Analysis of work organization in the Extended Family and Primary Health Care Centers in Rio de Janeiro

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Abstract: The implementation of Extended Family and Primary Health Care Centers (EFPHCC) has fostered more dialogic care strategies and the monitoring of population groups that, historically, had little access to Primary Health Care (PHC). However, in the municipality of Rio de Janeiro, oscillations in federal and municipal management implied the reduction or elimination of these teams. To understand the impacts of this scenario on the daily routine of EFPHCC teams, this research analyzed regulatory documents and the professionals' perception of the work organization. Accordingly, a qualitative study was conducted using data collection, document analysis, and semi-structured interviews with eight EFPHCC professionals from a region of Rio de Janeiro between August 2019 and February 2020. Data treatment was based on content analysis. The results expose the impacts of the changes in the organization and financing guidelines of EFPHCC and address the workers' perception of the work process. Thus, it was evident that EFPHCC has the potential to qualify actions and interventions in the context of PHC; however, the growing job insecurity overloads the workers and hinders the achievement of its original goals.

➤ **Palavras-chave:** Health care workers. Family Health Strategy. Qualitative research. Precarious work. EFPHCC.

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Introduction

The expansion of the Family Health Strategy (FHS), as a result of the increase in the possibilities and offers of care in Primary Health Care (PHC), has made the health needs of the population more visible, which has demanded the insertion of other professional categories in this part of the Health Care Network (HCN), which is the preferred gateway to the Unified Health System (UHS). Thus, in 2008, the Extended Family and Primary Health Care Center (EFPHCC) was created, whose innovative proposal was implemented based on a pioneering work logic (BRASIL, 2010; 2014; MELO *et al.*, 2018). According to the guidelines of the Ministry of Health (MoH), the activities of EFPHCC are (BRASIL, 2014): conducting groups, consultations, matrix supporting, and Permanent Health Education (PHE). Such activities are distributed in the technical-pedagogical and clinical-assistance axes.

The implementation of EFPHCC enabled the design of more dialogic care strategies in the perspective of the production of autonomy, creation of bonds, adherence, and ensuring the monitoring of population groups that, historically, had little access to PHC (OTHERO; DALMASO, 2009; SILVA, 2012). Thus, the work of EFPHCC has the power to democratize the production of care since it is a modality that operates predominantly through the sharing of knowledge, besides betting on the transformation of health practices (BRASIL, 2010; SILVA, 2012).

However, the implementation of EFPHCC did not happen linearly. It presented diverse realities and experiences reflected in a myriad of difficulties in operationalizing its initial proposal (MELO *et al.*, 2018). Studies that investigated the work process of EFPHCC pointed out the following problems related to the work organization of its teams: work incompatibility of the support teams with the core teams; work evaluation incompatible with the reality of the work developed; use of innovative work tools, which were challenging to implement; a.g. large number of Family Health Teams (FHTs) to be supported by EFPHCC; turnover of professionals; high care demand; and lack of back-up from the health care network (BARROS *et al.*, 2015; GONÇALVES *et al.*, 2015; LANCMAN *et al.*, 2013; MELO *et al.*, 2018).

This is compounded by political and planning oscillations that generate both discontinuities of ongoing projects and changes in the organization of work or the nature of care actions - which go against the meaning and beliefs that workers

have about the development of their work (LANCMAN *et al.*, 2012). It is about the current political oscillations, in which normative changes that dilapidated part of the proposals foreseen for EFPHCC stand out, thus reducing its scope of action and threatening its continuity. For example, the revision of the National Primary Care Policy (NPCP) published in 2017 (BRASIL, 2017) increased the EFPHCC arrangement's scope. It encompassed primary care teams, thus becoming known as the Extended Family and Primary Health Care Centers.

Within this framework, the centrality of the matrix logic was subtracted, given that the word "support" no longer appears in the name of the team and the guidelines of its operation that, until then, were substantially based on this theoretical reference (BARROS *et al.*, 2015; MELO *et al.*, 2018). Moreover, the new PHC funding model, regulated by Ordinance 2,979 of November 12, 2019 (BRASIL, 2019), revokes the financial incentives that reduce the possibilities for continuing the work of these teams.

Regarding the municipality of Rio de Janeiro, it is worth noting that the implementation of the FHS and EFPHCC was late compared to other municipalities in the country (SORANZ *et al.*, 2016). Moreover, it is a city with high population density and territories with different socioeconomic realities that coexist with parallel power and urban violence (SOUZA *et al.*, 2011), increasing the complexity of the EFPHCC professionals' actions.

In 2016, the municipality's Undersecretary of Primary Care, Surveillance and Health Promotion (UPCSHP) mobilized efforts to organize the work of EFPHCC, defining the standard agenda and the way of hiring professionals as an attempt to improve the work process. Nevertheless, the municipal management, which began in 2017, brought changes that printed their colors to the scenario drawn by the new federal norms related to PHC, implying the dismissal of EFPHCC professionals - which reduced or eliminated teams in the city. Therefore, the operation of EFPHCC in Rio de Janeiro shows an intrinsic complexity related to the peculiarities of the territories where these teams work and an extrinsic complexity, which is given by the way the municipal policy was implemented. To understand the impacts of the scenario presented here on the daily work of EFPHCC teams in Rio de Janeiro, this research aims to analyze normative documents and the perception of EFPHCC workers of a region of the city about the organization of their work.

Method

This article presents part of the results of the master's thesis. The work process from the perspective of professionals in the Extended Family and Primary Health Care Center in the municipality of Rio de Janeiro is qualitative research of the exploratory type. First, the official documents that establish guidelines for EFPHCC were identified and analyzed, which supported the analysis of the work process, especially regarding the comparison between the preconceived and the actual work, as shown in chart 1.

Chart 1. Documents related to EFPHCC

Document	Year published	Presentation
Primary Care Notebooks n. 27	2010	Presents the EFPHCC Guidelines
Primary Care Notebooks n. 39	2014	Extended Family and Primary Health Care Center : Tools for management and daily work.
RIO DE JANEIRO MUNICIPAL HEALTH SECRETARIAT (SMSRJ). Circular S/SUBPAV/ SAP/CPNASF Nº1/2016	2016	Presents guidelines for the operation of EFPHCC in the city of Rio de Janeiro.
RIO DE JANEIRO MUNICIPAL HEALTH SECRETARIAT (SMSRJ). Circular letter SMS No. 05/2016.	2016	Presents the Guidelines for EFPHCC 's actions and the Standard Agenda. Defines the hiring of professionals that must be done through the OS with the support of the General Coordinator of Primary Care
RIO DE JANEIRO MUNICIPAL HEALTH SECRETARIAT (SMSRJ). SMS Circular Letter No. 004/2017. Indicators for the Extended Family and Primary Health Care Center (EFPHCC)	2017	Informs the new parameters to be considered in the EFPHCC Standard Agenda and revokes the parameters established in the EFPHCC Standard Agenda by Circular Letter No. 05/2016.
National Primary Care Policy.	2017	Establishes the guidelines and norms for the organization of Primary Care, reviewing the previous policies (2006 and 2011)
RIO DE JANEIRO MUNICIPAL HEALTH SECRETARIAT (SMSRJ). Attributions of the EFPHCC supporter.	2018	Presents the assignments that aim to help the professionals who work as EFPHCC Supporter General Coordinator of Primary Care (PCC).

Source: Prepared by the author.

Data was collected through interviews with a semi-structured script, conducted between August 2019 and February 2020, with EFPHCC professionals, in their assigned health units (HU). Participants included were from programmatic area 3.1, in the northern region of the municipality of Rio de Janeiro. This region is formed by 28 neighborhoods with high population density - according to IBGE (2010) criteria - and low Human Development Index (HDI) (SORANZ *et al.*, 2016).

We randomly included one professional from each category (social worker, psychologist, physical therapist, occupational therapist, nutritionist, and physical educator) per EFPHCC team. Therefore, nine teams were contacted, and only one could not participate due to schedule incompatibility. Next, the EFPHCC professionals were contacted by team e-mail, whose addresses were requested from the social organization that manages the chosen area, for first contact with the professionals.

This e-mail provided information about the research, the objective, and the reason for the contact. The teams that accepted the invitation indicated the professional who would participate, and the interviews were then scheduled. Thus, the study had the participation of eight EFPHCC professionals, one from each team: three social workers, two physical educators, one occupational therapist, one psychologist, and one speech therapist.

The interviews were analyzed using content analysis, which, according to Bardin (2011), comprises a set of techniques that allow the description of the content emitted in any spoken or written communication process to understand senses and meanings. In addition, the thematic modality was used. Bardin defines theme as "the unit of meaning that is naturally released from an analyzed text according to criteria relating to the theory that serves as a guide to the reading" (2011, p. 135), and that can be represented by a word, a sentence, or a summary.

First, the interview recordings were listened to and transcribed. Then, the professionals' speeches related to the EFPHCC conceptions and practices were identified, which allowed the production of a second document, called the text corpus. According to Minayo (2013), the corpus is formed by exhaustive contact with the research material, impregnating itself by its content, allowing a new organization of the material in a way that considers the aspects contained in the research script and manages to represent the intended universe.

During this process, parts of the professionals' reports were selected by similarity and differentiation to define the nuclei of meaning (BARDIN, 2011). Then, these were grouped and regrouped successively to highlight internal trends or subthemes. From that point on, a final selection and ordering of these nuclei were made, giving rise to the analytical categories that represented the most frequent and relevant meanings in the speeches of the professionals related to the research theme and its objectives. Five categories were found: work's organization, activities performed; the relationship between EFPHCC and ESF; the ties between EFPHCC and management; and the relationship between NASF and the healthcare network. This article focuses only on "work organization" and "activities performed."

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Results and Discussion

The results of this research will be presented based on two axes. The first one deals with the impacts of the changes in the organization and financing guidelines of EFPHCC on the functioning of these teams. The second axis addresses the perception of EFPHCC workers about the consequences of this scenario in their work process.

EFPHCC in the changing scenario of PHC organization and financing guidelines

At the beginning of EFPHCC's implementation, 11 teams worked in the investigated territory. However, in 2018, changes in the municipal management of Rio de Janeiro determined the dismissals of several professional categories. This new situation led to the extinction of two entire EFPHCC teams and the reduction in the number of professionals of the other teams, as shown in Chart 2 below.

Chart 2. Evolution of the composition of EFPHCC teams in the region covered in this research

EFPHCC Teams	Previous Composition	Current Composition	Status
EFPHCC 1	Social worker, physical educator, physiotherapist, nutritionist, 2 psychologists, and an occupational therapist	Social worker, physical educator, physiotherapist, nutritionist, 2 psychologists, and an occupational therapist	Active
EFPHCC 2	Social worker, physical educator, physiotherapist, nutritionist, 2 psychologists, and an occupational therapist	Social worker, 2 psychologists and an occupational therapist	Active
EFPHCC 3	Social worker, a physical educator, 2 physiotherapists, a nutritionist, and 2 psychologists.	Social worker, physical educator, nutritionist, and 2 psychologists.	Active
EFPHCC 4	Social worker, physical educator, physiotherapist, nutritionist, and 2 psychologists.	Social worker, physical educator, physical therapist, and 1 psychologist.	Active
EFPHCC 5	Social worker, physical educator, physiotherapist, nutritionist, and 2 psychologists.	Social worker, 2 physical educators, a physiotherapist, a nutritionist, and 1 psychologist.	Active
EFPHCC 6	Social worker, physical educator, physiotherapist, nutritionist, 2 psychologists, and an occupational therapist.	Social worker, physical educator, psychologist, and occupational therapist.	Active
EFPHCC 7	Social worker, physical educator, physiotherapist, speech therapist, nutritionist, and 2 psychologists.	Physical educator, physiotherapist, speech therapist, nutritionist, and 2 psychologists.	Active
EFPHCC 8	Social worker, physical educator, physiotherapist, nutritionist, and 2 psychologists.	Social worker, physical educator, physiotherapist, and 1 psychologist,	Active
EFPHCC 9	Social worker, physical educator, physiotherapist, gynecologist, pulmonologist, cardiologist, nutritionist, pediatrician, psychologist, psychiatrist.	Physical educator, physiotherapist, gynecologist, pulmonologist, pediatrician, psychologist, psychiatrist	Active
EFPHCC 10	Social worker, physiotherapist, nutritionist, 2 psychologists	Not applicable	Terminated
EFPHCC 11	Social worker, physical educator, physiotherapist, nutritionist, 3 psychologists, and occupational therapist	Not applicable	Terminated

Source: Prepared by the author

This scenario illustrates the disarticulation of EFPHCC in Rio de Janeiro as a consequence of the changes guided by the new NPCP (BRASIL, 2017) and the reduction in financial incentives that supported the hiring of professionals for these teams. The decrease in EFPHCC staff is also reflected in the proportional increase in the number of core ESF teams enrolled in EFPHCC, implying noncompliance with the recommendation of the Ministry of Health, which states that each Type 1 EFPHCC team should support five to nine core teams. Moreover, even this parameter can already be considered excessive, as indicated by Moreira *et al.* (2020). Table 3 shows that five of the nine teams are in this condition.

Chart 3. EFPHCC teams by number of professionals, teams, and the supported HU

EFPHCC Team (all type 1)	Number of EFPHCC professionals	Number of supported teams	Number of supported HUs
1	6	14	2
2	3	13	1
3	5	10	2
4	4	8	2
5	6	12	2
6	4	8	2
7	7	11	1
8	4	9	2

Source: Prepared by the author

The research found that the number of HU enrolled has also increased. This poses another challenge for the work since the division among the HU causes divergences in selecting which unit will be contemplated with more EFPHCC professionals' shifts. This equation must be defined according to criteria related to the territory's needs. However, considering that the region covered by this research is a populated area with extreme social vulnerability, it is challenging to choose which teams or HU need more support. Furthermore, it should also be considered that the core FHS teams have suffered the impact of the new BF guidelines, such as layoffs, and therefore present varying degrees of fragility.

The EFPHCC work process

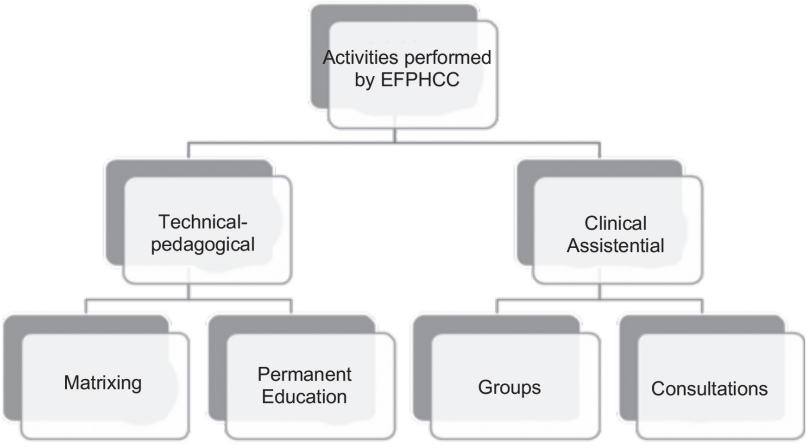
The work process in health concerns the microscopic dimension of everyday work, the praxis of health workers and professionals inserted in the day-to-day production and consumption of health services. All the dynamics of human labor are reproduced in this process. Current issues, referring to the work process in health, have addressed the changes in the world of work and its repercussions in the sector: technological incorporation, unemployment, and the flexibilization and precariousness of work, are some examples (PEDUZZI; SCHRAIBER, 2006).

This axis will discuss the perception of EFPHCCF workers about their work process in the scenario outlined by the new regulations and administrative changes in Primary Care in the municipality. The discussion will be based on two perspectives: the activities performed by EFPHCC and the themes emerging in the interviews that affect the work process to its full extent.

Activities performed by the teams

As mentioned in the introduction, one of the activities proposed to EFPHCC is the organization of groups. According to the guidelines of the MoH (BRASIL, 2014), the activities of EFPHCC are groups, consultations, matrixing, and Permanent Education in Health (PEH). They are distributed in the technical-pedagogical and clinical-assistance axes (figure 1).

Figure 1. Overview of the activities performed by the EFPHCC teams



Source: Prepared by the author based on BRASIL, 2014[3]

Group activities are developed in the SUS, especially in PHC, characterizing collective actions of an educational nature that aim at learning various ways of living and coping with the disease or changing habits.

EFPHCC professionals, as recommended in their standard schedule, have time for groups/collective activities in the unit. All EFPHCC teams included in this study highlighted the development of groups in their weekly work routine. They all had at least one group for each area: healthy eating, physical activity, rehabilitation, and mental health.

Although the group is an activity highlighted in the data collection, some challenges were observed. Generally, these groups are developed only by EFPHCC professionals, without the participation of the FHS. Like other studies (IACABO; FURTADO, 2020), few professionals from the minimal teams were cited as participating in these activities, with the community health agent (CHA) being the most quoted:

> In my experience, it is tough to have higher-level professionals in the groups, doctors, and nurses, so when we could have a CHW present, who had more sympathy for that theme [...] (I1).

Frequently, the group developed by EFPHCC is seen by the other FHS professionals as an activity that belongs exclusively to the support team. Usually, when other professionals attend the group, they become "part of the audience" and "helpers", not contributing to the discussion and joint planning of actions. This overloads EFPHCC, denoting a lack of integration between the support and FHS core teams. However, the speeches also show that EFPHCC professionals recognize that this lack of integration is mainly due to the overload of the FHS.

> […] I think that all this demand, all the work difficulties end up making people less willing to be in these spaces, and if there is someone who ends up in charge, they abandon the spaces. Even EFPHCC itself has not been able to maintain its groups alone […] (E3).

Other weaknesses related to the groups are the use of the groups as a means to filter and organize the demand for care, the lack of physical structure to conduct the activities, and the lack of training that qualifies them for group management.

> We have many groups here, and the OT makes several groups, auricular, meditation, integrative community therapy, art therapy. There is also a physio rehabilitation group, and I also have a group for oral breathing and stuttering. I think this is how we try to absorb the demand, which is vast; we try to group (E7).

The second group of activities performed by EFPHCC are a specific individual or shared consultations (BRASIL, 2014). The shared consultation can have the participation of at least one EFPHCC professional and one from the FHS core team and can also be shared between two EFPHCC professionals. This type of consultation is necessary for the work routine of NASF when a user or a family needs specialized follow-up. In addition, this tool contributes to the completeness of care, thus broadening the view for discussion and management of each case (BRAZIL, 2014).

In the participants' view, shared consultation is considered an action that should happen more often. They point to the core teams' lack of time as the main obstacle to conducting this activity, as illustrated by the following verbalization:

> Some professionals have a full schedule, like doctors, nurses [...]. When we schedule an inter-consultation, we know, for example, an inter-consultation with a psychologist. We understand that the consultation takes a while, that the consultation goes beyond the usual one that the doctor and the nurse do, for example (E1).

The little participation of FHS professionals in groups and consultations, together with the EFPHCC team, was also observed by Iacabo and Furtado (2020). As the authors note, although collaborative practices contribute to the expansion of knowledge, qualify referrals, and increase health care offerings, they are not sufficient to guarantee the increase of comprehensive care.

Matrix support is the third group of activities performed by EFPHCC professionals. This arrangement assumes a relationship of assistance and educational support between the professionals of one FHS team and another specialist (BARROS *et al.*, 2015; CAMPOS; DOMITTI, 2007). However, besides meeting different knowledge, the matrix support relationship requires an approximation between the professionals, without which the shared clinical work does not occur (CAMPOS; DOMITTI, 2007).

The subject of this matrix support process is the user, and the object of joint work is the individual care plan (MENDES, 2010). The matrix support proposes a horizontal work logic capable of expanding the reference team's ability to deal with the most emblematic cases present in increasingly vulnerable territories, thus making the units more powerful and effective in health care (CAMPOS; DOMITTI, 2007).

From the perspective of the EFPHCC professionals interviewed, the matrix support contributes to the integrality of care. In addition, it strengthens the concept of expanded clinical practice, one of the proposals of Primary Care.

> To be able to broaden the view of the patient, to leave the medical-centered logic and see this patient as a whole, is the central role of NASF for me; to show these teams that this patient is more than a foot pain; it is more than a mental health symptom (E2).

Therefore, based on these statements, it is evident that when EFPHCC works according to the logic of matrix support, it contributes to strengthening a work according to the assumptions of SUS and PHC. EFPHCC professionals identified that the lack of clarity about the matrix support proposal could be a source of difficulties, as illustrated in the following excerpt

> They do not understand the need to have an enrollment [...]. We realize why we ask for these sessions that would have to have the presence of the doctor and nurse, and there is resistance: ah, but I have a full schedule, I have a lot of things to do, I will waste my time. We support them, but many times we arrive at the appointments, and the ones who are there are the CHAs (E7).

This issue was discussed in Barros *et al.* (2015), whose study pointed out that matrix support was not fully assimilated by some FHS professionals, with reports that they felt supervised or considered that the demand for matrix support exposed failures or incompetence in the development of their work.

Moreover, with the changes in the EFPHCC guidelines proposed in the new NPCP (BRASIL, 2017), the role of the matrix facilitator is no longer prioritized by the management spheres, thus losing its institutional nature.

> There has been a dismantling of primary care, which hinders this work of matrix, which has never been easy. Those who have worked longer than I know that matrix is a difficult job, very interesting, but that all the time needs to be reaffirmed. With this precariousness and professional stress, I think we lose a little and are taken by the day-to-day requirements (E3).

From the perspective of the interviewed workers, the gradual weakening of the matrix support function undermines the noblest and most complex thing that EFPHCC does. Moreover, the burden of these changes presents negative impacts on the daily work of EFPHCC professionals and is reflected in the weakening of comprehensive care (MELO *et al.*, 2018).

The fourth typical activity of EFPHCC is Permanent Health Education (PHE), characterized by the collective construction of health care and management processes involving different players. HPS can be made operational through team meetings, matrixing, forums, discussion groups, and even when meeting with users (SANTOS LEITE; ROCHA, 2017).

The participants of this research identified difficulties in promoting HPS actions. The collective spaces in the HUs, such as technical meetings or general meetings, are overwhelmed by other requirements, as exemplified in the statement below. The "urgencies" mentioned refer to the dismissal of workers and delays in paying salaries.

> The post-strike period is very confusing because we ask for space for the technical meeting, usually on Wednesday afternoons. Still, there are so many things that go through that there is never enough time, so we do not get the permanent education itself. There are several urgencies sent by the central level that take up time, each week is an urgency, and you can never talk. (E7).

Moreover, the reports show that HPS depends on physical space and availability in the professionals' agenda to participate in the meetings, as also pointed out by Mazza *et al.* (2020) and as explained in the following excerpt:

> There isn't an official space for us to carry out permanent education [...]; these actions for the clinic professionals are concrete (E4).

The interviewees' statements highlight the tension between clinical-care activities (groups and consultations) and technical-pedagogical activities (matrix and continuing education). Tesser (2017) and Vendruscolo *et al.* (2019) point out the emphasis on technical-pedagogical activities in official regulations and Collective Health literature. According to the authors, this induces ambiguities and overlaps between EFPHCC teams and FHS teams, which worsens the pressure on care, reduces the ability of PHC to resolve problems, and weakens both the former's capacity for specialized action and the latter's generalist vocation. Tesser (2017) proposes an articulated organization of the routines of these teams that adequately values the specialized care provided by EFPHCC and allows overcoming the false dichotomy between supporting the FHS and direct care to users.

Vendruscolo *et al.* (2019) go further by indicating that by taking its place in specialized care and the articulation between it and PHC, EFPHCC would effectively contribute to the integrality and resoluteness of PHC, with benefit for the entire RAS. This study's findings support the idea that the enhancement of EFPHCC's role can increase its contribution to the system and its sustainability in the SUS, especially in a moment of depletion, such as the current one.

Cross-cutting issues impacting the organization of work

Many of the issues that affect the development of EFPHCC activities were also mentioned by the participants in the context of other aspects. This phenomenon occurred because such matters are transversal to the whole discussion about the work process. For this reason, some of the obstacles identified in the conduct of activities will be addressed again in this section.

The importance of team meetings for EFPHCC professionals

The EFPHCC team meeting was mentioned as a critical activity for organizing and planning work, discussing cases, and meeting the teams' most sensitive needs, such as facing situations of illness and job insecurity. Therefore, the decrease in the frequency of meetings and the lack of a guaranteed space for them was pointed out by the participants of this research as a point that weakens the collective work of EFPHCC, as expressed in the excerpts below:

> As a team, we have understood that we are not functioning as well as we would like, we can't even hold regular meetings [...] the team is very fragmented in this sense, each one does their own thing, and that's it (E3).

Nascimento (2015) research showed that the spaces for tightening bonds and strengthening collective work are fundamental for EFPHCC professionals. Other studies that investigated the interprofessional dimension of EFPHCC reinforce these ideas, stating that it is essential to promote the integration among the professionals of the EFPHCC team, taking into consideration that its proposed action is based on the management of the teams in the context of matrix support. These authors also mention that acting in a fragmented way can be a demotivating factor at work (ARAÚJO; GALIMBERTTI, 2013; MATUDA *et al.*, 2015).

The interviewed workers also highlighted the importance of their participation in the meetings of the core FHS teams. However, in some cases, the presence of EFPHCC is still seen as synonymous with passing points and making appointments to enjoy the moment with the specialists at the meeting.

> […] we would say: "we are also here to support you in the work process," but there was resistance [from] those who came to the meeting: "EFPHCC is here, so get the EFPHCC cases, [...] let's take advantage of the fact that you are here to talk about the cases that we have to share or even pass on to them...". (E3).

Work overload

The dismissal of professionals and the reduction of FHS have increased the overload of all FHS workers. In addition, this scenario has led to a new reality, in which each enrolled territory now has a more significant number of registered users. This, in turn, also overloaded the EFPHCC teams, which, faced with this new scenario, started to provide individual consultations without the presence of professionals from the core teams more often.

> Family health teams have very high demand, the areas covered are huge, there are many users seeking help, and we end up accepting the team's demand: "ah, help here, I can't help you, my schedule is tight," and we end up being absorbed by this (E3).

It is noteworthy that the standard schedule of EFPHCC teams should contain scheduled spaces for joint consultations with the core teams. However, the professionals interviewed reported that the increase in demand has made it unfeasible forEFPHCC to plan these activities:

> Sometimes they are in the office, and there is a case that needs a look, so they call the psychologist who is there, or "ah, you" come quickly to the office? Then it ends up being an interconsultation, but nothing programmed is what happens now. (E5).

In this framework, EFPHCC professionals absorb individual requests due to a lack of planning and incompatibility of schedules, given that the patient waits for the appointment.

> Sometimes we even schedule it, but when the time comes, in the rush of everyday life, we cannot be together, so we end up with just the psychologist, nutritionist, or myself, attending to the person alone. The patient has arrived; what will you do with the patient? Are you going to let him go? No, then you end up taking care of him, right? (E5).

The increased frequency of appointments performed by EFPHCC professionals has made them a reference for these cases. However, over time, EFPHCC professionals are recognized by the users as "the one who sees me," suggesting that the excessive emphasis on individual consultations weakens the supportive role of EFPHCC. Although the problem of overvaluing matrix support has already been pointed out (TESSER, 2017; VENDRUSCOLO *et al.*, 2019), it should be noted that the issue highlighted here is mainly related to the shortage of workers in the face of the number of users, both FHS and EFPHCC, caused by layoffs.

Attendees also emphasized that the high turnover of FHS professionals, especially physicians, brings difficulties for the continuity of the PTS built together with

EFPHCC. This is because a professional who arrives at the FHS does not always understand the importance of the support team's work.

> There is a considerable turnover of professionals, so we are always discussing this, sitting down to see this situation, and making inter-consultations, but we always have to strengthen, consistently reinforcing this importance (E6).

In addition to operational issues, the decrease in the number of EFPHCC professionals, which has lasted since 2018, is also expressed in the form of demotivation, distress, and feelings of professional devaluation:

> They could understand that we need all the professional categories that are recommended, now we lost a social worker (...) we have no nutritionist. So how many cases appear, and we have nothing to say because it is not our specialty, I think that if what is said on paper were done, it would be much better (E7).

Violence and vulnerabilities in the territory

Violence in the territory stood out in the interviewees' speech as another transversal point in this study. FHS professionals, for the most part, work in communities. As a result, they witness daily episodes of urban violence - mainly related to drug trafficking - and monitor populations where high unemployment, low education, and social isolation prevail.

According to the interviewees' perception, the issue of violence interferes with the professionals' daily work, causing cancellations of scheduled activities, demotivation of the team in planning actions in the territory, and the community's low adherence to collective, extramural activities.

> The issue of conflict in the territory, right, the armed conflict is very complicated, it makes our work very difficult. Once, a few years ago, when the unit was divided, I articulated for us, I programmed with a team to hold four craft groups, every group date, there was a conflict, in other words, we could not do it (E1).

Therefore, it can be seen those professionals suffer from limited access to users, the effects of violence on health, and experiencing the routine of armed violence at work. The planning of actions, hampered by daily and internal divergences among the professionals themselves, still needs to overcome those that are external and where solutions are beyond their reach. The study conducted by Prata and collaborators (2017) - in the same region studied in this research - identified that workers feel insecure when leaving home, have difficulty sleeping - especially after

tense episodes such as shootings - and described cases of professionals and patients had successive hypertensive peaks.

Final considerations

The course of this research was challenging due to the scenario experienced in the municipality by the healthcare workers, which was crossed by strikes, layoffs, and drastic changes in the organization and operational logic of EFPHCC teams. This scenario led to the extinction of two teams in the studied region and the reduction of the number of teams that kept working.

Furthermore, other studies on the work of EFPHCC in the national context have already pointed out the challenges related to the implementation of the ordinances that affect its organization and functioning and poorly defined guiding documents. The lack of a federal counterpart for the financing of EFPHCC makes its creation excessively dependent on the discretion of municipal managers. In addition, the extension of EFPHCC'ss action to traditional basic units - which made them EFPHCC-AB -tends to favor the outpatient logic to the detriment of Family Health.

Such norms also express the distance between those who plan and those who execute the work. In this regard, this research shows the fluidity in the work prescriptions of EFPHCC, which is a paradoxical condition since, while it leaves the workers of these teams more vulnerable to policy and management changes, it also makes it easier to incorporate actions more adapted to the reality of the territory where they work. However, this positive aspect can be nullified by the general precariousness of EFPHCC and should be achieved by measures aimed at its autonomy and not its degradation.

Although EFPHCC presents an excellent potential for the qualification of actions and interventions in the context of the FHS, the work overload of the FHS and EFPHCC professionals is identified due to the setbacks mentioned above. In addition to their constant search for the assurance of their place as matrix providers - which culminates with the difficulty of organizing the work of these professionals. In this sense, the study highlights the precariousness of EFPHCC's work and the increasing obstacles that prevent it from reaching its original goals.

The findings of this research do not intend to exhaust the debate but to encourage it. Furthermore, we acknowledge the need for more scientific productions that address the work of EFPHCC, especially those developed from its real work

context, and emphasize the point of view of its players. Finally, this study is expected to contribute to new reflections, considerations, and transformations in the work process of EFPHCC to strengthen the PHC by ensuring decent work for the professionals performing its services.[1]

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Note

[1] B. E. Saporito: concepção, análise de dados, redação e aprovação da versão final. D. C. de Barros e R. F. do Lago: análise de dados, redação e aprovação da versão final. C. M. do C. Alonso: redação e aprovação da versão final do artigo.

Resumo

Análise da organização do trabalho nos Núcleos Ampliados de Saúde da Família e Atenção Básica no Rio de Janeiro

A implantação dos Núcleos Ampliados de Saúde da Família e Atenção Básica (NASF) fomentou estratégias de cuidados mais dialógicas e o acompanhamento de grupos populacionais que, historicamente, tinham pouco acesso à Atenção Primária à Saúde (APS). No município do Rio de Janeiro, oscilações na gestão federal e municipal implicaram redução ou eliminação dessas equipes. Para apreender os impactos desse cenário no cotidiano das equipes do NASF, esta pesquisa analisou documentos normativos e a percepção dos profissionais a respeito da organização do trabalho. Para tanto, realizou-se pesquisa qualitativa que utilizou coleta de dados, análise documental e entrevistas semiestruturadas com oito profissionais do NASF de uma região do Rio de Janeiro, entre agosto de 2019 e fevereiro de 2020. O tratamento dos dados baseou-se na análise de conteúdo. Os resultados expõem os impactos das mudanças nas diretrizes de organização e financiamento do NASF e abordam a percepção dos trabalhadores sobre o processo de trabalho. Assim, evidenciou-se que o NASF apresenta grande potencial de qualificação das ações e intervenções no contexto da APS, porém, a crescente precarização do trabalho sobrecarrega os trabalhadores e dificulta o alcance de seus objetivos originais.

➤ **Palavras-chave:** Trabalhadores de saúde. Estratégia Saúde da Família. Pesquisa qualitativa. Trabalho precário. NASF.