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Practices developed by nurses in primary health care in southern Brazil

Práticas desenvolvidas pelo enfermeiro na atenção primária na região sul do Brasil

Practicas desarrolladas por los enfermeros en atención primaria de salud en el sur de Brasil

Beatriz Rosana Gonçalves de Oliveira Toso[a]
Bárbara Izabella Orth[a]
Leticia Becker Vieira[b]
Carlise Rigon Dalla Nora[b]
Daniela Savi Geremia[c]
Ana Valéria Machado Mendonça[d]
Maria Fátima de Sousa[d]

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ABSTRACT

Objective: To understand the practices developed by nurses in primary care in southern Brazil.
Method: Qualitative study, with data collection via online interviews, conducted between October 2020 and May 2021, and recorded. 174 nurses from 24 municipalities in southern Brazil participated. Data analysis used inductive thematic analysis.
Results: The activity that stood out among nurses was the nurse consultation, for all age groups and health conditions, especially when dealing with chronic disease, prenatal care, attention to women and children, mental health, home visits, and the management of the nursing team and the health unit.
Final considerations: This study demonstrated that an excess of responsibilities associated to care and management, added to a lack of balance in the activities common to the team make it difficult for nurses to develop clinical practices.
Descriptors: Primary health care. Nurse's role. Professional competence.

RESUMO

Objetivo: Compreender as práticas desenvolvidas pelo enfermeiro na atenção primária, na região Sul do Brasil.
Método: Estudo qualitativo, cuja coleta de dados foi com entrevistas online gravadas, entre outubro de 2020 e maio de 2021. Participaram 174 enfermeiros, de 24 municípios da região sul do Brasil. Análise temática indutiva dos dados.
Resultados: A consulta do enfermeiro é a atividade que se destaca, para todas as faixas etárias e condições de saúde, especialmente nas situações crônicas, pré-natal, atenção a mulher e a criança, saúde mental, visitas domiciliares, além do gerenciamento da equipe de enfermagem e da unidade de saúde.
Considerações finais: Demonstrou-se que o excesso de responsabilidades assistenciais e gerenciais e a falta de equilíbrio entre as atividades comuns à equipe, dificultam o desenvolvimento de práticas clínicas do enfermeiro.
Descritores: Atenção primária à saúde. Papel do profissional de enfermagem. Competência profissional.

RESUMEN

Objetivo: Comprender las prácticas desarrolladas por las enfermeras en la atención primaria en el sur de Brasil.
Método: Estudio cualitativo, con recolección de datos a través de entrevistas en línea, realizadas entre octubre de 2020 y mayo de 2021 y grabadas. Participaron 174 enfermeras de 24 municipios en el sur de Brasil. El análisis de los datos fue temático inductivo.
Resultados: La consulta de enfermería se destaca como actividad de los enfermerosen todas las edades y condiciones de salud, especialmente situaciones crónicas, atención prenatal, atención a mujeres y niños, salud mental, visitas domiciliarias y gestión del equipo de enfermería y la unidad de salud.
Consideraciones finales: El estudio ha demostrado que el exceso de responsabilidades asistenciales y de gestión y la falta de equilibrio entre las actividades comunes del equipo dificultan a las enfermeras el desarrollo de las prácticas clínicas.
Descriptores: Atención primaria de salud. Rol de la enfermera. Competencia profesional.

[a] Universidade Estadual do Oeste do Paraná (Unioeste). Campus Cascavel. Centro de Ciências Biológicas e da Saúde. Cascavel, Paraná, Brazil.
[b] Universidade Federal do Rio Grande do Sul (UFRGS). Escola de Enfermagem. Porto Alegre, Rio Grande do Sul, Brazil.
[c] Universidade Federal da Fronteira Sul (UFFS). Campus Chapecó. Curso de Graduação em Enfermagem. Chapecó, Santa Catarina, Brazil.
[d] Universidade de Brasília (UnB). Centro de Ciências da Saúde. Brasília, Distrito Federal, Brazil.

INTRODUCTION

Since the 1960s, Primary Health Care (PHC) has been presented as a model of health care in many countries. Since the international conference on PHC, convened in 1978 by the World Health Organization (WHO) in Alma Ata, Kazakhstan, it was determined that PHC should be universal, integral, and equitable. This meeting was a milestone to determine a health care model that included the entire world population and had quality, a model that would overcome the medical-centered one, providing an innovative integral health care network[1].

The concept of PHC, as defined in 1978 in the Alma Ata declaration on primary care, includes three main components: there should be universal access and the PHC should be the entryway into the health system; health and socioeconomic development should be indissociable, keeping social determinants in mind; and there should be social participation[2].

In Brazil, the implementation of PHC started with the Community Health Worker Program (PACS), in 1991, followed by the Family Health Program, in 1994. The PHC assumed the role of user entryway into the Single Health System (SUS), as well as that of first level of care. Its function was coordinating care and managing assistance, while also organizing the Health Care Network (RAS). In 2006, the pact for primary care was approved. Later, in 2011, the first National Policy for Primary Care (PNAB) was enacted, focusing on Family Health (FH) as the main model to reorganize PHC. Population coverage increased throughout the years, and the model became an international example in this regard[3,4]. This policy was reformulated in 2017.

In the PNAB, the primary health care is focused on the individual, considering their particularities and sociocultural position, seeking to achieve integral care, including: health surveillance measures, planning, and the implementation of public actions to protect the health of the population, prevent and control risks, health problems, and diseases, and to promote health[5].

These practices developed and consolidated with multidisciplinary and/or family health teams that work in the area covered by each unit, considering the registration of the families and becoming the main contact point between user and SUS. Their actions include the prevention of health issues, the promotion and protection of health, diagnosis, treatment, and health maintenance and rehabilitation, among others[6].

For the teams to reach the expected results, since the access also includes the problem-solving capacity of care, work processes must be organized. There must be good management and leadership, and the health network must function according to multiprofessional practices, with collective decision-making[7].

In Brazil, the nurse stands out in the PHC as an essential worker to carry out the model proposed by the Family Health Strategy (FHS), due to their potential to occupy specific roles in the direct care with users, coupling this type of care with FHS managerial activities[8]. Thus, based on the different professional activities of the PHC nurse, this research aimed to understand these practices and attempt to understand their specificities in the south of Brazil.

The PNAB determines that the nurse must, as part of their role, carry out activities related to[5]: a) providing health care to individuals and families in all stages of their life cycle; b) procedures; c) group activities; d) nursing consultations, complementary exams, and prescription of medications, as long as the legal requirements of the profession, its other protocols and the technical norms from the Ministry of Health, state managers, and other services are respected,, and send them, if need be, in addition to the referral of users to other services when necessary.

In countries whose health system is universal and similar to the Brazilian one, such as Portugal, Spain, United Kingdom, and Canada, nursing professional practices in the PHC are quite similar to those conducted by these workers in our country. However, this is not true for the adoption of advanced practices in the settings mentioned, since in this case the nurse has greater autonomy for clinical care[9–11].

The work of nurses has revolved around direct assistance and management, involving several activities related to system and team management, assistance administration, and monitoring of care, in addition to activities related to the promotion, maintenance and recovery of user health[6,7].

Considering the responsibilities mentioned, the research question of this study is: What are the practices developed by the nurse who work in primary health care in the south of Brazil? Which activities stand out among those performed by nurses? To answer these questions, the goal of this study was to understand the practices developed by nurses in the primary health care in the south of Brazil.

METHOD

Type of study

This is a qualitative study, emerging from a main project called "Nursing Practices in the Context of Primary Health

Care". This is a multicentric, national project, coordinated by a group of researchers from the Public Health Study Center at the Universidade de Brasília (UnB), together with the Federal Nursing Council (COFEN) and public universities in all Brazilian states.

The authors followed the Consolidated Criteria for Reporting Qualitative Research (COREQ). In each state, the study was coordinated by a PhD researcher who had ties to a federal or state higher education institution. In the South, it counted on a coordinator and a team formed by nursing graduation and post-graduation fellows. All were female. All those involved were trained to carry out the interviews through online workshops and simulated interviews among themselves. A field research manual was prepared and made available to the data collectors. They were also trained and received a manual for the transcription of the interviews. Their relationship with the participants was established via telephone before the interviews. The research was then explained, and the online data collection was scheduled. Participants did not know their interviewers beforehand. They were presented when they received the invitation to participate in the research.

Study location

The settings of the study were chosen at random in a randomization software. They included the PHC services, developed both in the traditional Basic Health Unit models, (UBS) and in FHS. Regions included had been classified by the Brazilian Institute of Geography and Statistics (IBGE) as urban, adjacent intermediary and remote, rural adjacent and remote, and in small, medium, and large sized municipalities, in all first 27 states of the country. The present paper addresses the three states in the south of Brazil, with 24 cities.

Study participants and inclusion/exclusion criteria

Of the participants from the South, 174 were nurses who worked in the PHC, 74 in Paraná (PR), 59 in Rio Grande do Sul (RS), and 41 in Santa Catarina (SC). The professionals were from 24 different cities.

Inclusion criteria contemplated nurses who worked in direct assistance or PHC management, whether they used a traditional model or a family health team, with 3 years or more of work in the PHC. Were excluded preceptor nurses, consultants, and any others who did not have a formal work relationship with the health services, in addition to nurses who were absent due to vacations or leaves of any kind during data collection.

Participants were recruited by: 1) finding the number of nurses in the city according to the National Registry of Health Services (CNES); 2) inputting these names in a randomization software to select nurses who were actively working in the PHC, according to the typology of the cities; 3) an invitation was sent to the Health Secretariat, aided by the supporters of State and Municipal Health Secretaries (COSEMS and CONASEMS). They sent the invitations to PHC nurses, so the interviewees could contact these worker and schedule the interview; 4) the snowball approach was used by asking the nurses to refer one other worker; 5) the referred person was contacted via WhatsApp or phone number, provided by the initial nurse; 6) in the case the interviewee was absent, two other calls were made to schedule the interview. If contact was not possible, attempts were made to contact the next participant.

Since data collection took place during the COVID-19 pandemic, from October 2020 to March 2022, 22.8% of the nurses who could participate in the interviews did not accept the invitation (28 from PR, 9 from RS, and 5 from SC). Many of them scheduled an online interview, but were not present on the date and time decided upon.

Data collection

Data collection took place through online video calls, using tools that allowed interviews to take place in real time and be recorded for later transcription. Participants chose the day and time of these interviews, which could be during work hours and in the workplace, or not. The platforms used for the interview were those made available by the institutions of the researchers who coordinated the research in each state (Google Meet, Cisco Webex, and Microsoft Teams). The quality of the connection to the internet impacted this data, and the interviews often had to be interrupted and restarted.

We asked questions to the nurses based on a pre-structured script that had been tested in a pilot study. The answers were open, and the questions were: How is your workday and what are your main activities? What do you find to be easy or difficult in your work as a nurse? Regarding your activities, in which field do you find that you have professional autonomy? Do you provide collective care to population groups in the health unit? What type of actions do you perform? What health needs occupy most of your attention?

The mean length of the interviews was one hour. Although we reached data saturation, interviews attempted to include

all nurses possible in the same city, and reaching saturation was not considered as the criteria to finish the interviews. We offered a copy of the transcription of the interviews to all participants for comments or corrections. However, less than 10% reviewed them, while the others simply agreed to their use.

Data analysis

Data analysis was inductive-thematic. This is a method to identify, analyze, interpret, and report standards using qualitative data, in such a way that we can organize and describe the rich details of data, with writing as an integrative part of the process[12]. Data was grouped, first, according to type of response, for an initial reading. Then, we marked the convergent and divergent answers with different colors and created the first units of meaning. The answers marked with different colors were separated into Word files and grouped according to category of analysis, originating thematic units for analysis. These included a unit called PHC nursing practices.

Data was coded by approximately 30 people, including research coordinators and the coordinators from the 27 participating states. This was done with the analytical support of the NVIVO software. The coordinators were trained to use the software before the data coding process started. The coding tree was elaborated according to the data.

Ethical considerations

This project was submitted to the ethics committee of the Universidade de Brasília, with amendments added for each state. It was approved by the CEP under opinion number 4.263.831 and CAAE 20814619.2.0000.0030. All ethical recommendations from resolutions CNS 466/2012 and 510/2016, as well as complementary rulings, were respected.

The participants signed the free and informed consent form, and authorized the use of their image, since the interviews were online and recorded in video. Participant identity was anonymous, and acronyms were used to identify them, such as ENF155-PR-PR, where ENF means nurse, the number indicates the order of the interview, and the abbreviation at the end indicated the state where the person works.

RESULTS

The participants were characterized according to social and professional characteristics, which can be found in Table 1.

Table 1 – Participant characterization regarding sociodemographic, professional education, and work-related variables. Southern Brazil, 2022.

VARIABLES	ASPECTS	n	%
Sociodemographic			
States	Paraná	74	42.53%
	Rio Grande do Sul	59	33.91%
	Santa Catarina	41	23.56%
Typology of the municipality	Adjacent Intermediate	40	22.99%
	Remote Intermediate	3	1.72%
	Rural Adjacent	46	26.44%
	Remote Rural	7	4.02%
	Urban	78	44.83%

Table 1 – Cont.

VARIABLES	ASPECTS	n	%
Sex	Female	163	93.68%
	Male	11	6.32%
Ethnicity/color	Asian	2	1.15%
	White	144	82.76%
	Brown	19	10.92%
	Black	8	4.60%
	No response	1	0.57%
Marital status	Married	100	57.47%
	Divorced	8	4.60%
	Single	52	29.89%
	Informal marriage/widow	13	7.47%
	No response	1	0.57%
Nurse's income	R$2001 to 3000	8	4.65%
	R$3001 to 4000	31	18.02%
	R$4001 to 5000	34	19.77%
	R$ 5001 to 6000	30	17.44%
	R$6001 to 7000	10	5.81%
	R$7001 to 8000	22	12.79%
	R$8001 to 9000	11	6.40%
	More than R$9000	26	15.12%
Professional education			
Type of educational institution	Private	102	58.62%
	Public	71	40.80%
	Not informed	1	0.57%

Table 1 – Cont.

VARIABLES	ASPECTS	n	%
Specialization in the area of expertise	No	69	39.66%
	Yes	100	57.47%
	No response	5	2.87%
Work-related			
Type of health unit	Rural	32	18.39%
	Urban	132	75.86%
	Not informed	10	5.75%
Care model	FHS	84	48.28%
	Mixed	10	5.75%
	PHU	47	27.01%
	No response	33	18.97%
Time working in the unit	Less than 1 year	21	12.07%
	1 to 2 years	53	34.64%
	3 to 4 years	30	27.31%
	5 to 6 years	15	18.78%
	7 to 8 years	20	21.08%
	9 to 10 years	10	4.59%
	More than 10 years	13	6.22%
	No response	12	6.13%
Reason for choosing this workplace	Selection Processes	92	53.18%
	Work contract	19	10.98%
	Because the nurse lives on site	25	14.45%
	It is near their residence	27	15.61%
	Others	10	1.73%

Source: The authors.

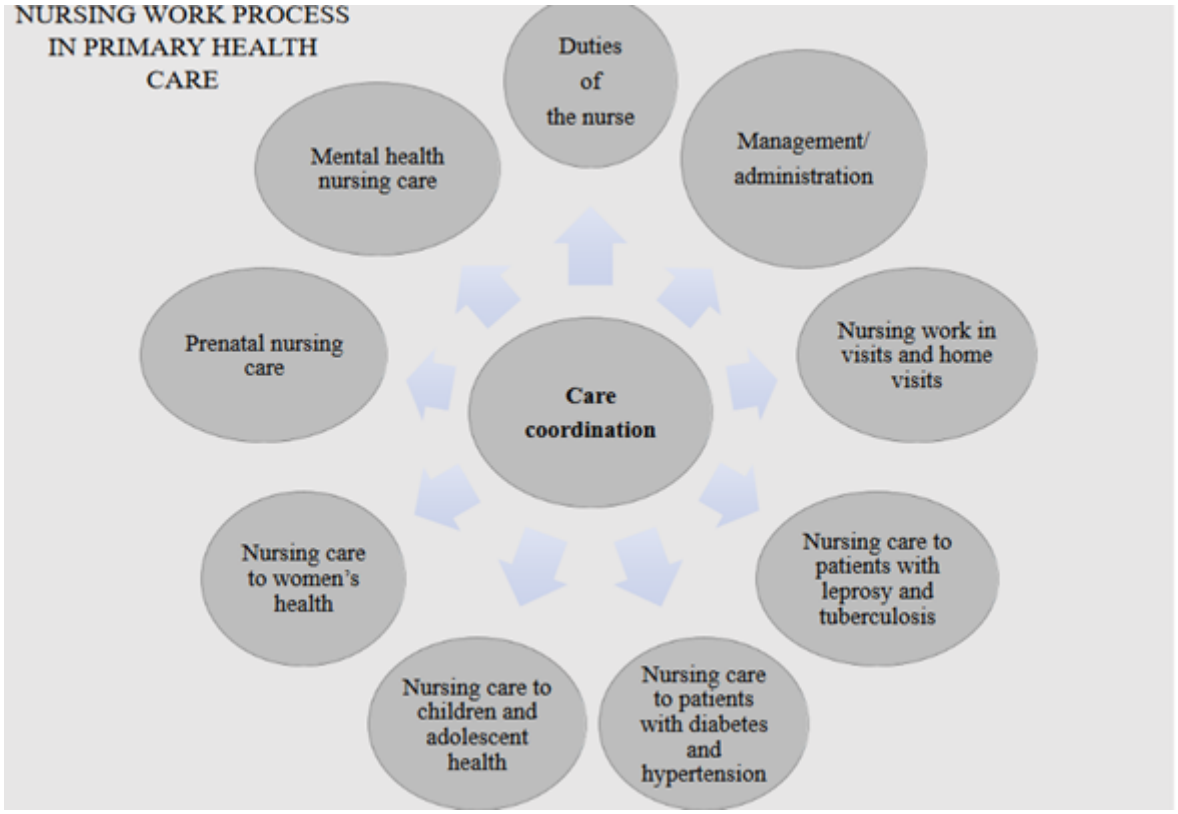
In the three states in the south, we interviewed nurses from capitals and other cities, according with the typology previously established. Most were from Paraná (42.53%) and lived in urban areas (44.83%). Most nurses were female (93.68%), with a mean age of 39 (SD 7.72), self-declared white (82.76%), married (57.47%), lived with three other people (32.18%), and the most common salary was from three to six thousand reais, approximately 20% in each of the statements.

Regarding professional data, most studied in private schools (58.62%) for a mean of 14 years (SD 6.63) and had specializations in their field of work (57.47%). Most interviewees worked in urban units (75.86%), in the FHS model (48.28%), had an experience of 10 years in the PHC (SD 5.48), and worked from one to two years in the unit in which they are (34.64%) now. The majority live in the same municipality in which they work (82.18%) and their work relationship with the municipality was formed via an official selection process (53.18%).

The category Nursing Practices in the PHC is expressed by the nurse in the coordination of care. It includes subcategories that stood out in the interviews, according to Figure 1.

The results are presented in Chart 1, below, in the form of a thematic matrix, including subcategory, an outline of the answers, and examples of statements that are representative of the sample.

Figure 1 – Categories and subcategories of the coordination of care in the work practices of the nurse in the PHC. South of Brazil, 2021.



Source: the authors.

Chart 1 – Statements of nurses according to subcategory. Southern of Brazil, 2021.

Subcategory/Outline	Statements
Nurse Duties The workers report about their activities in their daily life at work, showing that they share their time between managerial and care activities in the several lines of care, which are organized in weekly schedules. Furthermore, they assume extra activities necessary for the functioning of the unit.	*I am a direct care nurse, I work a lot with nursing consultations. A small part of my day I spend supervising the team, especially in the beginning of the shifts, to see if everything is working, everyone is on their scales, in short, the activities. Then, I take care of the direct assistance needs, which takes most of my time. I work with prescheduled patients and consultations, as well as with scheduling. [...] I conduct consultations related to women's health, gynecology consultations, prenatal consultations, diabetics, hypertensives, and other demands. I also carry out some specific nursing procedures, such as vesical catheterism, cystostomy tube replacement, special wound dressings, and home visits.* (ENF168-PR) *I work following a schedule, there are always some activities to be done. On Mondays we start prenatal consultations in the morning and make home visits in the afternoon. On Tuesday, preventive care in the morning, and every 15 days we have a team meeting, in the afternoon there is preventive care again. On Wednesday morning I attend pregnant women, and on the afternoon I do childcare. On Thursday I attend pregnant women too, make quick tests and prenatal care, in the afternoon I conduct quick tests too. On Friday, I provide general care.* (ENF155-PR) *Wound dressing, injections, these activities that would be the duty of a technician, we do them a lot too, depending on the demand, and if you are there you end up doing it, you provide assistance, coordination, and home family health.* (ENF55-RS) *Nurses do a bit of everything, and you know, it is not easy [smiles], because it seems that everything is part of the role of nurse, and when a role is not specifically made for a nurse, and there is something to do that is not anybody's specific role, you can bet they will ask the nurses to do it [...] that the nurses will find a way to solve it, such as a faucet is broken, the nurses will handle it, that definitely gets in the way.* (ENF88-RS) *Yes... the nurse here in [city name] is not a clinical nurse anymore, so we do a lot of nursing consultations (ENF8-SC).*

Chart 1 – Cont.

Subcategory/Outline	Statements
Administration/ management The reports mention daily work organization in the team, work scale verification, and professional distribution, organization of work schedules, vaccination rooms, team leadership, conflict management, management of daily issues, even if they are not the nurse's responsibility, such as filling in forms, managing human resources, and managing supplies and equipment.	*I arrived and had to do all that process of organizing the team using a scale, which activities would be done and how work would be carried out that day. Which public, which vaccines come first, which were the second application, and how to organize this whole process. I started work and made adjustments. Supporting the team in their solicitations, problem solving, and finding failures in the communication and record system, helping to overcome these failures, organizing supplies.* (ENF149-PR) *Of course, we have all managerial concerns to deal with, leading the clinic, leading the team, managing conflict and all that, but the clinic must become part of the practice. I have to organize my activities so that 60% of the time I'm attending people, in their different needs, and 40% of the time I do managerial tasks of the unit.* (ENF171-PR) *We spend some time going to the unit, especially in a city like ours, which is quite large, so you spend a lot of time going from the city offices to the health units.* (ENF112-PR) *But normally, "it goes together like this", I get there and I have to deal any problems that appear, everything, from a janitor that could not come, to the coffee, to the cooking gas that is over, to the broken bathroom, to the patient who is waiting at the door but has no schedule, and who is angry and screaming. Calls from the health secretariat.* (ENF129-PR) *I coordinate the team, carry out bimonthly meetings where they discuss cases, and the functioning of the unit, as well as practical issues related to functioning, teamwork issues, conflicts that could come up, I also dealt with that in these meetings. In monthly meetings with community health workers I asked them for their reports from home visits, and there are many details about activities involving hypertensive people, diabetics, smokers, pregnant women and their children, vaccination, and so, when getting the report I would also discuss with them specific cases of each of their micro-areas. [...] We make reports all the time, nurses make reports their whole lives, all we do has to be reported to the Ministry of Health. We have to attend every goal, there are goals to reach [...] so the municipality gets funding from the federal and state governments.* (ENF-70-RS). *I manage human resources, the service, and organize the working process with the team. Bureaucracy is a serious issue, including requests for supplies, organization, clocking out the workers, outsourced workers, organizing the work process as a whole, discussions with the process team, permanent education of the workers, weekly meetings, and HR management itself, HR evaluations are quite frequent, conflict mediation, meetings with the community, we have monthly meetings with community leaders.* (ENF96-RS) *In our unit there is a collegiate that does the management, we have a coordinator, and also a moment in the collegiate where we make decisions and share them, which also increases the autonomy of workers to make decisions regarding the work process of the teams.* (ENF23-SC)
Home visits This activity was present in the reports of all participants and was found to be routine in their services.	*On Thursday morning we conduct a lot of home visits, and those who do the visits make multidisciplinary meetings, so it is the physician, me, and the CHW of the territory, so I like to be there, to show the CHW, so she is there, I like this multidisciplinary work a lot, because I think that everyone has to know about the patient.* (ENF124-PR) *We have the Home Attention Program, there are also situations that require home visits, such as child or mother death investigations, violent cases that have been denounced, and the active search for some situation that requires treatment.* (ENF90-RS) *Of course, home visits, home consultations, home visits. And the part of territory surveillance, health surveillance.* (ENF15-SC)

Chart 1 – Cont.

Subcategory/Outline	Statements
Leprosy line of care in tuberculosis In the south of the country, the cases of tuberculosis and leprosy are frequent, and the nurses mention that they work in a more autonomous way in these cases.	*Following leprosy and tuberculosis requires many activities.* (ENF99-PR) *Tuberculosis (TB) patients, these are difficult. Because they want to abandon treatment, and it is a long treatment. You have to be on top of them, they give up, get tired, this is the hardest part for me, to be honest.* (ENF158-PR) *I follow up tuberculosis, with the physician, of course! But the nurse is the one who controls medication, its dispensation, requests for KB [*Koch's Bacillus], *for control. We also request KB in the invitation, the screening, but controlling is also with us, we leave the clinical evaluation scheduled, but the medication, the treatment, and the KBs are controlled by the nurse.* (ENF82-RS) *I monitor care spreadsheets and this is decided by each team, since I monitor it monthly, I see if they are using the medication correctly with the tuberculosis, check the LTBI*[Latent Tuberculosis Infection], and attend patients who are following prophylactic treatment with isoniazid.(ENF22-SC)
Line of care of diabetes and hypertension Caring for chronic conditions such as diabetes and hypertension is mentioned as a responsibility of nurses, both because they need to request exams and control medication, in addition to having their own schedule for dealing with this group.	*Hypertensive and diabetic patients are in the same situation, we check if they need to undergo tests, if they already have results, if the prescription is up to date, if there is any other issue, any complaints.* (ENF145-PR) *We try to develop a workflow, especially with diabetics and hypertensive patients, that enable us to control the number of consultations they come to, the degree of severity of the disease, whether they are insulin-dependent or not, this is all controlled, we are the ones who conduct the triage for more urgent issues in the unit. In terms of care, if the capillary glycemia of the diabetic patient is totally altered, we receive them and carry out a nursing consultation, and if necessary refer them to the physician.* (ENF143-PR) *The hypertensive and diabetics, in the beginning of the month, on Monday afternoons, Wednesday afternoons, and Thursday afternoons, I go to three different communities to provide care. This activity is exclusive for them, I deliver medication, measure vital signs, monitor medication intake, who is not taking it, who is unbalanced, who is not, I write new prescriptions, some educational activities on the topics [...].* (ENF54-RS) *You have a day for the hypertensive patients and diabetics. Now, with the changes in the indicators, the Ministry of Health states we must have a registered arterial pressure verification and the glycated hemoglobin must be on record too, for each diabetic or hypertensive patient, so you end up increasing nursing consultation and alternating them with clinical consultations.*(ENF34-SC)
Line of care in children/adolescent health Evaluation of the growth and development through childcare consultations of the nurse stood out in this group, in addition to student health.	*Children, we follow their development, note anthropometric data, fill out their vaccination records, give guidance about diet, weight, whether it is normal, fill in charts and attend the needs of the parents who are the guardians of the child.*(ENF145-PR) *We conduct childcare, development, vaccination, in short, we attend the requirements of* bolsa família *[a Brazilian welfare program], the follow up, part of health in school, home visits, active searches.* (ENF99-PR) *We generally conduct childcare consultations every month, with the children, collecting for the heel prick test. We do it at home, we go to the home and give orientation to the mother, see everything there is to do and conduct the first consultation there. Then, we schedule the follow up of these children, up to 10 days with the pediatrician, then 1 month, 6 months, these children go through pediatrics and, in other months, they come to us, and we try to alternate, one consultation with a nurse, one with a physician.*(ENF67-RS) *We do all the assessments too, neuropsychomotor development, reflexes, physical examinations, weight, height, give orientations to the mother [...]*(ENF12-SC)

Chart 1 – Cont.

Subcategory/Outline	Statements
Women's health care line Pap smear, breast exam, contraception, postpartum care, and IUD implementation were reported practices.	*Breast and cervix cancer prevention, adolescents who will start using contraceptives, who come for the first orientations after the menarche, postpartum care during pregnancy, the start of contraceptive use, conversations about these methods, orientation so they can decide/choose which methods are better for them.*(ENF145-PR) *Women's health consultations too, preventive exam collections, guidance, family planning, rapid tests as well. In my unit I was the only one to conduct both the preventive exam for women and the rapid tests.* (ENF86-RS) *We even implement IUD* [intrauterine device]*, not all of them do it. I am also an IUD facilitator, which means I have a practical and theoretical course on it, I am the replicator of this course, I teach the theoretical course and supervise the insertions. We are really careful, not all nurses here in* (name of the city) *are prepared, you cannot just arrive here and think you will place an IUD in your first day, it is not like that*. (ENF1-SC)
Prenatal care line The nurse has an active role in the prenatal, autonomy to request exams, carry out consultations, and prescribe medication according to the Ministry of Health	*This consultation takes a long time, I spend about one hour. Because we have to fill in the chart of the pregnant women, guide them about prenatal, consultations, exams, the first consultation, when to undergo the obstetric ultrasound. Since this is the prenatal, we check the tetanus and hepatitis B vaccines, and they have many demands, especially in the first pregnancy, they have a lot of questions and the consultation takes longer as a result. Including much guidance, we prescribe folic acid and ferrous sulfate.* (ENF169-PR) *For pregnant women, I do as the Ministry of Health requires: six consultations, four with the nurse and two with the physician. Then, in the unit, we do seven consultations: three with the physician, because we ask for lab and imaging exams in the first three trimesters.*(ENF54-RS) *Here in the unit we do the entirety of the low risk prenatal, and the reception is always done by the nurse, in our team. So, even if the physician detects the pregnancy in a first consultation, they ask the team's nurse to bring the women for the prenatal* (ENF9-SC).
Mental health care line The lack of activities toward mental health in PHC stood out, as well as the perception that the demand for these services increased.	*Currently, we notice a large demand regarding the use of controlled drugs, from children to elders. There is a lot of anxiety and many psychosomatic diseases that we have seen increase daily.* (ENF110-PR) *Mental health here does not receive much assistance, I have been noticing this for some time. We have no specific activities for mental health, and there is only one psychologist in the city who attends all patients.* (ENF55-RS) *What has required most of our attention are the issues related to mental health. A lot of people in our population use controlled medication to treat depression, so we even discuss this in team meetings, many patients seeking antidepressant treatment, many patients who come with many nonspecific demands that have a mental health component.*(ENF25-SC)

Source: The authors.

DISCUSSION

The practices reported by the nurses in this study include broad care related activities, be them carried out in nursing consultations or in care activities and home visits. They include all age groups and the management of teams or health units and were similar in all Southern states.

The profile of the professionals interviewed in this study is similar to that found in the 2017 Cofen research, in all variables analyzed. Nurses are predominantly female (85.1%), from 36 – 50 years old (40%), married/informally married (48.7%) and living where they work[13]. They graduated from private institutions of higher education (57.4%) 10 years ago or less (63.7%) and have one specialization (72.8%). They have been working for 2-10 years (42.4%) and 11-30 years (38.5%) in one professional activity (58%), in most cases, for 31-40 hours per week (35.4%) or between 41-60 hours per week (28.6%). The second highest number was in primary care (20.1%) and 37% had incomes below 3,000 reais[13]. This result is different from that in our study, where most participants earned from three to six thousand reais per month (55.23%).

Based on the reports that described the role of the nurses, and considering the descriptions of the PNAB for the working process of these professionals, we can see that their duties are numerous, including direct assistance practices, mentioned in the performance of actions for the programs and groups in the statements, and other, management related health units. Similarly, a study about the practices developed by nurses in primary care concluded that these workers do two different types of work. While they coordinate the activities of the unit, they also provide health care, developing established programs which are ensured by and based on laws and directives, both from the professional council and from health services[14].

Authors also mentioned that, among the activities performed by nurses, nursing consultations stand out in all priority groups and age groups, and it is the most common activity in their routine. These results corroborate the outcomes cited by the nurses interviewed in this research, who carry out health care and managerial activities, while also working in nursing consultations. The duties carried out and the consultations performed are in line with first contact care, enabling universal access and care relations based on the social determinants of the health-disease process[14].

The nurse is the key professional for expanding clinical practices in in universal systems with broad primary care, as in the case of Brazil, improving access and the problem-solving capabilities of care. In countries where advanced practices take place and nurses have a broader clinical role, they are considered essential in PHC[15].

It is possible and desirable for nurses and physicians to share their work in the PHC, as this would enable the expansion of the clinic, changing the medical-centered approach into a user-centered one, dividing the responsibilities of care among team members, welcoming and listening, improving problem-solving capabilities, and expanding access to services[16].

Still regarding nurses' duties and practices in care management, the authors listed that PHC nurses must promote the health of all users registered in the unit, whether in the unit itself or in the home of the users, in all stages of human development. They must aid in procedures, prescribe drugs according to protocols, refer patients, provide continued and permanent education for work groups, plan, manage, and evaluate with the team all activities carried out by Community Health Workers (CHW), and provide nursing consultations[17,18], as mentioned by the participants of this study.

In addition to these duties, the nurse who manages a health unit is responsible for leading the team, delegating roles, and supervising other workers, managing supplies so the unit works well and organizing the different procedures needed by the user. Since the nurse has a good handle on the health team in order to solve problems and conflicts, they end up becoming the manager of the health unit. These roles are in accordance with the reports of the nurses interviewed, who stated they have these two different roles, and that they never stop performing the attributions that are inherent to the profession[17,18].

In the statements found in this study, nurses reported that, despite performing their own activities, they often end up performing functions that are not their responsibility. This is mainly due to a lack of sufficient personnel and/or to employees who do not fulfill their duties, in addition to the excessive administrative requirements of the unit. The nurses report that they dispensed medication in the absence of the administrative employee that should carry out that activity, performed duties of nursing technicians, since the unit did not have this type of professional at all times, organized medical schedules, and even worked as drivers for the unit.

A study that analyzed the positive and negative points of nursing workloads in five Brazilian states found that, in most cases, the nurses have to stop carrying out their roles to attend excessive demands from the health unit and community (external activities). The factors that contributed to that include the lack of material, physical, and human resources. A previous study emphasized the fact that nurses become ill due to excessive workloads. The workers reported that they ask too much of themselves once they become responsible for the good progress of the health unit but cannot fulfill their duties, which leads to feelings of frustration[19].

The nurse, however, is seen as the manager or leader of the health unit because of their perspective regarding users and the team, even when this is not actually their responsibility. This affects their ability to fulfill their own duties. An investigation about the practice of nurses in primary care highlighted that, when the nurse has multiple roles to fulfill, they become overworked. This reiterates the idea that they are permanently busy professionals, which are unavailable for conversation, bringing the nurses away from team and community[20].

In the same study, nurses are seen as professionals responsible for doing everything. For example, they take on the role of managing basic supplies of the unit, buying cooking gas, solving issues related to the electrical system, and performing different activities which are emotionally exhausting. They end up losing their own professional identity, as they embrace a range of responsibilities that go beyond their function. Finally, there is a feeling of becoming distant from the essence of the professional, since, by assuming the roles of other workers, they have the feeling that they belong to other categories than nursing[20].

In their statements, nurses reported not being able to attend all that is expected of them, since they take on the role of team coordinators, as mentioned above, assuming other roles and, consequently, abandoning their own, which has become a characteristic of this professional. An integrative review[7] concluded that the nurse has the intrinsic characteristic of being the team leader. When the team looks at the nurse in this light, they have good results, since, in a leadership position, they can have a good interpersonal relationship and make qualified decisions.

The current PNAB includes managers in the Family Health Team among the professionals who work in this level of care. Nurses, in their daily practice, tend to assume this managerial role. A study that analyzed the competences that PHC managers need to have showed that nurses are uncomfortable and uneasy in regard to this double line of work. As they assume the management of the unit, the time they can devote to working processes and care is considerably reduced. This often prevents them from providing integral care to users. They also mentioned that they do not feel truly prepared to move between the dimensions of care, management, and education that work in health require, emphasizing the need for continued education[21].

The PHC, which had already been going through structural, physical, and organizational obstacles, underwent several changes in the routine of population attention in 2020, as the COVID-19 pandemic advanced. This is especially true for biosafety measures that affected the practices of care in this units, involving the nurses. The reports found in this research showed that the activities that underwent changes, be it due to lack of workers or orientations received in the municipal level, considering the contingency plans that aimed to avoid crowding and suspend services that would not be classified as urgent. The experience of a Brazilian municipality reported in a study highlighted the role of the PGC in the pandemic, according to contingency plans provided by the local municipal management. These included "identifying and managing suspected cases and cases confirmed early; preventing the transmission of the virus between health workers and their contacts; reinforce territory monitoring; disseminate information about preventive measures, involving the community; and maintaining all services that are essential for the population"[22].

The studies also highlighted the importance of valuing nursing and PHC, especially during pandemic outbreaks. After all, nurses stand out in the health workforce of the country, representing more than 50% of workers. Sanitary crises require us to value the profession by qualifying the nurses and developing their category according to the principles and directives of the SUS[23].

A study carried out with Australian nurses[24] reports that, during the COVID-19 pandemic, nurses did not feel valued or recognized for their role. They wanted the role of the nurse to be recognized as that of an educator, someone essential for the management of users with chronic diseases during the pandemic. In this regard, the role of nursing professional organizations stands out. They must take an active stance in the defense of the profession, guaranteeing that the voice of nurses is valued in primary health care and health policies[24].

Furthermore, the pandemic reinforced the leadership of nurses and the centrality of their role, especially in the case of PHC work. Not only PHC is the entryway into the health system, but the nurse is the main responsible for coordinating care in it. This is also true for other epidemics, such as dengue, yellow fever, zika, chikungunya, and others[25]. Thus, the nurse stands out in their bond with the users and the community, and for their knowledge about the territory the unit attends, facilitating notifications, orientations, and the referrals of new cases and symptomatic patients.

Home visits, health surveillance, and specific features of the care of different groups were reported by all nurses as part of their work activities. A study that analyzed the work of nurses in PHC showed similar findings. Nurses in PHC have a wide range of activities under their responsibility. They are responsible for managerial and assistance-related activities, regardless of the model of care. There were no actions for priority groups or health promotion. It is difficult for the

nurse to work as part of the teams and optimize their time, which is divided into organizational tasks and direct care to individuals and the population[11].

Considering the many different actions carried out by nurses in the primary health care units shown in this study, it became clear that these workers carry out their duties according to the PNAB, contributing to PHC services to have a high quality. The nurse is an indispensable professional in the health care network. They deserve recognition and should be valued for their performance in the profession and in the health sector. We expect the results found to call attention to nurses and the need to value them.

A limitation of this study includes the fact that data collection took place via online interviews. This was the only option to obtain data due to the COVID-19 pandemic, and it is a limitation as the workers could feel intimidated when responding due to the technique used.

FINAL CONSIDERATIONS

Nurses who work in PHC face many obstacles in the development of their clinical practices due to excessive responsibilities attributed to them, including direct care and management of the PHU, the team, and the users. The unbalance in the activities that are common to the team, especially regarding management, makes it more difficult for the nurse to carry out clinical activities.

Regarding their practice, it is worth noting that they coordinated actions in the lines of care established by the Ministry of Health, carried out nursing consultations, home visits, preventive activities, and health promotion. These were the activities most commonly mentioned by the professionals. The coordination of units and teams, human resource management, supply management, and equipment management meant that the nurse had multiple roles, and thus, became overloaded.

Nursing practices in the PHC were homogeneous considering the routine work of nurses in the three states of the South. Nonetheless, some differences were noted regarding nurse autonomy and protocol use, depending on the type of municipalities. The practice of nurses who work in smaller cities, more distant from urban centers, is more restricted. Furthermore, we found significant salary differences despite the fact the duties were the same, as determined by the PNAB.

In addition to the daily work in the PHC, it is very important to highlight that, in this study, many nurses had to face the challenge of leading their health teams through a pandemic. This certainly required managerial practices based on a broad view of health, and the need to adequately prioritize the issues and needs of the community.

In summary, we suggest, as a strategy to improve the quality of health, the access to it, and the performance of nursing practices, that the general responsibilities in the units should be reorganized and divided among team members, in addition to equal work journeys and salaries. PHC nurses carry out consolidated and effective practices when providing primary health care and have the potential to change habits and lifestyles. Their clinical practices are in accordance with the principles of the Alma Ata declaration and the PHC policies structured in Brazil.

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Authorship contribution:
Project administration: Beatriz Rosana Gonçalves de Oliveira Toso, Leticia Becker Vieira, Carlise Rigon Dalla Nora, Daniela Savi Geremia, Ana Valéria Machado Mendonça, Maria Fátima de Sousa.
Formal analysis: Beatriz Rosana Gonçalves de Oliveira Toso, Leticia Becker Vieira, Carlise Rigon Dalla Nora, Daniela Savi Geremia, Ana Valéria Machado Mendonça, Maria Fátima de Sousa.
Funding acquisition: Ana Valéria Machado Mendonça, Maria Fátima de Sousa.
Conceptualizaton: Beatriz Rosana Gonçalves de Oliveira Toso, Leticia Becker Vieira, Carlise Rigon Dalla Nora, Daniela Savi Geremia, Ana Valéria Machado Mendonça, Maria Fátima de Sousa.
Data curation: Beatriz Rosana Gonçalves de Oliveira Toso, Bárbara Izabella Orth, Leticia Becker Vieira, Carlise Rigon Dalla Nora, Daniela Savi Geremia, Ana Valéria Machado Mendonça, Maria Fátima de Sousa.
Writing – original draft: Beatriz Rosana Gonçalves de Oliveira Toso, Bárbara Izabella Orth, Leticia Becker Vieira, Carlise Rigon Dalla Nora, Daniela Savi Geremia.
Writing – review & editing: Beatriz Rosana Gonçalves de Oliveira Toso, Leticia Becker Vieira, Carlise Rigon Dalla Nora, Daniela Savi Geremia, Ana Valéria Machado Mendonça, Maria Fátima de Sousa.
Investigation: Beatriz Rosana Gonçalves de Oliveira Toso, Leticia Becker Vieira, Carlise Rigon Dalla Nora, Daniela Savi Geremia, Ana Valéria Machado Mendonça, Maria Fátima de Sousa.
Methodology: Ana Valéria Machado Mendonça, Maria Fátima de Sousa.
Resources: Ana Valéria Machado Mendonça, Maria Fátima de Sousa.
Software: Ana Valéria Machado Mendonça, Maria Fátima de Sousa.
Supervision: Beatriz Rosana Gonçalves de Oliveira Toso, Leticia Becker Vieira, Carlise Rigon Dalla Nora, Daniela Savi Geremia, Ana Valéria Machado Mendonça, Maria Fátima de Sousa.
Validation: Beatriz Rosana Gonçalves de Oliveira Toso, Leticia Becker Vieira, Carlise Rigon Dalla Nora, Daniela Savi Geremia, Ana Valéria Machado Mendonça, Maria Fátima de Sousa.
Visualization: Beatriz Rosana Gonçalves de Oliveira Toso, Leticia Becker Vieira, Carlise Rigon Dalla Nora, Daniela Savi Geremia, Ana Valéria Machado Mendonça, Maria Fátima de Sousa.

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Corresponding author:
Beatriz Rosana Gonçalves de Oliveira Toso
E-mail: beatriz.oliveira@unioeste.br

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