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ORIGINAL ARTICLE

CHALLENGES OF THE NURSING PROFESSIONAL IN THE FAMILY HEALTH STRATEGY: ADEPRECIATED KEY PIECE

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ABSTRACT

Objective: to know how nursing professionals describe aspects that interfere with their performance in the Family Health Strategy. **Method:** descriptive and exploratory study, with a qualitative nature, based on the Grounded Theory. Ten nurses who work in the Family Health Strategy from three municipalities in the hinterland of Bahia-Brazil participated in the interviews. The collection was conducted between August 2016 and August 2017. **Result:** the data analysis process gave rise to three categories that represent the theoretical model entitled "Challenges of the nursing professional in the Family Health Strategy: adepreciated key piece": a) The link with the Family Health Strategy, which portrays the affective involvement that the professional develops with the community and with the service; b) Many assignments; c) Little appreciation, which represents the barriers that the professional faces to work in the Family Health Strategy. **Final considerations:** work overload and professional depreciation demotivate, generate frustration andundermine the performance and the emotional health of nursing professionals who work in the Family Health Strategy.

Keywords: Family Health Strategy.Family Nurse Practitioners.Working Conditions. Primary Health Care. Job Market.

INTRODUCTION

The Family Health Strategy (FHS) is the main program for access to the Health services in Brazil. In 2019, the country showed that 62.6% of the population was covered by the program. The Northeast was the region with the highest number of accredited teams and had 81.4% of the population with assistance [1]. The importance of this service offering is undeniable, especially for the regions at greatest risk and vulnerability.

The program makes up the primary care line, but its team deals with the precarious health associated with social problems such as poverty, unemployment, violence, alcohol, drugs, lack of sanitation, poor housing and high crime rates. This fact demands from the FHS team skills that go beyond basic health knowledge. FHS has become an important means of implementing the principles of equity, integrality and resoluteness, as advocated by the Brazilian Unified Health System (SUS, as per its Portuguese acronym) [2].

The work in FHS is mainly characterized by developing prevention and health promotion actions with a focus on the family and community. In addition to the curative and health care work, the team needs to know and develop actions in accordance with the epidemiological characteristics of the territory, create a link with the community and be able to develop actions aimed at the integrality of care[3].

The nursing professional stands out in the practice of the dimension of care and for its professional competence that is essential for the effectiveness of Primary Health Care (PHC). In addition to carrying out the work with a focus on the human being, the family and the territory, the nurse articulates the dimension of care/assistance in an individual and collective way. In addition, the health care work performed by the nurse is added to other administrative roles such as coordination/management of the team and of the unit. Its multiple roles make the presence of this professional essential to the program[3].

Parallel to the efficiency of nursing work, there is a significant depreciation of its role. Nursing professionals face low wage levels, precarious employment links and lack of job security[2]. The wide range of activities performed by nurses exposes them to high workloads that can also be intensified by the poor physical and structural conditions found in some facilities[4].

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Furthermore, the current panorama of the labor market shows a mismatch between the supply of professionals and their inclusion in job posts. It is not uncommon to observe positions being made available by politicians as if they were at auction in exchange for favors. This unleashes an unfair competition for jobs. Added to this, the large supply of professionals has led to reduced salaries, tension, and concern about maintaining employment links.

In the field of labor rights, many family health nursing professionals work under provisional contracts. Therefore, they do not have any guarantee or security at work[2]. All the physical and emotional distresses associated with high workloads and professional depreciation produce direct impacts on the quality of the service provided by nurses, besides increasing the risk of illness and demotivation for the service [5].

Since this professional has great relevance for the effectiveness of FHS, it is necessary to expand the scope of information on the work dynamics of nurses working in this field. Scientific investigations that explore and underpin the theme of the experience of care and the difficulties in the service are essential to enhance the work process and the accomplishment of health care.

Accordingly, the question is: what is the nursing professionals' perception about aspects that interfere with the performance of FHS? Therefore, this study has the objective of understanding how nursing professionals describe aspects that interfere with their performance in FHS.

METHOD

Descriptive and exploratory study, with a qualitative nature, based on the Grounded Theory (GT), carried out in Family Health Units located in three cities in the Southwest of Bahia, belonging to the Microregional Health Center of Guanambí. The municipalities were: Ibiassucê, Lagoa Real and Rio do Antônio, which have 100% FHS coverage. The population is between 10,183 to 16,029 inhabitants[6]. The three selected municipalities have geographic and population similarities, and there is proximity among them, which made it easier to access the interviewees.

Nurses who worked in FHS were interviewed. Inclusion criteria were: nurses who worked in FHS and were enrolled in the National Registry of Health Facilities, with respect to the FHS unit of the selected municipality. Exclusion criteria were: professionals who worked in FHS for a period of less than six months. These criteria were applied considering that these professionals could have little experience in the studied reality. Of a total of 15 nurses enrolled in the FHS units of these cities in the period, four were considered unfit to participate according to the exclusion criteria and one nurse did not agree with the participation. The theoretical sampling was composed of ten nurses.

Data collection happened in August 2016 and August 2017 by means of interviews. The data collection instrument was composed of questions related to social and professional characterization, in addition to a script of triggering questions about the nurses' experience in FHS and aspects that contribute to drive them away from this service. A field diary was used to record the researcher's observations and impressions about informal conversations that took place during the process of approaching the collection field and the moments that preceded or followed the interview.

There was only one meeting with each participant. The interviews happened in a reserved and quiet place, chosen by the participants. The interviews lasted approximately 40 minutes, were recorded on digital media and transcribed in full for analysis. In order to preserve the nurses' identity, the letter "E" was used followed by the number that corresponded to the sequence of interviews.

The stages of data collection, analysis and categorization took place simultaneously by means of constant comparative analysis, as guided by the Grounded Theory (GT)[7]. The interviews were listened to and transcribed, and then there were data analysis and initial coding. At this stage, the interviews were carefully examined, line by line, to identify the incidents and the excerpts that deserved to be highlighted and that later gave rise to the codes. In the next step, the codes were compared to each other and grouped by similarity, in order to form the categories. During the coding process, the recording of ideas and perceptions was used, resulting in the writing of memorandums, which

were constituted by recording the researchers' observations, insights and interpretations. The memorandum makes it possible to adjust the continuity of data collection and guide the next interviews, in addition to gathering relevant information to assist in the other stages of collection, data analysis and preparation of the final text.

From the beginning of the collection to the final writing of the text, there was an exhaustive and cyclical process of analyzing and comparing incidents, codes, rereading the interviews, redefining codes, preparing memorandums, constructing categories, grouping categories and subcategories, identifying and defining central categories and performinginterpretative analysis of data (theoretical model). Several diagrams were constructed and modified several times, in an attempt to identify the best design that represented the categories of the theoretical model. The entire analysis process was constructed and validated by the two authors.

The research was authorized by the involved institutions and the project was approved by the Research Ethics Committee of the Pontifical Catholic University of Goiás (Opinion nº 1.107.155). All procedures were performed in accordance with the ethical guidelines for research with human beings, established by Resolution 466/2012 of the National Health Council.

RESULTS

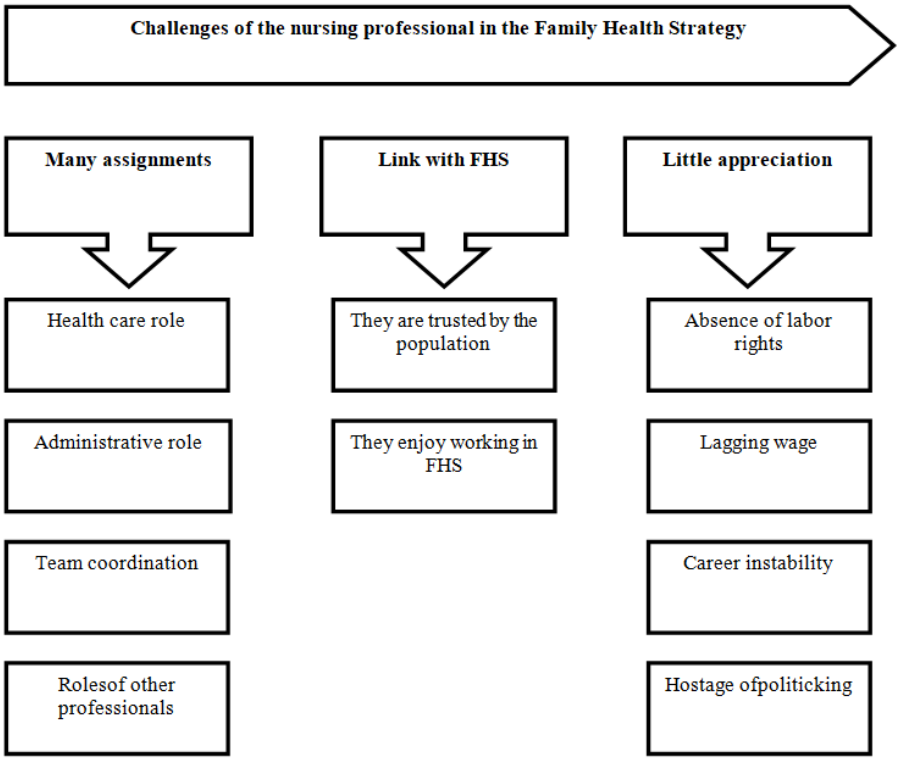

Figure 1. Theoretical model – Challenges of the nursing professional in the Family Health Strategy: adepreciated key piece.
Caption: FHS: Family Health Strategy
Source: Authors.

The theoretical sampling of this study was composed of ten nurses. The youngest was 26 years old, the oldest was 56 years old and the average age of the participants was 40.1 years. Eight nurses had provisional contractswith the municipalities, lasting from six months to one

year, and had no guarantee of labor rights (vacation, Christmas bonus salary, among others). Two did not live in the municipality where they worked, six had specialization in family health; two in other areas; and two had not obtained a specialization.

The length of experience in FHS ranged from seven months to 18 years, and three nurses had other employment link besides working in FHS. Only two were approved in a public contest and had some stability to remain in the job; however, they reported the possibility of changing careers. All ten nurses highlighted how much they appreciate and enjoy family health work. On the other hand, they showed dissatisfaction with the lack of opportunity for growth, with work overload (accumulation of roles), depreciation of the role, lack of support and highlighted uncertainties about the professional future.

The process of systematic data analysis allowed the construction of an interpretive theoretical model of the studied phenomenon, entitled "Challenges of the nursing professional in the Family Health Strategy: adepreciated key-piece". This model is represented by a diagram (Figure 1), underpinned by three categories, namely: a) Link with the Family Health Strategy; b) Many assignments; c) Little appreciation. The theory introduces the adverse reality experienced by nursing professionals in the operationalization of FHS.

The category **"Link with the Family Health Strategy"** represents the nurses' report about the link they have with the service. All interviewees express their passion for working in FHS, revealing their involvement with the service and with the target population.

> You have a link. Every patient that comes in here, you know his story. [...] We involve. We conquer a lot of people. We make friends. Myself, if I'd go to the fair on a Saturday, I'd look like a politician. Everyone knows me, it's so gratifying. [...]FHS is this link, this trust, this credibility. **(E4)**

> This link makes us get very close. It's pretty good! But it makes us work twice as hard. They have so much confidence in the nurse to the point as if it's the key piece of FHS, and calls at 8 and 10 in the evening, or at 3 in the morning [...]. Pregnant woman, for example, I give my phone number to all of them. Then, this is even a deal. Because it's a rural area, they don't know what to do. [...] but, they call you for all sorts of reasons. I'm at my house, at another job, and they call me. **(E6)**

The category **"Many assignments"** reflects the high work demands, the overload and the distresses that nurses face in the FHS service.

> I think it's a very big load for the nurse. I meant especially now, after the E-SUS forms. It overloaded both the assistance and the bureaucratic part, apart from the responsibilities. [...] I take them inside the house and fill out the sheets like this. During this very month, it was very difficult for me to deliver the production. **(E5)**

> When you face the difficulties, the charges, the overload, as I told you, we are the assistance, administration, coordination, let's say that it's much more complex [...] The responsibilities, everything that is imposed on you, and you don't have autonomy, you don't have the resources to solve it, you get stuck [...] So it's not just the bureaucratic part and our service, but it's a lot of things that influence. **(E4)**

The nurses report that, in addition to the health care role, specific to their profession, they also carry out other activities that are imposed on them in their daily work, such as: administrative roles, team coordination and, sometimes, they have the need to accomplish activities of professionals from other areas.

> That's issue of team coordination. The nurse doesn't have to be a coordinator. Due to his training, he ends up bringing it to himself and ends up being imposed by the management he hires. Why does it have to be the nurse? We do our nursing care and then the coordination comes along with everything that has to be solved in the unit. I think this ends up happening due to the large supply of professionals [...]. Because it turns out either you accept it or else you'll get fired. **(E7)**

> It's hard work, as we have a lot of obligations. Because, in addition to working in the health care part, he also works in the headship [...] All the difficulties that exist are targeted at the nurses, who have to face up to them. From the problem with the doctor and with the dentistto the cleaning of the place, we have to solve. **(E8)**

> Everything in the unit is the nurse's responsibility. I'm serving someone, and there's a knock in my room's door: "There's no water to drink, there's no more glove in that room", everything, everything [...] the employees' vacations, the doctor's schedule, everything besides the bureaucratic part, which is not slight. You arrived, and I was

> preparing the E-SUS forms for tomorrow's service. **(E4)**

The interviewees express dissatisfaction with the different treatment they receive compared to other professionals, as well as with the impositions they face, and the lack of support, which ratifies the category **"Little appreciation"** in the work environment.

> There'd also be appreciation, not only by the employees and the management, but by the population as well. We realize that the doctor is at the top and we are at the bottom. [...] It's as if the nurse were the doctor's secretary. We know things don'twork like that. We have our role. We are there side by side. You end up being depreciated. **(E7)**

> With respect todepreciation, because we know how important our role is, it is essential here in primary care. This is not seen at all. Sometimes not even by the user. It is not recognized from those who pay us to who we offer the service. **(E8)**

The little appreciation is still noticeable with the absence of labor rights. The interviewees expose the employability conditions to which they are exposed.

> I don't really have growth prospects here in the town. This is due to several factors. There's no support, we don't have any support. With respect to management, we don't have support. [...] We don't have a career plan, our wage is much lagged. We work so hard, we give our best, we work a lot, and there is no reward. **(E2)**

> We are often discouraged. We are hired. There is no vacation. We have a monthly break. [...] I feel discouraged for not having a contest, not having a wage increase, not having appreciation. I love my profession, but I already see myself straying. Working for myself [...] **(E4)**

In their complaints about the lagging wages, they report the values that have not undergone any adjustment for many years.

> In 2001, we earned two thousand seven hundred reais (Brazilian currency). It was equivalent to fifteen minimum wages. Since 2001 until today, there has been no wage increase. There was a reduction. Today, I receive two thousand five hundred in cash. That's how many minimum wages? The difference is very big. We put a child to study, but there's no way to keep it [...] **(E6)**

Professional insecurity, worsened by the precariousness of employment links and party-political influence, is also mentioned.

> You get to know the community, since you start to follow-up the pregnant woman in prenatal care, childcare, growth. Thus, you have a political position, your manager loses. You end up leaving. [...] When you adapt to that community, you like it, but you know it depends on the political issue. In a year, two years from now, nobody knows if you are [...] So, this demotivates you. **(E3)**

> Here you have a lot of political influence. The nurse doesn't have a contest in the region. There is no security. And it turns out that many professionals "drop". Today is one. Tomorrow comes another one. When the mayor "drops", the nurse "drops" too. **(E5)**

During the interview, the nurses' emotional state was observed when reporting the uncertain situation they experience. It was noticeable how much they suffer with frustration, anxiety and anguish in the face of the lack of prospects for the professional future. At times, the interviewer witnessed crying and anger stemming from the inability to change the circumstances.

> Next year, everyone has to manage their accounts. Making the unit organized because you might be quitting. Working this way is very bad. Will the professional have the motivation to prepare something this year? Since a year from now [...]What's the point? Is it going to continue? [...] Will all this work be worth it? [...] You end up getting unmotivated to do things. **(E9)**

> There is no career. There is no contest that we can do and become effective. In a small town like ours, every election year, the management changes, and all the professionals also change. This generates great frustration. It's anxiety, sadness [...] Because we hold a good job, but we know it's a job that has a deadline to start and a deadline to finish. **(E10)**

DISCUSSION

The theoretical model reveals the challenges faced by nursing professionals who, while they stand out as key players in the family health service, also face a lack of professional appreciation. The study points out a divergence between the engagement of professionals for the service and the recognition for what they do. It also reveals the dedication and involvement of nursing professionals with the practice of FHS and the importance of their work for the

community. Nevertheless, they suffer from workloads, political influence and job insecurity that do not guarantee their permanence in this career.

The work heldby nurses involves care with integrative and holistic practices that allow for a closer relationship with users. These characteristics are essential for the establishment of links with families and communities.

In this sense, the nursing professional admittedly works with empathy and humanization, understanding the uniqueness of the individual and the specificities of the context in which it is inserted. Therefore, it has an impact work on the quality of care and has a greater capacity to develop the practice aimed at the integrality of care[4,8].

Nonetheless, the excess of roles, combined with the lack of autonomy, operational conditions and problem solving increase the workload of nursing professionals[5]. In addition, the administrative and coordination activities of the team make their work excessively bureaucratic, since they are responsible for preparing lists, reports and documents to supply the unit with materials, human resources documents, productivity and data for the information systems[9].

There are elements related to the service that increase the workloads of nursing professionals. An important aspect of this overload is the fact that they develop duties of other professionals, in addition to all the roles that are imposed on them [5]. These impositions generate processes of anguish, frustration and suffering that harm the moral integrity of nurses and drive their practice away from the identity of the profession[10].

The work overload is an important obstacle for the professional to carry out the nursing consultation, the dimensions of care related to assistance and care, the planning and the implementation of the Systematization of Nursing Care in the FHS service. Therefore, there is a risk that the real role of the nursing professional may be undermined[10].

The depreciation evidenced by the research is materialized in employment contracts, which are exempt from any labor rights. Some contracts are governed by a legal entity, an arrangement used to circumvent the fiscal responsibility law and the high number of informal contracts in public services. This practice has been expanding as a result of the current political and economic situation and the labor reform. This fact directly affects nursing employability[10].

Employability is also affected by the considerable increase in nursing schools and, consequently, the number of professionals available in the market. The saturation of professionals directly influences wage decline, affects working conditions and generates professional and personal distresses[11,12].

The unequal distribution of nurses in Brazilian states requires that measures be taken by public authorities. One solution would be to direct the courses according to local realities, since there are areas with an excess of professionals and others with a shortage. It is also essential that public authorities effectively monitor and assess the quality of nursing education, especially in light of the expansion of nursing education institutions[12,13].

With respect to wage, nurses have the lowest income among higher education professionals working in FHS. This is also due to the high market demand, with a large supply of professionals, which triggers dishonorable wage practices, which harm the integrity of the worker who is very dedicated to the service.

The average income for nursing professionals working in the public sector is up to 2,000 reais (Brazilian currency) for 55.7% of servants and between 2,001 and 5,000 reais for 39.4% of workers,being that only 4.8% have higher incomes higher than 5,000 reais [13]. The low values practiced arereflected through the workload and can trigger low self-esteem and harmful consequences to health, in addition to negatively interfering with the effectiveness and quality of service results[12].

In order to reverse this situation, the Federal Council of Nursing is waiting for the approval of Bill nº 2.564/2020, which is in progress in the Brazilian Senate. The project sets the wage floor for nurses in the amount of R$7,315.00, taking into account a 30-hour workweek[14].

The lack of a wage floor means that the values and the binding of wages are based on different contracts depending on the region, city or unit where the professional works. The contracts stand out for their derisory values, divergence between working hours, provisionality, lack of institutional

links, thus generating, when possible, the search for multiple jobs to maintain a reasonable income. Nonetheless, many hours of work lead to physical and emotional distresses, which can undermine the worker's health [2,12].

The party-political influence is exacerbated in small towns, as in the current study. The hiring of professionals occurs through the indication of political supporters. This practice is not restricted to the region where the research occurred. A study carried out in the south of the country also unveils reports from nurses on the occurrence of "political sponsorship" in the choice of professionals to work in the municipality [15].

Nursing is considered core for FHS, for SUS and, consequently, for the users themselves. The context experienced by the interviewees and, possibly, by a large part of the nurses who work in small cities, especially in the North-Northeast of the country, produce negative effects on the worker's health.It should be considered the lack of motivation and the lack of career prospects as a triggering factor for the professionals to become ill [16]. Therefore, omitting nurses' labor rights and working conditions is the same as neglecting the population's health, as it is impossible to maintain quality care for the population, when the professionals themselves are underserved.

It cannot be forgotten that, despite all the scientific and technological development observed over the years, the human being is the main input of the health service. All care is involved in looking, touching, listening and trying to understand the other. Even with all the barriers they face in appreciating their profession, nurses are still at the forefront of care, as professionals who approach and commit themselves to the life and health of others, and certainly deserve to be appreciated for their service.

FINAL CONSIDERATIONS

This study highlights the need to focus on the nurses who work in FHS. The need to make investments to alleviate the precariousness of service contracts, respect labor rights and consolidate means that promote the retention of professionals is evident, as a condition to expand the link with the community, a fundamental aspect for the fulfillment of the role of FHS.

Certainly, when one thinks about the improvement and quality of the population's health and the commitment to the Brazilian health system, one cannot neglect the service conditions, the compatible working hours and the dignified salary floor for those professionals who are directly responsible for the continuous and direct contact with all the users of the Brazilian health service.

DESAFIOS DO PROFISSIONAL DE ENFERMAGEM DA ESTRATÉGIA DE SAÚDE DA FAMÍLIA: PEÇA-CHAVE NÃO VALORIZADA

RESUMO

Objetivo: conhecer como profissionais de enfermagem descrevem aspectos que interferem em sua atuação na Estratégia de Saúde da Família. **Método:** estudo descritivo, exploratório de cunho qualitativo com aporte na Teoria Fundamentada nos Dados. Participaram das entrevistas dez enfermeiras que atuam na Estratégia de Saúde da Família de três municípios do interior da Bahia-Brasil. A coleta foi realizada entre agosto de 2016 e agosto de 2017. **Resultado**: do processo de análise dos dados, emergiram três categorias que representam o modelo teórico intitulado "Desafios do profissional de enfermagem da Estratégia de Saúde da Família: peça-chave não valorizada": a) O vínculo com a Estratégia de Saúde da Família, que retrata o envolvimento afetivo que o profissional desenvolve com a comunidadee como serviço; b) Muitas atribuições; c) Pouca valorização, que representaasbarreirasque o profissional enfrenta para a atuação na Estratégia de Saúde da Família. **Considerações finais**: o excesso de trabalho e a desvalorização profissional desmotivam, geram frustração, comprometem a atuação e saúde emocional dos profissionais de enfermagem que atuam na Estratégia de Saúde da Família.

Palavras-chave: Estratégia de saúde da familia. Enfermagem de saúde da familia. Condições de trabalho. Atenção primária à saúde. Mercado de trabalho.

DESAFÍOS DEL PROFESIONAL DE ENFERMERÍA DE LA ESTRATEGIA SALUD DE LA FAMILIA: PIEZA CLAVE NO VALORADA

RESUMEN

Objetivo: conocer cómo profesionales de enfermería describen aspectos que interfieren en su actuación en la Estrategia Salud de la Familia. **Método**: estudio descriptivo, exploratorio con enfoque cualitativo y aporte en la Teoría

Fundamentada en los Datos. Participaron de las entrevistas diez enfermeras que actúan en la Estrategia Salud de la Familia de tres municipios del interior de Bahía-Brasil. La recolección fue realizada entre agosto de 2016 y agosto de 2017. **Resultado**: del proceso de análisis de los datos, surgieron tres categorías que representan el modelo teórico titulado "Desafíos del profesional de enfermería de la Estrategia Salud de la Familia: pieza clave no valorada": a) El vínculo con la Estrategia Salud de la Familia, que retrata el envolvimiento afectivo que el profesional desarrolla con la comunidad y con el servicio; b) Muchas atribuciones; c) Poca valoración, que representa las barreras que el profesional enfrenta para la actuación en la Estrategia Salud de la Familia. **Consideraciones finales**: el exceso de trabajo y la desvalorización profesional desmotivan, generan frustración, comprometen la actuación y salud emocional de los profesionales de enfermería que actúan en la Estrategia Salud de la Familia.

Palabras clave: Estrategia salud de la familia. Enfermería salud de la familia. Condiciones laborales. Atención primaria de salud. Mercado laboral.

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