in primary health care, with the aim of developing multi- and inter-professional work, so as to increase the ability to solve the population’s health care problems. It was a pioneering proposal, which reaffirmed and sought to respond to new paradigms

in the field of health care brought about by the SUS principles and directives.^{a,b,c}

However, from the form in which the work of these health care professionals is prescribed, it is possible that it will be delineated based on the experience of real situations throughout the development of actions, as well as the expertise, previous experience and know-how of each of the health care professionals. Thus, each NASF may have different work characteristics depending on the region in which it is located, the team and the EqSF profile. On the one hand, this is positive and expected, as it enables flexibility in activities when faced with the needs of the teams and of the population. On the other, it makes it difficult to create practices, collectives and experiences which can be shared with and aggregated to the various NASFs in a particular municipality, state or even the country, impacting on the development of the program as a whole.

As a recent strategy, technological tools, in other words, organizing the affiliate and the singular therapeutic project, are new forms of organizing work and need to be consolidated. The priority of the development of shared actions, group appointments and the work of co-responsibility proposes a logic of functioning which obliges all of the health care professionals involved to change their form of behaving.

As it is a support center, its activities are inseparable from and dependent on those of the EqSF. From this stems the necessity to establish adjustments in the work processes and, subsequently, in the actions of the two teams which currently possess distinct forms of organization. There is large demand for appointments directed at the EqSF which, often, requires rapid and urgent solutions. In contrast, the work of the NASF prioritizes discussion, reflection and sharing, which requires the time and availability of all involved. This creates a mismatch between the need to meet demand, the rapid resolution of some cases and the new logic of work proposed by the NASF.

As an example, we highlight the development of groups agreed between the two teams which, eventually,

and up being carried out by the NASF team. This is significantly influenced by differences in the nature of the work of the two teams, by the parameters of productivity required and by the diverging conceptions of each health care professional on their practice.

Shared work requires, in addition to changing paradigms and revising work processes, that the health care professional is prepared to do it, even when they have no previous experience of it or academic training for it, or if they do not understand the importance. The health care professional will have to learn by doing, which takes time, availability and interest.

It is also within this new context, with uncountable challenges, that the NASF teams need to invent and consolidate their identity, even with vulnerable points of support. They have great possibilities of contributing and, thus, have created strategies to manage to show the work developed and be recognized and be truly incorporated within their potential partnership, the EqSF.⁸

Introducing changes in work, including its organization and conditions, is a commitment which needs to be permanent and to involve the various levels of the hierarchy in order to be efficient. Only in this way will solutions be arrived at which really improve work processes and quality of care provided to the population, as well as also contributing to advances in primary health care policy itself in Brazil.

CONTRIBUTORS

Lancman S. took part in conceiving the project, coordinated all stages of the development of the research, with emphasis on Work Psychodynamics in Practice and reviewed the manuscript. Gonçalves R. M. A. planned the activities and the data collection in Ergonomics and also edited the manuscript. Cordone N. G. took part in the data collection in Ergonomics and in editing the report on this methodology. Barros J. O. took part in conceiving the project, was joint coordinator of the research, participated more directly in developing Work Psychodynamics in Practice, wrote the manuscript and edited the final version.

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HIGHLIGHTS

The article analyzes the work process of health care professionals working in family health care support centers, seeking to understand characteristics of the organization, the working conditions and the experiences reported by the workers, and how such characteristics may make it more difficult to consolidate these centers in Brazil.

In general, establishing the centers has not been done systematically, with insufficient provision or training with regards the particularities of the program and the work processes, which sometimes conflict with those of the family health care teams. In this context, the experience of these workers needs to be emphasized, as it may indicate creative solutions and innovative strategies to constitute and establish these centers. The results suggest that greater participation of the workers in the center and those of the Family Health Care Teams may contribute to improving some work-related aspects such as:

- Qualification of the training processes;
- Changes to the work processes of both teams;
- Requiring shared work from health care professionals in both teams, paradigm shifts and a review of work processes, and the will to do all of this, even without previous experience, academic training or lack of understanding of its importance. The health care professional needs to learn by doing, which requires time, availability and interest;
- Adjusting the technological tools adopted, such as organizing the affiliate support center, singular therapy, which are new forms of organizing work and need, therefore, to be consolidated by both teams.

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