

Work situations experienced by family health strategy professionals in Ceará-Mirim

SITUAÇÃO DE TRABALHO DOS PROFISSIONAIS DA ESTRATÉGIA SAÚDE DA FAMÍLIA EM CEARÁ-MIRIM

SITUACIÓN DE TRABAJO DE LOS PROFESIONALES DE ESTRATEGIA SALUD DE LA FAMILIA EN CEARÁ-MIRIM

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ABSTRACT

The purpose of this study was to analyze the work situations experienced by Family Health Strategy (FHS) professionals. This descriptive study was performed in Ceará-Mirim, Rio Grande do Norte state, in 2007. The population consisted of 190 FHS professionals, in which a questionnaire with closed-questions was applied. The results showed that 83.2% of the professionals consider that knowing the geographical area under their responsibility is a positive aspect that helps performing their activities, while 40.5% consider the number of families that each team has to follow to be a difficulty. Regarding work conditions, 93.2% reported the presence of professionals with a public health profile and 86.6% reported there is a lack of equipment and instruments. Of professionals who work exclusively with the FHS, 74% are community health agents. The commitment and responsibility to replace the traditional care practices should concern everyone, and there is a need for an interaction between historical, political, social, economic, and cultural factors.

KEY WORDS

Family Health Program.
Health personnel.
Working conditions.
Health promotion.
Public health nursing.

RESUMO

O objetivo deste estudo foi analisar as situações de trabalho vivenciadas pelos profissionais da Estratégia Saúde da Família (ESF). Estudo descritivo realizado em Ceará-Mirim, Rio Grande do Norte, em 2007. A população constituiu-se de 190 profissionais da ESF, na qual foi aplicada um questionário com questões fechadas. Os resultados apontaram que o conhecimento da área geográfica adstrita pelos profissionais da ESF foi considerado como um aspecto positivo para a realização das atividades executadas por 83,2% dos profissionais, e o número de famílias acompanhadas por equipe foi considerado como uma dificuldade por 40,5%. Em relação às condições de trabalho, 93,2% referiram a presença de profissionais com perfil em saúde pública, e 86,8%, indisponibilidade de equipamentos e instrumentos. Dos profissionais que trabalham exclusivamente na ESF, 74% são agentes comunitários de saúde. O compromisso e a responsabilidade para substituir as práticas tradicionais de assistência devem ser de todos, havendo a necessidade de interação de fatores históricos, políticos, sociais, econômicos e culturais.

DESCRIPTORIOS

Programa Saúde da Família.
Pessoal de saúde.
Condições de trabalho.
Promoção da saúde.
Enfermagem em saúde pública.

RESUMEN

El objetivo de este estudio fue analizar las condiciones de trabajo experimentadas por los profesionales de Estrategia Salud de la Familia (ESF). Estudio descriptivo, realizado en Ceará-Mirim-RN-Brasil en 2007. La población se constituyó de 190 profesionales de la ESF, en ella se aplicó un cuestionario con preguntas cerradas. Los resultados demostraron que el conocimiento del área geográfica adscripta por los profesionales de la ESF fue considerada como un aspecto positivo para la realización de las actividades ejecutadas por el 83,2% de los profesionales, y el número de familias acompañadas por equipo como una dificultad por el 40,5%. En relación a las condiciones de trabajo, 93,2% refirieron la presencia de profesionales con perfil de salud pública y 86,8%, indisponibilidad de equipamientos e instrumentos. De los profesionales que trabajan exclusivamente en la ESF, 74% son agentes comunitarios de salud. El compromiso y la responsabilidad para sustituir las prácticas tradicionales de atención deben ser de todos, existiendo la necesidad de interacción de factores históricos, políticos, sociales, económicos y culturales.

DESCRIPTORIOS

Programa de Salud Familiar.
Personal de salud.
Condiciones de trabajo.
Promoción de la salud.
Enfermería en salud pública.

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INTRODUCTION

The work process of professionals in the Family Health Strategy (FHS) team comprises elements of health surveillance with the perspective of guiding the care model once more as it proposes the integration of the health-disease process distinct moments.

Health surveillance focus overcomes the reducing format adopted by vertical programs, which have not responded to reality challenges, proposing, through acknowledgement of the territory-process, identifying, describing and explaining health macro-problems. For that reason, there is a need for articulating an intersectorial operations compound, guided to solving them. Health problems should be understood as a social representation of sanitary needs derived from life conditions⁽¹⁾.

Intersectoriality proposes the unification of actions and is associated to linking, reciprocity and complementarities of human actions. It starts from the concept that complex problems manifested in a process-territory cannot be faced in a single-sector perspective⁽¹⁾.

Therefore, thinking of FHS as a guiding strategy of the care model signals the rupture with conventional and hegemonic health practices and the adoption of new work technologies. As the main innovation for that technology, the search for a better understanding of the health-disease process and the full and continuous care for the families in the territory of this study are mentioned.

Basic health care has been associated to a low-cost care (although it involves qualified technologies and people, also requiring resources), in which the main objective is to restructure the current care model (cure-centered, hospital-centered) into a basic care-centered model⁽²⁾.

The FHS consists of a new work market. Currently, a tension in health practice is noticed between the clinical knowledge and promotional-preventive character actions, which are prioritized by that health care model. Therefore, a concern emerges on the absence of team work and the great turnover of professionals composing the FHS. Therefore, would that absence be a result of work instability?

Work instability in health is commanded by technological and economic requirements of modern capitalism evolution, revealing a fragile FHS structure and compromising its effectiveness. Those aspects signal the need for prioritizing reflections that will aim at supporting strategies in the search for a definite regulation of those professionals' work contract⁽³⁾.

The work proposal for the FHS service starts from guidelines of a team composition pattern, of professionals profile from their selection process, training, program and

methodology training contents until supervision operational features of personnel evaluation⁽⁴⁾.

Regarding health professionals' work condition situations, in Ceará-Mirim in the State of Rio Grande do Norte (RN) FHS professionals are observed as being underpaid in relation to their personal needs, contributing for the search and maintenance of other jobs with a view for salary complementation. It regards the health reality of that location, which becomes a great obstacle for executing the FHS. Moreover, besides those problems, FHS professionals face the challenge of having or not their annual work contract renewed. The renewal depends on their professional performance and political-election interests.

In face of that context, and according to the difficulties faced by those professionals, (as contract modality divergences, differences in salary and in daily hours load among them, as well as equipment, instruments and raw material availability), this study intends to investigate which factors do effectively interfere in the execution of the FHS care model.

OBJECTIVE

General

- Analyze work situations experienced by Family Health Strategy professionals

Specific

- Characterize socio-demographic and work aspects of professionals in the family health teams in Ceará-Mirim/RN;

- Investigate work situations experienced by Family Health Strategy professionals

Regarding health professionals' work condition situations, in Ceará-Mirim in the State of Rio Grande do Norte (RN) FHS professionals are observed as being underpaid...

METHOD

This is a descriptive study carried out in Ceará-Mirim, RN, which is located in the coastal area, with population of 72,228 inhabitants⁽⁵⁾ spread around 95 communities that have agriculture and cattle raising as the main activity. Agriculture lands are mainly occupied by sugarcane culture.

The physical network of the Municipal Secretary of Health is composed by 01 hospital, 01 health center and 25 health units with physical capacity for offering hospital care in the internal medicine, pediatrics, obstetrics, surgery, and urgency care areas. The clinics sector offers medical specialties.

The municipality counts with 21 family health teams, composed by 21 doctors, 21 nurses, 21 nursing assistants and 159 health community agents (HCA). Regarding mouth health, there are 13 teams, composed by 13 dentists and 13 dental office assistants (DOA).

The study population was composed by 190 FHS professionals, they are distributed as follows: 124 health community agents, 21 nursing assistants, 04 dental office assistants, 15 doctors, 21 nurses, and 05 dentists. The inclusion criteria were the professionals' registration in the Basic Health Information System (BHIS) and accepting to participate in the survey.

Data collection was executed with the use of a questionnaire with closed-questions, applied after the approval of the Research Ethics Committee of the Federal University of Rio Grande do Norte (REC - UFRN in Brazilian acronyms), under protocol 056 - 07.

Data collection occurred from October to December of 2007, in the professionals' acting area in the Family Health

Strategy - or in the Municipal Secretary of Health, and the choice for the interview location was at the professionals' will.

Results were organized, categorized, codified and typed into an electronic spreadsheet. A data base was elaborated using the Microsoft Excel to analyze results. Results were analyzed, discussed and presented into tables and charts.

RESULTS

Table 1 presents the interviewed professionals' characterization; they were the following: 21 nurses, 15 doctors, 05 dentists, 124 HCA, 21 nursing assistants, and 04 DOA.

Table 1 - Distribution of socio-demographic variables of FHS professionals - Ceará-Mirim, RN - 2007

Professional Categories	Nurses N=21	Doctors N=15	Dentists N=5	HCA N=124	Nursing assistants N=21	ACD N=4	Total N=190
Average Age and Standard deviation)	35.4 ± 7.8	38.9 ± 11.3	28.0 ± 2.1	33.0 ± 6.6	36.5 ± 8.3	27.0 ± 4.1	33.9 ± 7.6
Salary Range	5 wages	10 wages	5 wages	1 wage	1 wage	1 wage	4 wages
Gender:							
Male	1	9	1	36	6	0	53
Female	20	6	4	88	15	4	137
Marital Status							
Single	9	7	3	56	9	4	88
Married	6	8	1	44	8	0	67
Stable union	2	0	1	15	1	0	19
Widow	0	0	0	5	0	0	5
Divorced	3	0	0	0	3	0	6
No answer	1	0	0	4	0	0	5

Regarding salary range, the highest range was of 10 minimum wages (corresponding to a doctors' salary) followed by dentists with 5 minimum wages each. Presenting the lowest salary range, 1 minimum wage, there is the HCA, the nursing assistant and the DOA. Regarding the averages related to income, a salary distancing is observed between the superior level categories (as between the doctor and the dental nurse) and the medium level.

The differentiated income for doctors attracts them to the FHS. The fact, most times, disregards the general professional education, which has a higher understanding of the individual in his sickness process⁽⁶⁾. On the other hand, a lack of motivation and/or lack of responsibility of some professionals who work in the SUS (Unique Health System) are identified related to low salaries and precarious work conditions⁽⁷⁾.

Currently, work instability results in low salaries and in the lack of legalization between other factors. It leads work into becoming a social segregation and even exclusion mechanism⁽⁸⁾. Therefore, the university level professionals' salary income presented in Table 1 is perceived as paradoxical.

Regarding gender, most professionals were females in almost all professional categories, with a total of 137, except for doctors.

Factors as the expansion and elevation of educational and training levels, in addition to the reduction of birth rates are reasons that propelled women to enter the stipendiary work market⁽⁹⁾. Moreover, the economic changes in Brazil throughout the past decades have favored a work market, open to women, mainly in the outsourced sector of the economy, allowing for their current progress into other instances and sectors.

Regarding marital status, among interviewees, there is a predominance of unmarried professionals, totaling 88 in comparison to 67 married professionals. Regarding the situation demonstrated here, it seems that young professionals have delayed marriage a while; other types of union have emerged, among them, the stable union.

Data presented in Chart 1 demonstrate that the professional with the highest time in the job for the FHS is the HCA (15 years); also, they are the only professionals who have been through a public exam in the city. On the other hand, the time in the job mentioned by nurses and doctors does not only regard the time in the job in the studied location, but also their previous contracts, sometimes in other locations, justifying the time in the job mentioned, including the implementation of HCAP (Health Community Agents Program) in the city, in 1992, followed by the FHS in 2001, and the mouth health program in 2005.

Chart 1 - Distribution of the variables time in the job, daily working hours and weekly day-off of FHS professionals - Ceará-Mirim, RN - 2007

Categories	Average time in the job	Time in the job		Daily working hours (average)	Weekly day-off (average)
		Minimum	Maximum		
Nurses	4 years	1 year	12 years	6 hours	1 day-off
Doctors	4 years	1 year	9 years	6 hours	1 day-off
Dentists	2 years	1 month	3 years and 7 months	5 hours	1 day-off
HCA	7 years	1 year	15 years	8 hours	None
Nursing assistant	4 years	3 months	7 years	8 hours	1 day-off
DOA	2 years	6 months	3 years	6 hours	1 day-off

* Time in the job mentioned by professionals includes the years worked in the studied location, as well as in other cities.

FHS professionals' turnover is related to the working contract flexibility and the market demand for new jobs that can bring better salary options⁽¹⁰⁾.

Regarding daily hours for FHS professionals, both doctors and nurses have a daily load of 6 hours. Dentists, on the other hand, have a daily load of 5 hours. Professionals in the medium level, as HCAs and nursing assistants have a daily load of 8 hours, while DOAs have 6 hours. Regarding the weekly day-off, HCA is the only category in the FHS that have no day-off during the week.

Regarding this issue, Regulation 648/GM of March 28 of 2006, which approves the Basic Health National Policy, determines for the health professionals who are full time

workers to accomplish a weekly load of 40 hours for family health team, mouth health and health community agent professionals⁽¹¹⁾.

According to results demonstrated in Table 2 (regarding the facilitating factors mentioned by FHS professionals), they indicated that for 83.2% of them, the knowledge about the geographic area was constituted as one of the main factor to help them perform their activities, followed by 76.3%, who mentioned health secretary technicians' supervision and inspection as facilitating factors. The FHS proposes to follow-up the population's health in an inter and multidisciplinary way, giving the basic health unit the full responsibility on monitoring the population living in that area⁽¹²⁾.

Table 2 - distribution of the activities according to the difficulty or facilitating factors faced by FHS professionals - Ceará-Mirim, RN - 2007

Activities	Difficulty		Facilitating factors		No answer	
	N	%	N	%	N	%
Number of families in the program	77	40.5	110	57.9	3	1.6
Educational activities	75	39.5	111	58.4	4	2.1
House calls	44	23.2	144	75.8	2	1.0
Service by specific groups	55	28.9	133	70.0	2	2.6
Population's acknowledgement in the territory	23	12.1	158	83.2	9	4.7
Map/statistics delivery in time	50	26.3	132	69.5	8	4.2
Supervision and inspection by health secretary technicians	34	17.9	145	76.3	11	5.8

Regarding the difficulties, 40.5% of professionals mentioned the excessive number of families per team as the main obstacle for the effective execution of activities, suggesting enhancing FHS coverage, with the aim of guiding care practice towards a family-centered health, understood and perceived in its physical and social environment⁽¹³⁾. The aspect demonstrates everyday more, the need for teams to be complete and work within the maximum limit of families.

According to results in Table 3, regarding the facilitating factors experienced by FHS professionals, 177 (93.2%) affirmed that the presence of public health professionals in the team has been one of the biggest facilitating factors to develop FHS activities, followed by 76.8% who indicated team work as another important factor that facilitated performing their work. As for the difficulties in their routine, for 165 (86.8%) of the interviewees, instruments and equipments

availability is a difficulty, followed by 158 (83.2%) who mentioned medication availability. Health work organization perspective should include from materials, equipments and procedures to incidents management⁽¹⁴⁾. The difference between what is previewed to what is performed, between the desirable and the real, must be analyzed, because in working situations there are frequent variations resulting from a number of factors. Work organization is one of them, along with what is related to the workers' features.

Regarding base salary, 156 (82.1%) professionals mentioned it as low and as a difficulty factor. Moreover, there is the diversity between the defined hourly loads for team professionals. Under this aspect, within the same team, the work load varies from 5 to 8 daily hours. Work instability and, consequently the insecurity it causes to professionals have been pointed as one of the main difficulties in those professionals' routine⁽¹⁵⁾.

Table 3 - Distribution of FHS professionals' work conditions according to their difficulties or facilitating factors - Ceará-Mirim, RN - 2007

Work conditions	Difficulty		Facilitating factors		No answer	
	N	%	N	%	N	%
Introductory training	41	21.6	137	72.1	12	6.3
Team work	40	20.1	146	76.8	4	2.2
Public health profile professionals in the team	9	4.7	177	93.2	4	4.1
Instruments and equipments availability	165	86.8	22	11.6	3	1.6
Raw materials availability	150	78.9	30	15.8	10	5.3
Medications availability	158	83.2	25	13.2	7	3.6
Professionals' time acting in the area	74	38.9	110	57.9	6	3.2
Professionals' work load	83	43.7	96	50.5	11	5.8
Professionals' work model	128	67.4	53	27.9	9	4.7
Professionals' salary range	156	82.1	24	12.6	10	5.3

Results demonstrated in table 4, regarding work location per FHS professional category, indicate that 166 professionals mentioned other jobs and, among those, 23 worked in hospitals: 9 (39.1%) doctors, 8 (34.8%) nurses, 41 (17.4%) HCA and 2 (8.7%) nursing assistants. Dentists and DOA were the only ones who mentioned working only for the FHS. One of the doctors works in 3 health services:

a hospital, in the FHS and in his office; other 5 professionals in the team, work in the FHS and in education, they are 3 (60%) HCAs and 2 (40%) nurses. Only 1 nurse (100%) works in the FHS, in a hospital and in education. Moreover, 5 professionals, 4 (80%) dentists and 1 (20%) doctor mentioned that they worked in the FHS and in an office.

Table 4 - Distribution of the variables employment and work location, of FHS professionals - Ceará-Mirim, RN, 2007

Category	Hospital and FHS		Hospital, FHS and Offices		FHS and Education		FHS, Hospital and Education		FHS and Offices		FHS		no answer	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Nurses	8	34.8	0	0.0	2	40.0	1	100	0	0.0	8	6.1	2	8.3
Doctors	9	39.1	1	100	0	0.0	0	0.0	1	20.0	3	2.3	1	4.2
Dentists	0	0.0	0	0.0	0	0.0	0	0.0	4	80.0	1	1.0	0	0.0
HCA	4	17.4	0	0.0	3	60.0	0	0.0	0	0.0	97	74.0	19	79.2
Nursing assistant	2	8.7	0	0.0	0	0.0	0	0.0	0	0.0	18	13.6	2	8.3
DOA	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	4	3.0	0	0.0
Total	23	100	1	100	5	100	1	100	5	100	131	100	24	100

In face of those results, we can affirm that the biggest proportion of professionals work exclusively in the FHS, as the HCA category with 97 (74%), followed by 1 (1%) of the dentists and 2.3% (n=3) of the doctors.

DISCUSSION

In the FHS care model, salary differences are observed between health professionals, as shown in this study. A differentiated income for doctors is a way to attract them to the FHS, disregarding, most of the times, their general professional education, which enables them to a global understanding of the individual and the sickness-health process⁽²⁾. In this present study, the doctors' income is demonstrated as twice the income for nurses and dentists.

Regarding the female presence among FHS professionals, results are compatible to other authors who reveal the female presence as a tendency in health work⁽¹⁶⁻¹⁷⁾ and in the family health team professionals⁽¹⁸⁾.

Regarding the marital status, single professionals are predominant, 88 subjects who are, in a certain way, more available for the service, while married professionals - specifically the women - face a double work load. Moreover, it has been a current tendency in society, some people have chosen not to marry, or they have delayed it for a latter phase of their lives.

Regarding the most time in the FHS, the HCAs demonstrated the longest period, 15 years. It can be related to the fact that those are the only professionals who have been through a public exam in Ceará-Mirim. The fact explains the high turnover of health professionals in the FHS. FHS professionals' turnover is related to the working contract flexibility and the market demand for new jobs that can offer better salary options.

Regulation 648GM, from March 28 of 2006, determines that FHS professionals should work for 40 hours per week⁽¹¹⁾. In this study, data reveal 1 day-off per week among FHS professionals, an internal negotiation, apart from Sat-

urdays and Sundays. HCA is the only category that has no day-off between Monday and Friday.

Therefore, the fact that dentist, doctors, nurses, and HCA professionals were found to have less than 8 hours period per working day, which is not corresponding to what is stated by regulation 648 of 2006, compromises the health team activities performance⁽¹¹⁾.

When reporting the difficulties mentioned while performing their activities, 86.8% of professionals indicated that they did not have equipments and instruments availability, followed by 83.2% who pointed medication availability. Those results seem to indicate that FHS professionals use very little of the guiding instruments to the community, of collective reach, guided to the groups in the territory.

On the other hand, they seem to indicate that they have their activities centered in hard technology (availability of equipments and medications) and in soft-hard technology (professional knowledge). Therefore, they acknowledge the importance of the public health professional profile to compose the FHS team. The team with public health or basic care education and profile was mentioned by 93.2% as a facilitating aspect of the development of those professionals' actions who work in the FHS.

It is acknowledged that since it regards a differentiated proposal of the care model parting from a reformulation of the previous model - intervening-curative to the educational-preventive, still centered in providing the service for the population - it is essential that professionals are qualified and identified through prior conjectures that are the base for the FHS.

A care model that produces a user-centered care and guided to their needs should operate centrally from soft technologies, registered in the relations at the same moment health producing actions are executed. Soft-hard technologies should be registered within the structured technical knowledge⁽¹⁹⁾.

Finally, regarding the situation of the work contract only at the FHS, the largest proportions of professionals who work exclusively in the FHS correspond to the HCA category, with 74%. It can be a consequence of the contract modality in which most professionals are submitted to in the city, leading them to search for other jobs due to employment instability. Even when it is understood that a 40-hours per week contract for FHS professionals⁽¹¹⁾ makes it impossible for them to have other jobs, this study found that 31% of professionals do have it.

HCAs are the only professionals who have been through public exam in Ceará-Mirim. All other members of the team have temporary work contracts. Most professionals conciliate, or try to conciliate, at least two institutional work contracts, demanding a permanent situation adjustment movement⁽²⁰⁾.

Although Regulation 648, of March 28 of 2006, establishes a 40-hour weekly load for FHS professionals⁽¹¹⁾, this study demonstrated that 31% of professionals have other jobs, corroborating with the results from a study carried out in another city, where the exclusive dedication to the

FHS was of 32.1% of their workers working in the other locations and accumulating professional activities⁽²¹⁾.

For the authors mentioned here, the market and work conditions vary from hospitals that use high technology and clinics, or hospitals with low technological incorporation. The institutional work reveals another perverse side of the neoliberal project: work and contract flexibility and instability. The incorporation of the FHS model to the unique health system needs maturity regarding the available resources⁽²²⁾.

CONCLUSION

The purpose of this study was to analyze the work situations experienced by FHS professionals in a way to contribute for the organization of health services in the context where it was performed.

Results demonstrated that there are a few determining factors that facilitate the work process, among them, the following stand out: public health profile and education, knowledge on the geographic area of the study and the team work of professionals who compose the strategy. On the other hand, a few divergences are observed in the salaries between professionals in the same level, in addition to a differentiated work load within the FHS team.

An important aspect to be considered and demonstrated by the study regards the great majority of professionals who have other work contracts originated, as they suggest, by the work instability in the FHS. For this reason, the work contract modality has been highly questioned by them. The existence of temporary work leads part of those professionals to keep more than one job, a fact that is supported by the findings in this study. Therefore, a great problem generated by the unstable work is its vulnerability, exposing workers to subordination, making it impossible for them to fully exercise their labor rights.

Another difficulty is the little organization of those services in performing those professionals' activities. Non-availability of equipments and instruments is observed, demonstrating that those activities are soft and soft-hard technologies-centered. It is sure that for the performance of any of those activities, the use of compatible material for its execution is needed, and activities and/or actions local planning is also needed. However, it is still a questioning situation, since the non-availability of hard technologies is a frequently present complaint in this care model guided to health prevention actions.

It is important to point out that there is a need of those professionals to incorporate the health surveillance principle in a way to contribute and guide their care model. The territory, health and intersectoriality problems routinely faced by them in the work are pillars that support the health surveillance practice and should not yield to other activities.

Finally, a compound of intersectorial operations should be articulated, guided to solving the population's health problems, based on the commitment and responsibility in

substituting traditional care practices, with the need for interacting historical, political, social, economic and cultural

factors related to the managers, the community and health professionals.

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