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POTENTIALITIES AND CHALLENGES FOR CARE IN THE PRIMARY HEALTH CARE CONTEXT

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ABSTRACT

Objective: to understand the potentialities and challenges for the care provided by professionals in the primary health care context.
Method: a qualitative research study of the participatory action type, based on Paulo Freire's Research Itinerary, which consists of Thematic Investigation; Coding and Decoding; and Critical Unveiling. It was developed in the first half of 2021, with the participation of 20 professionals, including physicians, nurses, dentists, nursing technicians, dental assistants and community agents, all from a Basic Health Unit in Santa Catarina.
Results: the health professionals revealed the team's engagement as potentialities, as well as welcoming, which strengthens interpersonal relationships in Primary Care. As challenges, they highlighted the limited professional appreciation and scarce material and human resources, factors that generate tensions for the assistance to be provided.
Conclusion: engagement and interpersonal relationships reveal the professionals' commitment and dedication to promoting comprehensive and good quality care, seeking to overcome the limitations inherent to assistance in Primary Health Care.

DESCRIPTORS: Health promotion. Health. Primary health care. Health professionals. Welcoming.

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POTENCIALIDADES E DESAFIOS PARA A ASSISTÊNCIA NO CONTEXTO DA ATENÇÃO PRIMÁRIA À SAÚDE

RESUMO

Objetivo: compreender as potencialidades e desafios para a assistência desenvolvida pelos profissionais no contexto da atenção primária à saúde.
Método: pesquisa qualitativa, do tipo ação participante, fundamentada no Itinerário de Pesquisa de Paulo Freire, que consiste de Investigação Temática; Codificação e Descodificação; e, Desvelamento Crítico. Foi desenvolvida no primeiro semestre de 2021, com a participação de 20 profissionais, entre médico, enfermeiro, odontólogo, técnico de enfermagem, auxiliar de consultório dentário e agente comunitário, todos de uma Unidade Básica de Saúde de Santa Catarina.
Resultados: os profissionais de saúde desvelaram como potencialidades o engajamento da equipe, assim como o acolhimento que fortalece as relações interpessoais na atenção primária. Como desafios ressaltaram a limitada valorização profissional e parcos recursos materiais e humanos, fatores esses que geram tensionamentos para a assistência.
Conclusão: o engajamento e a relação interpessoal revelam o comprometimento e dedicação dos profissionais em promover uma atenção integral e de qualidade, buscando suprir as limitações da assistência na atenção primária à saúde.

DESCRITORES: Promoção da saúde. Saúde. Atenção primária à saúde. Profissionais de saúde. Acolhimento.

POTENCIALIDADES Y DESAFÍOS PARA LA ASISTENCIA EN EL CONTEXTO DE LA ATENCIÓN PRIMARIA DE LA SALUD

RESUMEN

Objetivo: comprender las potencialidades y los desafíos para la asistencia desarrollada por los profesionales en el contexto de la Atención Primaria de la Salud.
Método: investigación cualitativa y del tipo acción participante, fundamentada en el Itinerario de Investigación de Paulo Freire, que consiste en Investigación Temática; Codificación y Decodificación; y Revelación Crítica. Se desarrolló en el primer semestre de 2021 con la participación de 20 profesionales, entre médicos, enfermeros, odontólogos, técnicos de Enfermería, auxiliares de consultorio dental y agentes comunitarios, todos de una Unidad Básica de Salud de Santa Catarina.
Resultados: los profesionales de la salud indicaron lo siguiente como potencialidades: compromiso del equipo, al igual que la recepción, que fortalece las relaciones interpersonales en la Atención Primaria. Como desafíos, destacaron la limitada valorización profesional y escasos recursos materiales y humanos, factores que generan tensiones sobre la asistencia.
Conclusión: el compromiso y las relaciones interpersonales revelan la dedicación de los profesionales por promover una atención integral y de buena calidad, procurando suplir las limitaciones de la asistencia provista en la Atención Primaria de la Salud.

DESCRIPTORES: Promoción de la salud. Salud. Atención primaria de la salud. Profesionales de la salud. Recepción.

INTRODUCTION

Since the 1970s, starting in Alma-Ata, the importance of Primary Health Care (PHC) as a central element in the organization of systems aimed at promoting universal health has been pointed out. The greater importance of PHC for guaranteeing access to health services in developing countries is highlighted[1]. The PHC principles are strongly related to health promotion and presuppose the indissociability between health and social development to address social inequalities, democratize social participation and guarantee universal access to a network of health care services. It is a space of paramount importance for the development of healthy promotion practices aimed at community engagement and public policies, in order to modify the social determinants of health, contributing to combat inequalities[2–4].

The direction of PHC assumes the organization of actions, having the following as attributes: first contact of the user; longitudinality; comprehensive care; and community guidance. The Brazilian PHC was organized through the Family Health Strategy (*Estratégia Saúde da Família*, ESF) and Primary Care teams (*equipes de Atenção Básica*, eABs), which plan and execute actions within an assigned territory, together with the population living in this delimited area.

In this sense, a strategy to improve performance and problem-solving ability is to expand welcoming as a practice to improve health work. Welcoming makes it possible to receive the demand of health and disease situations in a given region. As PHC represents the population's gateway to health services, it is fundamental to promote welcoming assistance in order to reduce inequalities and provide comprehensive care. Welcoming provokes the challenge of guaranteeing comprehensive care, requiring actions that allow for the social participation of the actors involved[5].

The PHC context is a viable way to build a new health care model. Experiences and innovations in PHC, such as the articulation of interdisciplinary knowledge in individual and collective assistance, the social determination approach in the health-disease process, intersectoral actions, community participation and strengthening of bonds, can bring about changes and contribute to the reorganization of health systems. The challenges for the development of healthy practices are enormous, mainly regarding the determinants of health and the focus on its promotion[6–7].

Problems and challenges faced by the PHC teams are related to medical care centralization, bureaucratization translated by restricted hours that impair the access of users who work during the opening hours of the health units, low communicative intention/competence of administrative professionals working in the receptions, as well as poor command of communication and information technologies for administrative purposes[3,8]. In addition to that, the difficulties carrying out intersectoral actions are highlighted, as well as the dialogue between professionals for joint action between the e-NASF and the family health team[5]. Certainly, the changes resulting from the National Primary Care Policy exert an even greater impact on the health care provided by the teams. In view of the relevance of the topic presented, the question is as follows: which are the potentialities and challenges for the assistance developed by professionals in the Primary Health Care context? The objective of this paper is to understand the potentialities and challenges for the assistance provided by professionals in the Primary Health Care context.

METHOD

A research study with a qualitative approach and of the participatory action type, based on Paulo Freire' methodological framework. The Freirean Research Itinerary consists of three dialectical and interconnected moments: Thematic Research; Coding and Decoding; and Critical Unveiling[9].

In the Thematic Research stage, the generating topics are raised, encouraging the participants to dialogue on the theme under study. In Coding and Decoding, the meanings of the themes are debated, allowing for awareness to be exercised with a critical and reflective look. In Critical Unveiling, there is analysis and apprehension of the diverse information that emerges from the debate, enabling the participants' emancipation and the change of the reality experienced[9].

The Freirean Research Itinerary takes place in the Culture Circle, in which people dialogue, share experiences and reflections on the reality of life[9]. The Culture Circle took place in a Basic Health Unit (BHU) from a municipality in the greater Florianópolis region, state of Santa Catarina. The writing organization of this article followed the *Consolidated Criteria for Reporting Qualitative Research* (COREQ) protocol.

The participants were a manager (nurse) and BHU workers (three physicians, two nurses, two dentists, five nursing technicians, two dental assistants and five community agents). As inclusion criteria, we considered the health professionals linked to PHC and the consent authorization from the BHU coordination, to adapt the agendas. In turn, the exclusion criteria corresponded to professionals who were away on vacation or leave during the thematic investigation period.

Investigation of the themes took place in May 2021 during a Culture Circle, lasting two hours. The meeting was conducted in the BHU auditorium, at the time and day of the team meeting, previously negotiated with the participants. Researchers with experience in approaching Paulo Freire's Research Itinerary were the Culture Circle mediators.

Choice of the participating teams was based on indications from the municipal health management, which recognized that such team developed health promotion activities and consisted of three complete Family Health Strategy teams working in the same Basic Unit and involving all professional categories.

The coordinator of the chosen unit was previously invited to participate in the Culture Circle and forwarded the invitation to the team. Of the health professionals who worked in the BHU, 20 people were willing to participate in the research.

On the day the Culture Circle was held, the study objectives were initially presented, as well as the work methodology to be developed. Subsequently, there was a dynamic session in which the participants introduced themselves and filled in the socioeconomic data. From then on, the first stage was initiates: Thematic Investigation. The participants were divided into three subgroups and, encouraged to dialogue, wrote down the generating topics on colored cards, based on the guiding question: Which are the potentialities and challenges to develop work in PHC? After the investigation, the subgroups got back together in a large group and shared their themes. Sixteen generating themes were identified: nine strengths and seven challenges to develop health care in PHC.

In the second stage - Coding and Decoding - the themes arising from the investigation in the large group were discussed, exploring two generating themes. One of them pointed out the positive aspects that made working in the PHC possible, with the following emerging theme: Potentialities for working in PHC. The other generating topic was the moment when they reflected on the negative aspects of health care in PHC, which converged to the second theme: Challenges that discourage professionals from working in Primary Care.

In the Critical Unveiling stage, the debate about both topics was deepened, revealing as a positive aspect the participants' empowerment to promote good quality work and greater professional appreciation. The act of unveiling refers to a careful reading, reflection and interpretation of the emerging topics throughout the Culture Circle[9].

With the participants' consent, the dialogues were recorded and later transcribed. Data analysis (themes identified, coded and decoded, critical unveiling) was carried out simultaneously with the

development of the Culture Circle and in accordance with the precepts of Paulo Freire's Research Itinerary, with the involvement of all study participants[9].

Before starting the Culture Circle, the participants were introduced to the research and read and signed the Free and Informed Consent Form (FICF). The research was approved by the Research Ethics Committee and followed all the precepts set forth in National Health Council Resolutions 466 of 2012, 510 of 2016, and 580 of 2018. The respondents' anonymity was respected, who were identified with names of adjectives that represent pillars in interpersonal relationships, and chosen by the participants, such as Ethics, Respect, Honesty, Justice, Responsibility and Tolerance, among others.

RESULTS

All twenty study participants worked in different professions within the PHC scope: three physicians, two nurses, a dental surgeon, two oral health assistants, three nursing technicians and eight community health agents. Of these, 15 were female and five were male. At the time of the research, one interviewee acted as the coordinator of the service. Their age range varied from 24 to 55 years old and their time working in PHC ranged from one month to 20 years.

The two generating themes that emerged for discussion in the Culture Circle were the following: 1) Potentialities for acting in PHC; 2) Challenges that discourage professionals from providing assistance in Primary Care. In the first generating topic, the participants discussed the potentialities for acting in PHC and revealed that the team's engagement and interpersonal relationship are facilitators for work. They reflected on the importance of the team acting in a united and engaged way, which is an essential issue in health care.

[…] *and the positive points, teamwork, I saw that it was unanimous, it's certainly wonderful here* (Empathy).

[…] *now we go to our potentialities: engagement of our team, which is top ten* [...], *the good interpersonal relationships* (Ethic).

Another potentiality mentioned was welcoming, which enables the construction of a trusting relationship between users and professionals. It eases the development of health promotion practices and the reduction of queues, as highlighted by the participants.

[...] *because we're maintaining the welcoming part* [...] *and this care at that moment contributes promotion and prevention to the patients* (Honesty).

[...] *we reduced a giant spreadsheet* (of scheduled consultations) *because of welcoming* (Justice).

Care organization in the BHU was evidenced as a potentiality through planning. The professionals highlighted that they have the opportunity to effectively dialogue and discuss their actions in team meetings.

[…] *practicalities and organization of the work process* [...] (Responsibility).

[…] *everything that's done here is planned. And one practicality is also in the meetings that we can talk about everything* [...] (Respect).

Using technology in the communication and population guidance process was also cited in this study as a potentiality for the health team to integrate with the users, easing the PHC professionals' work.

[…] *we also have ease with WhatsApp, which a person may be at risk of coming here to cluster with others or catch a disease. And from home, they can access, talk and ask questions.* (Empathy).

The participants also discussed that mapping and acknowledging the coverage area are potentialities at work, as they qualify strategic planning and accessibility of the enrolled population.

[…] *mapping and recognition of the area, this is being a process* [...] *this is happening so that we can better develop strategic planning and accessibility* (Respect).

In this study, the participants highlighted mapping as a relevant instrument, which qualifies the planning of health team actions and accessibility.

Advanced access was discussed in the Culture Circle as a potentiality for health care in the PHC context.

[...] *at the center, they put the advanced access, so, in the morning, we have demand and that's giving a good flow and the schedules too...* (Respect).

In the second generating topic, the challenges of the PHC professionals' work stood out. In the dialogues, elements such as reduced motivation of the health team to develop work emerged, with emphasis on the reduction in the number of professionals and the low salaries.

[...] *incomplete staff, it's overloading us* [...] *and the salary, which is incompatible* [...] (Ethic).

The participants also discussed the inappropriate conditions of the BHU infrastructure, which interferes with work, referring to scarce basic materials to maintain their own personal hygiene.

[…] *there's lack of physical structure, sometimes we don't have water, there's a leak, there's mold, there's lack of paper towels and we have to beg for basic things* [...] (Respect).

[...] *I think that the physical structure* [...] *our situation of the basics missing, even for our team, even for our day-to-day hygiene* (Patience).

Another problem discussed was the professionals' lack of active voice while developing their work. They also highlighted the users' lack of patience in understanding that it is not only their case but that there are countless health situations that need to be solved. Since then, some users have been disrespectful to professionals.

[…] *we really wanted professionals to have a little more voice, but unfortunately it doesn't work that way here* (Lovingness).

[…] *patients aren't always flexible. He arrives with the problem, that's his problem and thinks he's the only one with the problem* [...] *it's very complicated, they come up with the disrespect issue and the team tries to explain it in the most correct way, but not always with good results* (Dialogue).

As for the relationship between the actors involved in health care in PHC, the study participants vehemently cited political interference and receiving threats, especially when some action recommended in the service displeases the population.

[...] *there are situations that the population comes to us with: they know they can turn to the secretariat, with councilor A or councilor B. And those who don't have stability, end up giving in* (Humility).

[…] *we're faced with some cases of situations that occur here, of a political nature. Politics is very embedded, linked to the BHU, so sometimes we follow rules that are recommended by the secretariat or that are passed on to us and the population doesn't accept that rule and, many times, we're threatened with situations like 'look, we'll go to the secretariat and complain!'* (Participation).

The participants also discussed that, due to COVID-19, the care flow had the pandemic situation as a priority, which affected health assistance in Primary Care, with prevention and health promotion actions being canceled.

[...] *the priority now is the pandemic issue, it's going as they release* [...] *There's certain difficulty in some processes* [...] *and some are not being done because of the pandemic* (Sympathy).

DISCUSSION

Teamwork in PHC involves structuring and organization of the health practices based on interpersonal relationships through effective dialogue, with actions and collectively constructed knowledge. Therefore, as mentioned by the participants in this study, teamwork and the professionals' engagement are fundamental for the development of the ESF principles, contributing to reorienting the health care model, in search of comprehensiveness and health promotion[10]. In this way, management of the health services must encourage teamwork and the professionals' engagement in the Primary Care practice.

They also revealed welcoming as a potentiality for the development of assistance in the PHC context. Welcoming is revealed as an effective strategy to achieve better results, enhancing the resoluteness levels and organization of the services[11].

Welcoming in PHC has favored the Clinical Nursing practice and teamwork, as well as improved access[3]. In addition to that, it facilitates the development of health promotion actions, as pointed out in this study, as it improves the relationship between professionals and users[12]. However, the high demand, the scarce training of professionals and the difficulty reorganizing work in a democratic way can limit the benefits of this guideline[3].

As highlighted by the participants, team meetings are also an important tool for structuring and organizing planning, establishing guidelines and making decisions through dialogue. Added to this, meetings favor the reorganization of assistance in PHC, based on the diverse information discussed among the professionals[13]. It should be noted that these work meetings must be carried out in a democratic manner, involving the participation of all professionals working in this scenario. However, there are still remnants of the hierarchical model, with prevalence of nurses and physicians in decision-making, where the opinion of other professionals is sometimes not considered, for example, that of community health agents, who are the workers that establish the strongest link between the health team and the community[13].

On the other hand, it is in PHC that we seek to reduce distances and strengthen the link between the community and the team's professionals. An effective strategy is the use of technologies, which ease communication with users and promote care continuity, especially in pandemic times[14].

Mapping and territorialization were also highlighted as potentialities for health care in the PHC context. One of the attributions of all ESF professionals is participation in the territorialization process. However, its development is sometimes reduced and simplified, being merely considered as a bureaucratic action, without proper application in the PHC professionals' work[15].

Currently, the Advanced Access model is one of the ways to qualify access within the PHC scope, which allows users to seek care from their reference professional at the most opportune time, generally on the same day, as needed. This model organizes the daily schedule, without reserving times for specific groups, seeking to meet the demand of each day[16].

However, work overload and excess demand in PHC are identified as challenges for health care development, as they can trigger the development of mental diseases in the professionals. This is mainly related to the difficulty involved in implementing the principles advocated by the SUS, given the precarious working conditions. These professionals are exposed to intense work, with scarce manpower, being directly linked to the reality and needs of the community they assist, which can lead to exhaustion, constituting the Burnout Syndrome[17]. Therefore, it is extremely important that health professionals have good working conditions so that they can carry out their work with motivation, fully and appropriately with their workload[18].

Professional devaluation, which includes low wages, was also pointed out in other studies, as work overload and intense demands on managers directly affect motivation and development of health work[19,20–21]. It is also worth remembering that many workers enter PHC without a public tender to hire them and ensure them economically[20–21]. The literature mentions that there is constant turnover of professionals in the service, with instability of contracts and low wages, jeopardizing health care of the ESF teams,[19–21] with difficulty establishing a bond with the team and the community. These factors can demotivate health professionals and, consequently, disqualify assistance to users and the community[18].

In line with the negative results found in the current study regarding the structure of the UBS, other surveys reveal as main problems the absence of computer equipment, telephone, Internet access and vehicles to carry out activities in the community[19,22]. Such difficulties can hinder work continuity in

PHC, limiting potentiality of the actions in this sector[22]. In this scenario, policies that favor possibilities for municipal, state and national managers to ensure an adequate structure and sufficient materials in the BHUs become urgent, with a view to maintaining adequate working conditions for the professionals.

In order to achieve good results in the services provided in PHC, the professionals' autonomy and effective local management are postulated[23]. In Primary Care, the actors involved in the care process are the community, managers and professionals. Therefore, workers need to be heard by the population and management, with an active voice and respect, as protagonists in health practices, having autonomy to define the best strategies to assist individuals, families and the community. Sometimes, there is ineffective communication between health professionals and managers, and between these workers and the community, which can generate tension in these relationships,[23] as pointed out by the participants of this study.

In the relationship between health professionals and the community, users generally expect resolute assistance, which solves their problem quickly and satisfies them[23].

The pandemic amplified the existing challenges in PHC and demanded efforts from the Union to the states and municipalities, with a view to supporting surveillance actions and assistance to the population. In the pandemic context, PHC professionals acted on several fronts, seeking to develop their work: health surveillance in the territories; care provision to users with COVID-19; social support for vulnerable groups; and continuity of PHC actions, seeking to adapt to the new health situation, which required care measures to maintain social distancing[24]. In the face of COVID-19, PHC was a protagonist in mitigating the effects of the pandemic[25]. During this period, the World Health Organization (WHO) and researchers from different countries reinforced the need to strengthen PHC, considering quick access and close assistance to individuals and groups, according to the reality and culture of each territory, comprehensiveness and care coordination[26–28].

Strengthening PHC attributes such as longitudinality is essential for the development of good quality health care. Diverse Brazilian evidence shows that the longitudinal bond of care consists of monitoring users over time, in which a therapeutic relationship is expected that involves responsibility on the part of the health professionals and trust on the part of the users, a person-centered model[29].

As a limiting factor in carrying out this study, it is mentioned that it was developed in a single reality. It is suggested to continue and expand research, involving the Primary Care professionals' work in different regions of both Brazil and the world, in favor of reflections and improvements in this sector. From the results achieved, it was possible to expand the diverse scientific evidence on health care in PHC, which is the gateway to the Health Care Network in Brazil, deserving attention from researchers. It is time to discuss and implement policies that assist in health professionals' quality of life, well-being and work process, in order to instill their motivation in their work, according to the SUS guidelines and fulfilling their role in PHC with quality.

CONCLUSION

The participants revealed the professionals' empowerment and involvement in health care as potentialities. As challenges, they revealed the lack of human and material resources and pointed out the importance of expanding the health care focus and improving the professionals' performance.

They highlighted that it is necessary to deal with political, economic and social issues. These actions will interfere with structuring of the services and protocols, interference which, in most cases, is negative both for the population and for health workers.

The results of this study can support discussions between managers and health professionals, in order to identify the possibilities and limitations for the development of the work performed by teams in primary care.

This study revealed the reality faced by Primary Care professionals when identifying health care potentialities and challenges, allowing advances in the everyday work practices.

By using participatory action research, through Freire's praxis, there is reflection and intervention on reality, mainly in its political dimension. The importance of dialogue during the Culture Circle provided a critical reading of the situations experienced by the participants.

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NOTES

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CONFLICT OF INTEREST

There is no conflict of interests.

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