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THE WORK OF FAMILY HEALTH SUPPORT CENTERS FROM THE PERSPECTIVE OF WORKERS[1]

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ABSTRACT
Understanding the work process of professionals working in Family Health Support Centers (NASF) is extremely important to achieve problem-solving capacity in primary health care. Therefore, this study's aim was to identify the workers' perception concerning the work they perform. This is a qualitative study with a descriptive and exploratory approach. Data were collected using semi-structured interviews, applied to 40 NASF workers composing the teams in each of the five regional health coordination centers in the city of São Paulo, Brazil. Three core meanings emerged from the content analysis: understanding of the Family Health Strategy (FHS) teams concerning the NASF work process; understanding of the population regarding the NASF work process from the perspective of workers; and understanding of NASF workers regarding their work process. According to the workers' perceptions, the NASF workers themselves, FHS workers, or even the patients have not totally and clearly understood the NASF work process. Therefore, greater and better integration is necessary with a view to improving the quality and effectiveness of the work at this level of care.

Keywords: Primary Health Care.Family Health Strategy. Labor. Quality of Life..

INTRODUCTION

Family Care Support Centers (NASF) were established in Brazil in 2008 to support Family Health Strategy (FHS) teams by working together and developing new health care practices[1]. The NASF's purpose is to improve the problem-solving capacity of Primary Health Care (PHC) by sharing responsibility and implementingintegratedcare management, providing shared care and developing therapeutic projects jointly with FHS teams – from the enlarged clinical perspective as recommended by the National Humanization Policy. Its tools include Apoio Matricial (Matrix Support), Singular Therapeutic Project, Health Project in the Territory, and Support Pact[1,2].

NASF's proposal is still recent in the field of public policy, and even though it has innovative tools and ways to organize the work, it does not present fully established and nationally systematized work processes[3]. Although there are guiding documents and ministerial and municipal guidelines, the composition of NASF's interventions and practices is singular, depending on the population's particularities, territorial characteristics, working conditions and resources, as well as the workers' profiles, given their professional experience and background[4]. Additionally, NASF's work establishes a direct relationship with the work performed by FHS teams, and they often influence each other, interfering in the dynamics of the work performed.

NASF represents an investment in the integrality of care and the interdisciplinary nature of health actions, aiming for the consolidation of FHS; advancements in its implementation are already visible[5,6]. There are, however, numerous challenges to fully put it into operation, so that it is necessary to clarify what roles and actions are responsibilities of NASF when working together with FHS teams[7] and compare prescribed work and actual work.

The fact that the workers in FHS teams are still unaware of NASF's work process affects the continuity of the supply of specialized actions and fragments the care provided. Weaknesses pointed out by patients, such as lack of

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dissemination and clarification regarding NASF's mission, also compromise the redirection of health actions, the expansion of coverage, socialization of roles, and responsibilities of all those involved in healthcare delivery[8].

Understanding the work process of professionals who compose NASF's teams, as well as those who work with these teams and recipients of care, is extremely important to enable the integration and bonding and ensure that teams are aligned to strengthen PHC, so that NASF's work and its various forms of organization are identified, monitored and assessed.

Given the diversity and complexity of actions developed by NASF's teams, as well as the responsibilities and competences of NASF professionals, the extension and territorial differences and, moreover, a lack of studies addressing this topic, we sought to analyze the perceptions of NASF's workers from the city of São Paulo regarding the work they perform.

METHODOLOGY

This is a qualitative study of a descriptive and exploratory nature. A qualitative method was used because it is appropriate for a study addressing relationships, representations, beliefs, perceptions and opinions, resulting from interpretations of individuals regarding how they produce their material life and themselves. It is also more appropriate to investigate groups and delimited segments and to analyze resources and documents[9].

Data were collected from the professionals of one NASF team of each of the five Regional Health Coordination Centers inthe city of São Paulo, namely: East, Midwest, North, Southeast and South. The teams were randomly drawn from the PHC units enrolled in the National Registration of Health Facilities in July 2011, totaling 47 workers. Of these, seven were unable to take part in the study, either because their schedules were incompatible with that of this study's researchers or because they were on vacation during the data collection. Hence, a total of 40 workers were interviewed. Nine of them were affiliated with the East Coordination Center, seven with the North, 12 with the Midwest Coordination, six with the Southeast, and the other six with the South Coordination. The number of PHC and FHS teams supported by the NASF teams which took part in this study in each region at the time of data collection were: three PHC units and ten teams from the East Coordination, two PHC units and nine teams from the Midwest, four PHC units and 18 teams from the North, four PHC units and 17 teams from the Southeast, and three PHC and 19 teams from the South coordination.

Data were collected between August and October 2011. A semi-structured interview was especially prepared for this interview and then adapted after a pre-testhad been applied to a NASF team that did not take part in this study. The instrument was composed of general data concerning the characterization of the subjects, in addition to five questions that focused on the NASF's work process, quality of life at work, and the aspects that either facilitated or hindered daily work.

Interviews were previously scheduled by phone and individually held at the units of each of the teams; recorded and then transcribed verbatim. All participants signed free and informed consent forms in agreement with Resolution 466/12, Brazilian Council of Health.The study was approved by the Institutional Review Board at the City Health Department of São Paulo (report 214/11).

After the transcription of interviews, the empirical material was submitted to content analysis. This technique employs systematic and objective analysis procedures to describe the content of messages by using quantitative and non-quantitative indicators. Its purpose is to infer knowledge regarding the conditions of production and reception of messages[10].

RESULTS AND DISCUSSION

NASF was implemented in July 2008 at the five regional coordination centers in the city of São Paulo. In May 2011, the city already had 86 NASF teams supporting FHS teams in agreement with Decree154, from January 24th 2008, and Decree 2,488, from October 21st 2011[11].

Unlike other cities in the country in which NASF workers are hired through competition

and respond to the city health departments, FHS and NASF teams in the city of São Paulo are managed by Social Health Organizations – institutions linked to the city hall responsible for the hiring of workers as well as their training, coordination and direct supervision[12].

Of the 40 workers interviewed, 31 were women, aged 32.4 years on average. In regard to their professions, eight were physical therapists, five were occupational therapists, five speech therapists, three nutritionists, four physical educators, five psychologists, four social workers, one pharmacist, two gynecologists, one psychiatrist, one geriatric physician, and one pediatrician. Time since graduation was 8.67 years on average; 12 had a graduate degree in Public Health or Family Health and the average time working in an NASF's team was 1.81 year.

Three core meanings, related to the workers' perceptions and understanding of the work performed within NASF, emerged from content analysis: understanding of the FHS teams concerning the NASF's work process; understanding of the population concerning NASF's work process from the workers' perspectives; and understanding of NASF workers about their own work process.

Analysis of the workers' perceptions concerning NASF's work process revealed the practice of these teams. Since its implementation, NASF's work has been established and structured together with FHS teams and care has been provided to the population in the PHC sphere in the city of São Paulo according to the particularities and needs of each region.

Understanding of the family health strategy teams concerning NASF's work process

The interviewed workers reported that lack of clarity on the part of FHS teams regarding NASF's work process hinders the development of cooperative work. When, however, the FHS teams understand NASF's proposal more clearly, the work becomes easier in regard to the changes this interaction leads:

> Other workers have a hard time to understand what NASF is and what its mission is, which is not that idea of outpatientcare […]. (P4)

> [...] it's difficult when the health staff does not understand NASF's work. So, the more in tune we get regarding what it is, what we do, the easier it gets, but the less they understand our work, the more difficult it gets. (P19)

> [...] the quality, we are in a process of one year and four months, I guess we had a calmer beginning, compared with the other NASF I worked in. So, I think the teams knew what NASF was or had a better idea of it, so, it wasn't a shock when we arrived. [...] So, lack of understanding on the part of FHS teams about what NASF is makes it really difficult. (P26)

> [...] When we think that people are starting to understand how these work processes take place, we realize that people sometimes have a hard time to understand what FHS is, let alone what NASF is and the interaction between these two is difficult [...] It's difficult… it's difficult to understand the work process. The [FHS] teams already have their way to organize things and when we arrive, we change all this, so, it bothers them. (P25)

In another study addressing NASF, the authors note that the differences between NASF and FHS teams hinders the work process, especially differences regarding the composition and nature of the work of both teams, their background and experiences, work dynamics, parameters of productivity demanded, strength or weakness of each worker in sharing the work and various conceptions workers have their own practice[3].

The appropriation of NASF's proposals, such as the matrix, implies exchanging ideas and information, adjusting expectations in addition to expressing doubts, difficulties or lack of theoretical or practical knowledge, which demands workers to be available, to trust and cooperate[4]. The NASF teams addressed in this study reported that FHS professionals did not seem very available for this practice, which restricted the performance ofjoint activities.

Integration between NASF and FHS teams is essential to reveal some critical knots of the health system, based on active and efficacious interaction of different types of professional knowledge to ensure the development of a cohesive care plan[13].

The reports show that, over time, FHS teams tend to improve their understanding regarding NASF work processes and experience advancements in cooperative work. There are, however, some difficulties and even setbacks

when professionals leave these teams and new professionals are hired:

> [...]there is another situation, which is understanding the NASF's work process within the FHS, this is a second problem. Given the ambulatory rationale, it is still really difficult talk about matrix, about NASF work process… It is a change in the paradigm. Some units work well but others have a hard time if there is much turnover; it's a setback. When there's a new physician, who doesn't have experience with public health, has never worked with a NASF team, has never been in a FHS unit… So we have to start the process all over again. (P2)

> Yeah...here at NASF we're going through a nice process, I guess we're here for more than two years and I think the teams have already understood NASF work. From my point of view, they already understood the function and are already realizing it improves their work. [...] I guess that those who are new here have a bit more difficulty understanding it but then, because the teams are cohesive, even the new ones understand our role here. So, I don't see much problem like: - 'Oh, I don't know what NASF does!' I don't see it anymore, I used to see it, but not anymore [...] I no longer listen complaints like: - 'Oh, I don't know what you do or why you are here' I no longer see it.(P35)

The consequences of high turnover are generally related to the impossibility of keeping the team integrated. When the replacement of professionals is slow, there is loss of productivity, the work dynamics decreases and disrupts the standards of the care provided to patients. Additionally, recently hired workers do not always have the knowledge or skills necessary to perform their work. The most frequent causes of turnover in the health field include: dissatisfaction with the job, poor remuneration and long working hours. In some cases, we infer that professionals do not feel appreciated, which leads to dissatisfaction[14].

Understanding of the population concerning NASF's work process from the workers' perspective

The population's lack of understanding regarding the work performed by NASF, even the work performed by FHS, is another difficulty that may lead to stress and consequently affect the quality of life of workers:

> Ah, another thing that hinders the work process is… the population itself, people often don't understanding what the work is[…]. (P2)

> [...] Like you're a speech therapist, but then you do not have a room to give consultations, lines, a schedule… So, it is really stressful [...]it is difficult because people do not understand what NASF is. (P10)

> [...] it's an impediment: how patients understand what the unit is or how it should function, what the recommended model is. Today it's the model based on specialists…if I have a headache I want a neurologist… And everybody who works experiences this kind of impasse, this lack of understanding on the part of the population of what our work is. So, I guess it also affects quality of life […]. (P19)

> [...] another thing that affects my quality of life is that, unfortunately, I believe the population has not appropriated the idea of the team, of the Family Health Strategy per se. Unfortunately, it doesn't have this thing of traditional model of taking care of health, so it's difficult. Most already got it, but there's still a lot of people who did not buy this idea and sometimes you have to explain and convince people of how important it is to have an activity to prevent and promote health, that health is not synonymous with no disease, you know?! And it's difficult to convince people, so it's also tiresome. And I, as a professional, I guess it considerably affects my quality of life at work. You have to explain, you know, explain over and over …but I deal well with this, though I think it interferes in my quality of life. Sometimes I express myself a little bit but I still organize it inside my work routine. [...] if people, if patients understood the program [...]consequently it'd improve our quality of life at work. (P23)

NASF workers face various situations that lead to stress and suffering in their daily routine, such as difficulty to accept the care model proposed, lack of understanding of NASF's supporting role, and lack of preparation on the part of workers (FHS and NASF) to work in the team from an interdisciplinary perspective, which often compromises the quality of care delivery and even quality of life at work[15].

Likewise, the population, and in some cases not even the professionals themselves understand the importance of and effectiveness of actions performed in the groups – especially educational groups. This compromises NASF

work and negatively impacts the effectiveness and appreciation of health actions. Additionally, they report that the population still expects specialized curative-based care delivery:

> Adherence from the population… when people realize they won't have individual consultations but a treatment provided in groups, this is one of the greatest impediments we face. Because, for the population, attending a group consultation is not the same as individual consultations, individual consultations are better. And making them understand it… I have a group here in the unit that started with 12 people on the first day and I have this group for three months now and there're five people at most who take part in this group, those who were able to understand this view […]. (P4)

> Particularly in my case, there are some groups with children that did not work properly because of a lack of understanding on the part of the population[...] having an opportunity to provide education where you won't check heart beat, won't check bellies, is also important… and sometimes they come: --'Ah, but you didn't weight, didn't take measurements, you didn't took my child's clothes off, so this isn't a valid consultation.' [...] I guess that what gets in the way is that, all the time, we experience a total lack of understanding, on the part of the population or even on the part of the Family Health Strategy […]. (P17)

Some structural difficulties, such as lack of specialized health services, can distort the work performed by NASF, that is, NASF starts providing these services to meet the population's demands[16]. It weakens the care provided and hinders even more the understanding regarding the NASF's role to be performed together with the FHS teams.

Health promotion should be the focus of activities developed by SUS. Lack of investment in this type of action triggers a health model focused on curative actions, generating more demands and paralyzing the system. The mobilization and maintenance of these actions should be the objective of all the workers involved by sensitizing the population through dialogue and educational actions, so that the population understands and internalizes that these health activities are a right and a duty, not only of the team but of the entire community[8].

Understanding of NASF workers about their own work process

According to the interviewees, lack of understanding regarding NASF's mission and work process on the part of the professionals themselves is an important obstacle in the work routine:

> I guess that a lack of understanding regarding the proposal is a problem that makes things difficult. I guess that some people, even those within NASF, do not have a clear understanding about what the work of a matrix support team is, what multi (multidisciplinary) work is. I guess it makes things really difficult. One thing is the discourse, another thing is the practice. [...] But I think it is also related to a lack of understanding of the proposal. (P25)

The difficulty of the NASF professionals became apparent, especially during the period in which the teams were being implemented. On the one hand, the FHS teams expect an outpatient model and, on the other hand, people from the new team, even though they defend the proposal, do not understand it very well:

> When I started working in NASF, I did not know what NASF was, I guess few people knew. (P10)

> [...] we didn't have it very clear what it was and what we had to defend, we had to defend what NASF was for the teams based on the outpatient model. We had to insist: - 'No, it's not it…' But even we didn't have it very clear what it was. So, the implementation was a very difficult time. (P29)

The results also show daily effort by the professionals to defend NASF's mission considering the existing gap between the ideal and actual work, as well as in the presence of a strong immediatist and curative culture. Even years after the NASF implementation and the publication of guidelines, professionals still experience various problems due to a lack of understanding of their role in the FHS context, as well as a lack of instruments to assess and monitor the work process itself[17].

On the other hand, the fact that some professionals already have a prior experience related to the NASF work process eases the understanding of its mission, which does not follow a traditional line of care:

> [...] For instance, this is my first job within NASF. Most of the professionals work in other NASF units. So, even for me, sometimes I don't fully understand it and they come with some proposal that for me, is sort offarfetched, I have to give it sometime to understand [...] It definitely does not follow that usual line of treatment but it's valid. So, I guess that it gets in the way a little [...] (P17)

The workers' experiences are part of their personal and professional learning and are decisive in directing their view of the work, as well as the relationships established with the work and within its scope, contributing to construct its meanings[18].

Another aspect that is relevant for the development of NASF activities is the constant search for new knowledge, which facilitates the work and helps workers to better understand their role considering that formal education not always encompasses the knowledge necessary for these workers to perform in the teams:

> [...] I don't know what the current requirements are to enter NASF, whether it changed the education [of health workers] but, when I graduated, we didn't know much about the family health program, we didn't know about the work performed in the units, the supervised training I went through in the PHC unit was not related to the work I do today. (P4)

> [...] and I guess that constantly seeking knowledge is extremely important, if I don't it's difficult to work. [...] And it will be difficult if you don't know what you came for […]. (P36)

Deficient education and qualification of the health workers in the NASF teams and those from the FHS teams is one of the biggest challenges to be faced because it directly impacts the quality of care provided, whether it is public or individual care delivery[19]. Hence, changing health education and health practices is also a challenge, because it implies changing paradigms already established in teaching institutions, in the services, and in inter-professional relationships.

Dialogue and approximation in the field of practices and new understanding regarding healthcare can decrease the gap between education and the context of services, increasing the possibility to construct a new configuration of health work with greater cohesion between education and professional qualification based on quality, integrality, equity and problem-solving capacity focusing on patients[2,20].

The professional work of NASF teams can also be based on the experience of real situationsin the course of health practices, as well as on previous experience and know-how of each worker. Each team can experience particularities in its work depending on the region, on the professionals composing these teams, and the profile of the FHS teams they support. Flexibility is expected and is a positive aspect of NASF work becauseactions can be adaptedto the demand of the teams and the population. On the other hand, itmay impede the creation of practices and experiences that can be shared and aggregated to the various NASF teams in a city, state or even in the country, harming the development of the program as a whole[3].

The perception of NASF workers in this study shows thatunderstanding regarding the teams' work process is not totally clear for those involved in the routine of the health work (NASF, FHS and population). It is essential to promote changes in favor of the consolidation of the NASF work, through measures such as reflecting about the work routine among all those involved, strengthening bonds and creating opportunities for a collective dialogue among the different areas and professions that are part of the work process and care production(19), so that interdisciplinary work, so much desired by NASF workers, is actually achieved[21].

Further reflections regarding the work process that has been developed in diverse contexts and territories since the NASF implementation is necessary to support future changes in favor of the quality of the service provided to the population and the workers' quality of life.

FINAL CONSIDERATIONS

According to the workers, their own perceptions and those of the care recipients concerning the work process of the NASF and FHS teams reveal some weaknesses in regard to the understanding of NASF actions and those performed by FHS. They also showed a need for greater and better integration among those involved in health actions in the PHC scopein

order to aggregate quality and effectiveness, enhancing the work at this level of care. Only then can the work of these teams in their various forms of organization positively influence the population's health.

O TRABALHO DO NÚCLEO DE APOIO À SAÚDE DA FAMÍLIA NA PERSPECTIVA DE SEUS TRABALHADORES

RESUMO

A compreensão do processo de trabalho dos profissionais que compõem as equipes do Núcleo de Apoio à Saúde da Família (NASF) é de extrema importância para a resolubilidade na Atenção Básica, por isso esta investigação teve como objetivo analisar as percepções dos profissionais do NASF sobre o trabalho que realizam. Trata-se de um estudo qualitativo, de caráter descritivo e exploratório. Os dados foram coletados por meio de entrevista semiestruturada com 40 profissionais de equipes do NASF de cada uma das cinco Coordenadorias Regionais de Saúde do Município de São Paulo. A análise de conteúdo identificou três núcleos de sentido: a compreensão das equipes da Estratégia Saúde da Família (ESF) sobre o processo de trabalho do NASF; a compreensão da população sobre o processo de trabalho do NASF na perspectiva dos profissionais e a compreensão dos profissionais do NASF sobre seu processo de trabalho. De acordo com as percepções dos profissionais, o entendimento do processo de trabalho do NASF ainda não é totalmente claro e apropriado pelos profissionais do próprio NASF, da ESF e nempelos usuários, fazendo-se necessário uma maior e melhor integração entre eles, com vistas à qualidade e à efetividade do trabalho nesse nível de atenção.

Palabras-chave: Atenção Primária à Saúde. Estratégia de Saúde da Família. Trabalho. Qualidade de Vida.

EL TRABAJO DEL NÚCLEO DE APOYO A LA SALUD DE LA FAMILIA EN LA PERSPECTIVA DE SUS TRABAJADORES

RESUMEN

La comprensión del proceso de trabajo de los profesionales que componen los equipos del Núcleo de Apoyo a la Salud de la Familia (NASF) es de extrema importancia para la resolución en la Atención Básica, por ello esta investigación tuvo como objetivo analizar las percepciones de los profesionales del NASF sobre el trabajo que realizan. Se trata de un estudio cualitativo, de carácter descriptivo y exploratorio. Los datos fueron recolectados por medio de entrevista semiestructurada con 40 profesionales de equipos del NASF de cada una de las cinco Coordinaciones Regionales de Salud del Municipio de São Paulo. El análisis de contenido identificó tres núcleos de sentido: la comprensión de los equipos de la Estrategia Salud de la Familia (ESF) sobre el proceso de trabajo del NASF; la comprensión de la población sobre el proceso de trabajo del NASF en la perspectiva de los profesionales y la comprensión de los profesionales del NASF sobre su proceso de trabajo. De acuerdo con las percepciones de los profesionales, el entendimiento del proceso de trabajo del NASF aún no es totalmente claro y apropiado por los profesionales del propio NASF, de la ESF y tampoco por los usuarios, volviéndose necesaria una mayor y mejor integración entre ellos, con miras a la calidad y efectividad del trabajo en este nivel de atención.

Palabras clave: Atención Primaria a la Salud. Estrategia de Salud de la Familia. Trabajo. Calidad de Vida.

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