Skills and competencies among workers in the Family Health Strategy

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ABSTRACT

This article focuses on the interdisciplinary work developed in the scope of the Family Health Strategy in the city of Fortaleza, Northeastern Brazil. It aims to understand the perceptions of health workers about the positions held by different professional categories within this proposal for primary health care. The study is based on a qualitative approach, using in depth interviews. Eighteen interviews were conducted with doctors, nurses and community health agents. The analysis of the empirical material followed the procedures of *thematic analysis*. The results showed the existence of different degrees of familiarity among the employees concerning job skills and competencies. The cognitive, procedural and attitudinal dimensions stand out with more or less expressiveness, showing the *place* occupied by each of the categories and the relationships vertically established among them according to control over professional knowledge and action.

Key-words: primary health care; professional competence, human resource training; qualitative research; public health.

Introduction

The present paper approaches the interdisciplinary work developed in the scope of *Estratégia Saúde da Família* (ESF – Family Health Strategy) in the Municipality of Fortaleza, State of Ceará (Northeast of Brazil). It aims to understand the perceptions of workers involved in the daily routine of the practices, concerning the places occupied by different professional categories in this primary healthcare proposal.
The Family Health Strategy was created in Brazil in 1994 as PSF – *Programa Saúde da Família* (Family Health Program), in an attempt to contribute to the consolidation of *Sistema Único de Saúde* (SUS – National Health System), through the strengthening of primary healthcare. Its appropriation as a strategy, with the purpose of transcending the restricted and electioneering notion attributed to the program category, started in 1997, when the Ministry of Health mentioned its outstanding role in the reorientation of the care model (Brasil, 1997; Fraiz, 2007).

In fact, from this benchmark the Family Health Strategy started to be seen as being responsible for the development and application of proposals referring to working process organization and healthcare. The aim was to overcome the eminently curative care practices leveraged by the Privatizing Medical Care Model (Paim, 2003).
In short, the Family Health Strategy would be responsible for enabling SUS as a plural care model, whose emphasis would be on health promotion, with the objective of altering the large spontaneous demand for health actions and services through the organization and control of this demand.
To carry out such a complex task, it would be indispensable to perform, in healthcare production, countless transformations. Among these, we highlight the health action approach targeted at the family and its context, which demands an interdisciplinary view and action (Fraiz, 2007).
According to the Ministry of Health (Brasil, 2011), "this conception overcomes the former proposition that was exclusively centered on disease, and it is developed by means of managerial and sanitary practices, democratic and participatory, **in the form of teamwork**, targeted at the populations of delimited territories, for which they are responsible" [our emphasis][1].
It is important to highlight that the daily healthcare production depends, to a great extent, on the health workers' competencies, as well as on the degree of interaction among the many professional identities within the Family Health Strategy (Silva, Félix, 2007). This set of attributes that is desirable in health workers is called *competencies* and *skills* in the National Curriculum Guidelines for Health Courses (Brasil, 2001).
The competencies that the health professionals should have can be circumscribed to three dimensions (Saupe et al., 2007; Silva, Felix, 2007): knowledge (knowing); skills (know-how); and attitudes (knowing how to be and coexist/wanting to do). In addition, it is possible to identify, in these dimensions, clinical and non-clinical competencies (Silva, Tanaka, 1999).
The entry *competency* is defined in Ferreira (2009) as the "quality of those who are capable of appraising and solving a certain matter, doing a certain thing; capacity, ability, capability, suitability". To Perrenoud (1999, p. 7), it means "a capacity of acting efficiently in a certain kind of situation, supported by knowledge, but without being limited to it". The author also states that, "to face a situation in the best possible way, one must, generally speaking, use, in synergy, many complementary *cognitive resources*, and knowledge is one of them."
In the field of health education and work, competencies are resources demanded from workers, materialized through knowledge, abilities and attitudes indispensable for the consolidation of the National Health System and Family Health Strategy (Saupe et al., 2007), and understood as a set of technical and social processes.
We understand that the several professional identities that interact in the Family Health Strategy, if horizontally organized and articulated, can act synergistically and see the social and psychoaffective context of the health histories of individuals and families (Silva, Félix, 2007), extending the resolution potential of primary care to closer levels than what is announced (Fraiz, 2007).
This expectation, in relation to the human processes that are established in health work and which is reiterated in the official documents, invariably takes us to the discussion about the hierarchy of knowledge and powers in the daily routine of practices and care. However, despite its importance, the scientific production concerning this theme is still scarce, signaling a gap that needs to be filled, so as to identify the intensity of the advance or permanence registered in these relations and, consequently, to produce answers that contribute to overcome the lacunas that still remain between theory and practice in the daily routine of the health services.

Methodological Course

In view of the diversity of lines that characterize the qualitative tradition (Tesch, 1995; Denzin, Lincoln, 2006), this investigation is aligned with the critical-interpretative focus, as it considers

[1] All quotations were translated into English for the purposes of this paper.

subjectivity in the interface with the materiality to which it is linked, dialectically. In other words, this conjunction enables the construction of a critical reflection on the object with the intention of subsidizing intervention actions, understanding research as a transforming process in the sense of amplifying the comprehension horizons of the involved players.

The observation space of this study is the Municipality of Fortaleza, the capital city of the State of Ceará, Northeastern Brazil, due to the significant amplification of the Family Health Teams and of the coverage of the Family Health Strategy, and to the incorporation of a set of actions targeted at the effective alteration in the care model, which has been observed from 2006 onwards.

The population of the municipality of Fortaleza is estimated at 2,458,545 inhabitants. The municipality is politically-administratively subdivided into six *Secretarias Executivas Regionais* (SER – Regional Executive Departments), which are responsible for the operationalization of the government's public policies. Six Health Districts that assist the population that lives in 84 neighborhoods are included in the SERs (Fortaleza, 2007). Primary Healthcare is constituted of 304 Family Health Teams, distributed over 87 Family Health Centers (Fortaleza, 2011).

The study involved doctors, nurses and community health agents who were members of the Family Health Teams. The non-inclusion of the category of dentists is justified by the fact that, on the occasion of the elaboration of the project to which this research is linked, the amplified team – which included the oral health workers – had not been instituted yet in the Family Health Teams in the above-mentioned Municipality.

Thus, the professional categories included in this study belong to the minimum team established by the Ministry of Health to the Family Health Teams. The category of nursing assistant was not included in the scope of this work. Professionals of those categories who, at the moment of the interview, had been working in this model for a period equal to or above six months, were invited to participate in the research, in order to enable a subjective accumulation capable of promoting the understanding of the object delimited for study.

In the qualitative tradition, the numerical validation of the sample so as to enable the generalization of the findings is not relevant (Triviños, 1987; Patton, 1987; Minayo, 1998). Therefore, its selection was intentional, as it is usually the case in qualitative research (Coyne, 1997), in line with the proposal for theoretical sampling, defined by Strauss and Corbin (2008, p. 195) in the sense of "making categories dense in terms of their properties and dimensions".

Devoid of probabilistic logic, the sample was dimensioned so as to enable "... *exhaustion*, that is, the recurrence of categories in the collected material" (Bosi, 1996, p. 30), or else *theoretical saturation* (Strauss, Corbin, 2008; Fontanella, Ricas, Turato, 2008), which proposes data collection until all categories are *saturated*, and the subsequent in-depth understanding of the subjective production that emerges in the relation with the investigated groups/actors is achieved.

To collect the informants' narratives, individual interviews were performed, and the content was recorded after their consent. In a subsequent moment, these interviews were transcribed. According to the principle of non-directiveness (Thiollent, 2008), the instrument used to obtain the material was a flexible guiding script containing some open questions, which were opportunely unfolded into new questions, based on the content that emerged from the interviewees' discourses. The questions asked their free speech about the proposal and their work in the Family Health Strategy, approaching aspects such as feelings, experiences, relationship with users and with other workers.

The workers were invited to participate through free informed adhesion and, subsequently, they were interviewed at their workplace. The interviews – a total of 18 – lasted, on average, 30 minutes. The transcriptions were made under the supervision of the researchers themselves, right after the collection of the empirical material.

After the transcription, the empirical material was submitted to transversal and horizontal reading, so as to allow impregnation with the meaning of the "whole" of each testimony, as well as the identification of the *central themes* and *dimensions* that are present in the narratives and that constitute the *signification axes* of the conducted analysis, as proposed in the *thematic analysis*

approach (Pope, Ziebland, Mays, 2009).
This process began with the compilation of the information or categories by themes, taking care so that all the manifestations about the themes that were found were included. From this initial stage, of a more descriptive nature, we moved on to the analysis of interconnections between the themes and dimensions and, afterwards, to the process of interpretation of the meanings of the discourses, that is, to the construction of the "network of meanings" (Bosi et al., 2010). The analytical categories were not, therefore, established *a priori*; they were constructed from the discourses that emerged in the empirical material.

In the end, we analyzed comparatively the correspondences and discrepancies of the discourses produced by the social players of the different professional categories that compose the researched universe, relating them to singularities and/or specific historical conditions.

Results and Discussion

The resource adopted to display the results consists of the presentation of the most evocative discourses, which are reiterated in almost all testimonies. The discourses were codified according to the group to which his/her author belongs. In this sense, the following codes were used: N = nurse; D = doctor; CHA = community health agent.

Among the interviewed *doctors*, we highlight the **fluency** with which the doctrinal principles that guide the strategy are present in their discourses, when they were requested to talk about it.

> "It's a different view, it's a view in which we work within equity, diversity, integrality, longitudinal access". (D1)
> "The Family Health Program basically consists of a follow-up through the longitudinality system and also through the principle of universality and equity. Taking care to favor those who are least favored…" (D3).

In the *nurses'* narratives, the organizational or **operational** aspects deriving from the implementation of the strategy in the Municipality emerge more sharply when compared to the theoretical or conceptual dimension regarding the SUS and ESF. Concerning these themes, it was observed that the mention to the principles is devoid of a concern about pretending to have knowledge or understanding. On the other hand, their familiarity with the description of the operationalization of the actions is unequivocal.

> "It's very good because that stuff of working at the office every day, just assisting people, prescribing, also tires out; and this is good about PSF: there are lots of different things and it's not always the same stuff and we **can do** this" (N1).
> "Here we work basically with elderly people, and the highest incidence is of hypertension and diabetes. We work with childcare and pediatrics up to five years of age, we work with women in childbearing age in family planning, in the prevention of gynecologic cancer. We also hold groups, provide prenatal assistance. I think that it is basically this, the programs codified by the PSF and educational groups" (N1b).

It is remarkable the understanding of the proposal of the Family Health Strategy in the two interviewed professional categories. However, the predominance of one of the resources of the competencies – *knowledge*, represented by the concern about giving visibility to the *theoretical dimension* of the proposal, through the use of the technical-scientific terms that are present in the official texts - prevails in the doctors' discourse. The dimension of *knowledge* is defined by Saupe et al. (2007, p. 656) as the "set of contents obtained predominantly by means of exposition, reading

and critical re-elaboration, which gives to the professional the cognitive control of knowledge and the capacity to make decisions and solve problems in his/her working area".
"Doctors have a good level of knowledge, but they come with difficulties in applying these other things" (D1).

On the other hand, among nurses, it is clear the understanding of the proposal based on the implications of this new reference in the healthcare practices, that is, in the field of skills – the *know-how*, as the principles that guide the proposal and the most employed technical terms in its characterization are not highlighted. The skills (Saupe et al., 2007, p. 656):

> "represent the know-how of the psychomotor dimension and are indicated by the 'set of acquired practices, mainly through demonstration, repetition and critical re-elaboration, which provide the professional with the psychomotor dimension, the expertise of knowing how to do something and the capacity to make decisions and solve questions in his/her working field'".

The testimonies of the Community Health Agents (CHA) demand a particular reading, as it is a category that does not need an institutionalized professionalizing education. In this sense, we were surprised by the fact that this category was the only one that mentioned the need of 'looking at health in a new way' and 'working in the health area in another way', suggesting not only the knowledge of theoretical presuppositions that support the proposal, but also the *commitment* to aspects like health promotion and the philosophical principles of the SUS, thus revealing an amplified understanding of health.

> "I think that the PSF is a very important program because in it you assist that community **already with another way of looking at it**" (CHA1)
> "I didn't understand very well how the Family Health Program was, but as time passes by you gradually see how it happens, you see that **it's another way of working in the health area**. I see this, people are used to having curative health: they come, receive assistance, return and the doctor doesn't know the patient's name, the patient doesn't know the doctor's name and goes away …" (CHA5).

These discourses reveal a change in the way these professionals view the user and a change of attitude regarding the user and their health needs. *The attitudes*:

> "represent knowing how to be and how to coexist - affective dimension - and encompass the 'set of behaviors acquired by means of observation, introjection and critical re-elaboration that provide the professional with the ethical and affective dimension of knowing how to be and knowing how to coexist, besides the capacity to make decisions and solve problems in their working area'" (Saupe et al., 2007, p. 656).

In short, while the medical discourse reveals its correspondence with the cognitive dimension – knowing -, we have, among the nurses, the understanding of the proposal based on the skills – doing – and, among the CHA, whose identity is built in the daily routine of the work, the attitudinal dimension is valued – being and coexisting.
The fact that the different resources that involve the competencies are not present with the same intensity in the discourse of the professional categories that participated in this study does not necessarily mean that they are completely absent; however, it reveals the existence of a hierarchy of values that is internally similar – as it is shared by the members – and externally differentiated – as one recognizes the specificity and interdependence between the valuation codes and the social construction of each one of them.

Based on this premise, we believe it is pertinent to propose the reflection on how such dimensions – knowing, doing and *wanting to do* – have been approached in the education process.
To achieve this, we revisit a discussion that we initiated before (Bosi, Uchimura, 2007) about the values that are present in health education: although knowledge is approached, what can we say about the skills and attitudes, as important as the cognitive dimension for the consolidation of the plural assistance model? For this reason, we reiterate, now in a contextualized way, the following issue (Bosi, Uchimura, 2007), which unequivocally takes us to questioning health education: how can we transform the system, attempting to make it be what we are not yet?
Illustrative of this situation are the narratives that point to the frail influence of the medical education process on the choice of the working area:

> "After we left university [...] they were beginning to change the curriculum to focus more on primary care. Yes, and now the course lasts six months more […]. For my part it was my interest, I came from a less favored family that had problems with assistance and is more attentive to this area. This was what made me choose this area, not the university". (D2a)

Furthermore, education did not offer the adequate technical preparation to work in primary care:

> "Then, five years go by without studying anything. Without studying anything, without going to the healthcare unit. Then, in the last year, we spent one month in the healthcare unit. It's too little in view of the need; not to mention the fact that the majority of graduates, in one way or the other, end up going to a PSF, end up going to primary care, at least initially. And many times they go unprepared, because their education was not for primary care, it was for secondary and tertiary care. This is changing now, which is good". (D2b)

> "Because when we complete the medicine course – and it's not different today – we're not prepared to work here. [...] because the practical part we only learn with the daily routine. Thus, internship, either in the family health program or in any other area, I think it's important so that you have safety in what you're really going to do". (D4)

To effectively change the assistance model, education assumes, evidently, a very important position. And, about medical education, Feuerwerker (2002, p. 1) states:

> It is possible to say that there is almost a social requirement for the educational process to change so that different doctors are produced. Doctors with general education, **capable of providing integral and humanized care for people, who work in teams, who know how to make decisions taking into account** not only the individual clinical situation, but the context in which patients live, the available resources, and the most effective measures (our emphasis).

Freidson (1998) defends that the analysis of the consolidation of competencies, in the service of the professionalization of a given professional category, requires recognizing the relations between specific competencies and their expressions in the history of this same category, as an indispensable condition to the definition of its social identity. Based on this premise, we recovered some elements of the history of the formation of these two professional categories that work in the health area.
In the history of medical education, the traditional modality of teaching has predominated, based on knowledge transmission, on the teacher's experience and on the valuation of content *to the detriment of the formation of values* (Feuerwerker, 2002). Not by chance, as such education has been strongly conditioned by the economic and political macrostructures, by the understanding of health-disease and of health needs, by the organization of the health services and policies and,

particularly, by medical practice, although the educational schools have, to a certain extent, freedom concerning their functioning (Feuerwerker, 2002).

In a recently published document, the Pan-American Health Organization (2008) points to the main problems of medical education in the American countries, among which we highlight: graduates' **scarce knowledge and skills for handling primary care**; emphasis on the biological model; **centralization of the** learning **practices on hospitals**; **absence** of a focus on **health promotion** and disease prevention in the individual, familiar and community levels since the first years of education; and **lack of an integral education** in the technical and humanist perspectives.

Concerning the route adopted by Nursing towards its professionalization, the advance of the occupational practice to this professional category was supported by an effort of image improvement, so as to achieve recognition, by means of investment in academic education or in the cognitive dimension (De Domenico and Ide, 2006).

In fact, the history of Nursing education – and of other health occupations – in Brazil reveals contours that are similar to those presented by medical education, as, in its origin, the teaching of Nursing was influenced by the Hospital-Centered Model, oriented by the market demands that were present at that time. Up to 1972, all changes to the minimum curriculum of nursing favored the medical-hospital model (Ito et al., 2006).

In a study about the nurse's competencies based on technicians' and teachers' perceptions, De Domenico and Ide (2006, p. 399) found a similar result. They argue that "competencies referred to as of daily exercise did not translate all the dimensions of the professional exercise that are desired by the guidelines for the graduate's education…". In this context, it is remarkable that the technical-scientific competencies emerged more prominently in actions of curative nature, associated with prescriptive **action**.

Transposing the reflection to another domain beyond education, the work division among the categories inside the teams also influences this differentiation of positions occupied within the Family Health Strategy.

Some doctors mentioned that the integration and the feeling of belonging to the team result from receptiveness initiatives of one category by another (or others). In these discourses, the statement about accepting *the other* and being accepted *by the other* assumes special relevance in the constitution of teamwork:

> "And, from the group here, we brought the nursing assistant who was only in the unit and she is participating and it has been excellent, she is satisfied, **she is feeling that she is part of the team**. And the community agents, **I showed them that they are important**, that they are the ones who are in contact with the patients, they are the ones who make the beginning, explain the age, make the invitations to return. So, the entire team is working – the doctor, the nurse, the assistant and the community agent". (D1)

> "Family Health through the network is teamwork, if there is no teamwork it is difficult, so **there must be a good interaction** between doctor and nurse, mainly between doctor and nurse (…). Mainly the doctor and the nurse, they must be united, they must have the same ideal, work together with the global view of the patient, and the team should make all the decisions together, the strategies, how to act preventively in the community, investigating what risks that community, that area has been facing". (D6)

The fragment below confirms the importance of acceptance and mutual respect, so that teamwork can be considered good or productive:

> "I think that at the moment I work with a good team, I think we speak the same language, so it is easy. **I particularly don't have anything to say, we have the team's support, we have the**

> **doctor's support, have the nurse's support. They have our support too**. So, I think that each one works as if each one has a function, but a function that depends on the others". (CHA. 2)

On the other hand, those same discourses (of doctors) authorize us to suppose that there is the recognition of an alleged technical superiority or simply of a distinct relevance that would favor some categories that integrate the teams to the detriment of others. This (unofficial) technical hierarchy among the team members is pointed as an obstacle for nurses; on the other hand, the **technical autonomy** that becomes viable and the greater recognition of its importance, in public health, are reasons to celebrate:

> "Well, nursing is something that has advanced a lot nowadays. We know that it has been crawling little by little, and with PSF, thank God our autonomy has increased a lot" (N3).

> "We have the opportunity to act with more autonomy, we assist children in childcare. I feel great working in the family health program because I think it's a program that satisfies the nurse because she can act with more autonomy, it's a multidisciplinary work, it's teamwork, but we feel more at ease to work". (N5)

According to Bosi (1996, p. 51), "autonomy (…) represents the capacity to evaluate and control the development of work. It is in this that lies the essence of professionalism." And she complements: "The concept of *autonomy*, in Freidson, is intrinsically connected with the knowledge dimension, with **knowing**, as it expresses a legitimated technical competence" (our emphasis).

This notion of technical superiority of one category in relation to the others, in the field of health, has its roots in the Privatizing Medical-Assistance Model. It is this way of *working with health* that the construction of SUS intends to overcome, carried out through the Family Health Strategy (Brasil, 1997).

In that perspective - curative -, any technical act in health – except for immunizations – would only begin with disease, which evidently puts the doctor in a central position, as every therapeutic action derived and still derives, necessarily, from a clinical diagnosis – a medical prerogative. Nevertheless, the Family Health Strategy aims at contributing to alter the assistance model, prioritizing, together with curative actions, health promotion actions. And not by chance, because the Pan-American Health Organization (2008, p. 8) recognizes that Primary Care "continues to be the main and most effective strategy to promote health and achieve the highest possible level of health to each person". Invariably, this change in focus – health instead of disease – alters the power relations that had been previously instituted.

We understand that it is important to establish new relations among health professionals, based on interdisciplinarity and not only on multidisciplinarity, so as to build new ways of care production that question the "professional certainties" instituted by the biomedical model (Saupe et al., 2005).

In fact, interdisciplinaity – discussed in Vilela and Mendes (2003) as the need to overcome knowledge fragmentation, aiming at knowledge unity – leads to the need to transform the forms of relation that had been previously instituted, which is presented to us as a huge challenge to be transposed because, as Assunção (2005) argues, when proposing the inseparability between interdisciplinarity and intersubjectivity, there is no way of escaping from this encounter, from this interaction between different professional identities that have been historically constructed.

Nevertheless, recognizing that all health workers "provide care and operate sanitary practices", which constitute a common nucleus to be generated by the specificities of each background, the movement of change of this relation, from verticality to horizontality, may also make the technical action become closer to users' universe and logic (Merhy, 2007).

Final Remarks

This study enabled us to identify the existence of different degrees of familiarity, among health professionals, with professional competencies and skills. In this perspective, the cognitive dimension (knowledge), the procedural dimension (know-how) and the attitudinal dimension (wanting to do) emerge with more or less significance in each one of the professional categories considered in the scope of this study, denoting the *place* occupied by each one of them and the relations vertically established according to the control over professional knowledge and action.
In fact, the institution of such **places** or spaces obeys the dynamics of the history of the organization and professionalization of each one of these categories, inherent in the social and technical division of work and in the evolution of the health policies in our society and, consequently, in the evolution of the health education process in the Western world.
So that interdisciplinarity can be materialized in the health practices, it demands other relation forms that are distant from the power hierarchy instituted by curative assistance models; and new **places** for the diverse categories that work in the health filed, which nowadays are much more diversified and numerous than those considered in the scope of this study.
Therefore, we support the need to create conditions, in the education process, for integrative and interdisciplinary experiences, so that differentiated **knowledge** and **actions** are present in the process of the student's connection with a certain professional identity, aiming not to associate it with only one **category** or professional corporation, but with a *field* of knowledge and practices, focusing on meeting social needs and demands, especially those that emerge in the health scope.

Collaborators

Kátia Y. Uchimura and Maria Lucia M. Bosi worked together in the study's conception and design and in the analysis and interpretation of the empirical material. Kátia Y. Uchimura wrote the paper and Maria Lucia M. Bosi revised it critically and approved the version to be published.

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