# When the entrance does not solves: analysis of the health family units in the city of Rio Branco, Acre

## Quando a porta de entrada não resolve: análise das unidades de saúde da família no município de Rio Branco, Acre

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## Resumo

Esta pesquisa tem como objetivo conhecer e compreender a realidade de algumas Unidades de Saúde da Família (USF) do município de Rio Branco – Acre, no sentido de contribuir para a reflexão sobre uma das estruturas tão complexa, como as demais, que é "a porta de entrada" na atenção básica, do sistema de saúde brasileiro. A experiência de campo deste estudo concentrou-se em um Segmento de Saúde localizado na Região da Baixada do Sol, tendo como Unidade de Referência o Centro de Saúde Augusto Hidalgo de Lima; a pesquisa foi realizada em quatro Unidades de Saúde da Família, entre os anos 2008 e 2009. Trata-se de um estudo qualitativo de perspectiva etnográfica que teve como técnicas de coleta de dados a observação participante e o grupo focal. Observou-se, durante a pesquisa de campo, que a comunidade não identifica a Unidade de Saúde da Família como um serviço capaz de resolver seus problemas de saúde, fato que leva à procura por outros serviços. Dentre as fragilidades encontradas, podemos citar: o acolhimento nas USF; recursos humanos não qualificados; a desorganização do processo de trabalho nos aspectos assistenciais, gerenciais e organizacionais. Os resultados mostram que o trabalho das equipes de saúde da família no Município de Rio Branco é centrado no médico e no atendimento curativo e que alguns profissionais organizam seu processo de trabalho de forma individual e fragmentada, dificultando o trabalho em equipe.
**Palavras-chave:** Atenção Básica; Processo de Trabalho; Organização do Trabalho.

## Abstract

The objective of this research is to know and to understand the reality of Family Health Units in the city of Rio Branco, to contribute to a critical analysis of an extremely complex structure, primary care units that are the main entrance to the Brazilian health system. The field research was conducted in four Family Health Units in the Baixada do Sol region, between the years 2008 and 2009. It is a qualitative study with an ethnographic approach; data were collected through participative observation and a focus group. During the field research, it was seen that the community does not identify the Family Health Unit as a service able to solve their health problems, a fact that leads them to seek help from other services. Among the vulnerabilities we encountered are: reception in the FHUs, unqualified human resources, and disorganized work processes in terms of assistential, management, and organizational aspects. The results show that the work of the FHUs in Rio Branco centers on the doctor and curative assistance, and some professionals organize their work individually and in a fragmented manner, making teamwork difficult.

**Keywords**: Primary Care; Work Process; Health Care Management.

## Introduction

The Brazilian National Health System (Sistema Unica de Saude: SUS) guarantees all citizens the right to access the services it offers in the areas of promoting, protecting, and recovering health; according to current policies, this access is given primarily to basic care services. Brazil's Pact for Health (Brasil, 2006b), in defining the national policy, "characterizes basic care as a set of health actions, in the individual and public arenas, which cover the promotion and protection of health, prevention of illness, diagnostics, treatment, rehabilitation and maintenance of health" (p. 12). Basic care as a port of entry is referenced in the Bill of Rights for SUS Users (Brasil, 2006a, p. 2) published by the Ministry of Health, in which the first principle guaranteed to all citizens is access to health services which "should be orderly and organized". As the first item of this principle establishes that this access should occur "primarily through the Basic Health Care Services near the citizen's residence", which should be capable of resolving 80% of health problems and referring those services which are not resolved to services that are more technologically complex.

However, it is good to remember that the users utilize various strategies to access the health services that they need, many times without considering (or without being aware of) the norms which organize the system.

The National Council of Secretaries of Health (Brasil, 2006b) recognizes that "Basic Health Care still is not the main entryway to health services, losing this spot to specialized medium-complexity clinics and urgent care services (emergency rooms)..." (p. 121).

Our theory is that the implementation of basic health care services in Brazil is far from attaining the ideals described in recommendations, theoretical texts and norms. There are problems with quality, with the ability to resolve cases, with coverage, with integration into the hospital and specialty systems, and with personnel (HR), among other problems, which impede its effectiveness as a point of entry into the system.

In 1994, with support from the Ministry of Health, the first teams of the Family Health Program

were established in communities in the northeast; their objective was to become the point of entry to the health system. Through primary care, they sought to reverse the model of assistance at that time using new bases and criteria to substitute traditional assistance which was oriented towards curing diseases and the hospital setting.

Considering that the Family Health strategy is currently important for the Ministry of Health and the municipalities in which it is established, namely in seeing how far its social and assistential reach covers the population, and its political dividends in public health policy both nationally and internationally, there has been interest in research showing how Family Health has come to be organized in the city of Rio Branco, Acre.

The initial questions that guided our study were: How are the Family Health teams in this city being monitored and trained, considering that these are the people who operate the system known as "the point of entry to SUS"? What are the main demands/needs, complaints, and doubts of the people who seek Family Health services in this city? How do the professionals typically deal with these issues? Are there standardized behaviors, information, referrals by professionals in Family Health? Are the physical conditions necessary to conduct these activities adequate?

In order to know and understand the situation in some Family Health units in the city of Rio Branco, Acre, we conducted our study to contribute to reflection on the very complex structure which is the "point of entry" to the Brazilian health system.

## Family health in the context of the Brazilian health system

Family Health is the Ministry of Health's main proposal for reorganizing basic health care in Brazil. Its main directive is to connect the clientele with a health team, and operates centrally in the knowledge of health vigilance which is instrumentalized through epidemiology. In the context of caring for the population, it works territorially in micro-areas in order to optimize its work in health promotion and disease prevention.

The central objectives of the Family Health teams, which are typically made up of a family doctor or general practitioner, nurse, nursing assistant or technician, community health agents, dental surgeon and dental hygiene assistant or technician, are the provision of assistance which is complete, continuous, with resolution and quality to the health needs of the population served, highlighting the Family perspective. To reach these objectives, a multidisciplinary approach is required, as well as realistic diagnostic processes, planning of activities and horizontal organization, sharing in the decision-making process, and stimulation of the exercise of social control.

The work of the Family Health project, according to its proponents, consists of a "structuring strategy" of a new model of assistance in health. However, studies of the current reality show that there are as many positive points in the proposal, in the area of breaking with Taylorist thinking about organization and project management, as there are problems related to working conditions. On the other hand, the persistent fragmentation and technicality of the work carried out by the Family Health project can also be seen. Some studies of the current day-to-day reality of the Family Health teams show this that this practice holds potential for change; others, however, show that there are great barriers to this occurring. Franco and Merhy (2006a), in conducting an analysis of the possibilities and limitations of the Family Health Program (Programa de Saúde da Família: PSF) based on the process and the technologies of health work such as territory of duty and, consequently, producers of health care, concluded that:

> "[...] implementation of the PSF itself does not signify that the assistential model is being changed, since by remodeling health assistance, the PSF should modify its work processes, making them operate as 'dependent light technologies', even if the use of other technologies is required to produce care. Therefore, acceptance or rejection of the Family Health Program should consider that the way in which PSF is structured by the Ministry of Health will not bring about the possibility that it will in fact become a tool for change...(p. 122)"

## Family Health and reception

Reception implies receiving clients well, hearing their demands, seeking ways to understand them, and sympathizing with them. It involves developing appropriate ways of receiving the distinct ways in which the population seeks health services, respecting the existence of each person (Campos, 2003).

Reception and intake is a powerful tool for re-organizing family health care; it can legitimize the Family Health Team (Equipe de Saúde da Família: ESF) as a "point of entry" in the way that it can positively influence the standard of utilization of services by individuals, and can also bear on social and organizational issues of the service.

According to the National Policy on Humanization, also known as HumanizaSUS (Brasil, 2004), reception in health is the construction of a new posture for the professionals and for the service, which seeks to amplify access with an approach to risk and vulnerability, as a social responsibility, the construction of new values of solidarity, commitment, and construction of citizenship. Its objectives are: to humanize care, organize the service, optimize care, improve resolution, establish the flow of care for spontaneous demands, reduce stress on teams and unify the professionals towards a common objective, intensify teamwork, increase community satisfaction, commitment to the construction of citizenship and community independence, and to provide elements for local diagnostics.

"Reception can regulate access by offering more appropriate activities and services, contributing to user satisfaction. The link between patient/professional stimulates autonomy and citizenship, promoting its participation during the provision of services" (Schimith, 2004, p. 1487).

For Carvalho and Campos (2000), reception is a technological arrangement which seeks to guarantee access to users with the objective of listening to all patients, resolving simpler problems and/or referring them elsewhere if necessary. Reception consists of opening the services to demand, and being responsible for all the health problems in a region. It anticipates plasticity, which is a service's capacity to adapt techniques and combine activities in order to better respond to them, adjusting them to scarce resources and social, cultural, and economic aspects which are present in daily life. By feeling that they are welcome, the population procures services which are not just geographically close, but which are receptive and solve the problem.

Matumoto (1998) "[...] explains that reception is determined by the concept of being human and sickness/health in what the work is based on, and concludes that *why* we welcome people into the service reveals how effectively the Health System (SUS) is established, and how the workers involved "*position themselves with regards to the motto 'Health as a right for all and for citizenship", through the principles of universality, equality, integrality and access" [...].* (p. 21).

The practice of "receiving" consists of qualified listening, which all the employees of the Basic Health Units should carry out, hearing all the needs that bring the user to the service, giving direction or referring the patient according to his or her professional competency. It is desirable that the sense of welcoming overflow the borders of the team/user relationship and begin to permeate relationships among the team itself, creating welcoming environments in meetings and in day-to-day work.

## The process of working with health in the Family Health Program

The work process in health also has directionality, which materializes in the relationships between man and others and with nature, in which adaptations, transformations or maintenance are necessary.

According to Pires (2000) "[...] work in health is an essential task for human life, and is part of the service sector. It is a type of work in the sphere of non-material production, which is completed in the act of its being done. It does not result in a material product, regardless of the production process which is able to be sold on the market. The product is indistinguishable from the process that produces it; it is the realization of the activity itself" (p.85).

The work process in health, at the micropolicy level, when the in the hegemony of live work, reveals to us a rich, dynamic world which is unstructured, with great inventive possibility, with many connec-

tions that move through diverse areas; it assumes characteristics of multiplicity and heterogeneity, being capable of operating at a high level of creativity. It works with its very logic, which pertains to the subject who operates the productive system; it is capable of finding new territories of meanings, which bring sense to, for example, the production of care when we discuss the case of health.

The organization of the National Health System's (SUS) basic network is extremely standardized. As an example we can cite Family Health, which proposes the same standards for the functioning of teams throughout the entire country, regardless of the specific characteristics of territories and regions. When the network operates under the logic of programmatic activities and sets specific times for receiving certain types of clientele, distributing slips and numbers for appointments and certain procedures, this imposes a constraint on the workers in terms of producing the care; in other words, this imprisons their live work, which makes positive relations with the users more complicated.

In order for an effective change to occur from the Family Health strategy, it is necessary to rethink practices, values, and knowledge for all people involved in the social process of producing health. The professionals in the Family Health Teams, living in the community where they work, can unlock significant change in their areas if they observe the daily lives of these people.

Based on the Practical Guide for Family Health (Guia Prático da Saúde da Família) published by the Ministry of Health in 2001, the fundamental attributes of the Family Health Units are the following: planning activities; health, promotion and vigilance; interdisciplinary work as a team and complete approach to the family.

Working as a team is a practice in which communication between professionals should be part of the daily work routine. The continuous exchange of information, which brings about good evaluations and behavioral prospects, should occur through team meetings, as a routine part of working in Family Health to facilitate communication, exchange experiences and expectations, improve coexistence and quantitative evaluation.

The process of working in health has a coop-

erative dimension, which integrates the activity and complements the production process; it is a technical directionality, which speaks to scientific knowledge and the use of technology. Organization and the division of the work process are defined by the final objective to be attained. In this sense, the final objective of the model of care centered on the medical-curative concept is the production of a cure, guided by the fragmentation of the procedures, technification of assistance and the mechanization of actions. An assistive model of health production should be based on production of care, with an emphasis on teamwork, on humanizing care, and on the ethics of responsibility.

## Methodology

The study was conducted in the city of Rio Branco, capital of the state of Acre in Brazil, in the health center located in the Baixada do Sol area, and its reference unit, the Augusto Hidalgo de Lima Health Center. Seven thousand families are registered for the Family Health program in this center, a total of 28,000 people, which corresponds to 56% of residents in that area. The study was conducted in four Family Health Units.

In this study, we used a qualitative approach from an ethnographic perspective. According to Victora et al. (2000):

The ethnographic method is a set of conceptions and procedures traditionally used by anthropology in order to gain scientific knowledge of the social reality [...]. The ethnographic approach is constructed based on the idea that human behaviors can only be duly understood and explained if we take the social context where they take place as a reference [...] The ethnographic method of research enables the investigator to understand the cultural practices within a wider social context, establishing relations between specific phenomena and a determined vision of the world [...]" (p.53-54).

To conduct the present study, two techniques were used to collect data: participant observation and focus groups. The field work occurred during the period between August 2008 and May 2009.

The study was undertaken in two stages: the first consisted of observation in four Family Health Units

(FHU); the second involved focus groups conducted by the Family Health Team, which in total included the presence of the following professionals: 2 doctors, 3 dentists, 4 nurses, 4 nursing technicians, 4 dental clinic assistants, and 24 community health agents.

The procedure adopted to analyze the material began with a reading and re-reading of each entry in the field diary and of the interviews in the focus groups until all was clearly understood. This process led to the creation of an integrated portrait, in other words, a provisory scheme for interpreting each entry in light of the theoretical reference. After this reading came a horizontal reading of the set of entries and interviews by unit and health team, which allowed for the identification of thematic concentrations or empirical categories, which were analyzed based on the categories of analysis which were formulated in the theoretical portrait. The following categories were identified:

· Reception in the waiting room;

· Disorganization of the service and the work process;

## Reception in the Waiting Room

When users spontaneously seek service at one of the units, they are received by the receptionist when they enter the waiting room; their complaint or need is heard, and then they are forwarded to the relevant sectors or services. It was observed that the professionals attend and listen to users in the waiting room in an open environment that does not guarantee privacy. This fact was proven through field observations:

> *"...a young woman in a green shirt comes in to get condoms, and the health agent who just arrived gives her the condoms, and the receptionist writes down her name..."* (FHU 1)

> *"...two men come into the unit requesting condoms; the receptionist gives them to them, writes their names in the register, and they go away..."* (FHU 2)

This type of service interferes with a welcoming reception, since the user feels constrained, rapidly expressing his or her problem or complaint. There is no private space reserved for this.

The physical spaces which were observed can be considered inadequate due to the fact that they are open spaces which suffer from interfering ambient sounds (conversations, children crying, and other noises). Furthermore, when the patient is being seen, the professional may be interrupted to give information, to speak with other people, and to attend people who are ill.

Preparing the environment to receive the community is also an important aspect to be considered; a clean and organized environment reflects prior consideration of the user. During the study, we observed that in some units, cleaning services took place during care services, demonstrating that the health service did not adequately prepare to attend the users, causing a bad impression at the beginning of the worker/user relationship.

Another factor observed in the units was with regards to signage and information about the location of rooms and care departments. From the entrance, signs or informative panels were not emphasized, and in many situations and sectors no one was available to give information. It is important that workers orient the users about where they are in the unit, as a way to guarantee access beyond reception, especially considering the difficulties that users suffer which include pain, anxiety, fear, and educational limitations, among others.

Furthermore, it was noted that the professionals who attend users in the reception area are not adequately prepared, from a technical and humane point of view, to meet the demands of the users. On several occasions, the receptionist used the criteria of "high fever" to guarantee that those who could not obtain referral slips could be seen by the doctor, not corresponding to the patient's medical history. Many times, without even hearing complaints, access is denied, even with no alternative given to resolve the problem, in other words, with no responsibility for the users' problems.

In many situations, the receptionist himself or herself denies service, based on the number of slots for medical treatment, without speaking with the professional. The nurse is not called to evaluate the case; the receptionist is the one who assesses the need for a consult (or lack thereof), despite the nurse's presence in the unit.

Lack of access also can be observed in lines waiting for medical appointments, disputes at the

time when appointment slots are distributed, and full schedules. Another characteristic found in organizing the services we investigated were previous scheduling of services, despite the fact that local residents are not given priority, and professionals attend people "outside the area" (those users who are not included in that unit's territory); all four units reserve two slots for medical appointments for users who do not live in the area covered, which reduces the number of slots available for the population which does live in that area.

The field observations give examples:

*...at 6:45AM the unit is closed, but there are already users sitting outside, waiting for the unit to open so they can schedule their appointments for the afternoon...* (FHU 1)

*...a man arrives and requests to be seen; the receptionist asks if he is from outside the area, and he says yes. The receptionist fits him in, since there only was a slot for people outside the area...* (FHU 1)

*However, even previously scheduled consults are not always respected.*

*...at 3:05PM the doctor arrives at the unit and starts to see patients; some users complain, since every time is like this, they arrive very late to begin the appointments...* (FHU 1)

This demonstrates that the service is structured and organized to meet its own needs and priorities, establishing the flow of demand from people in a way that best suits the professionals' working performance. With no concern for the users' needs, they set a time for them to arrive, but not a time to be seen. In this way, there is a failure in credibility and confidence, which will be reflected in the link between these users and the service, as well as in reception.

Another problem which drew our attention in the study was difficulty in accessing dental consults, since the manner adopted for this service is completed treatment, and the scheduling is done through the Community Health Agents (Agentes Comunitários de Saúde: ACS); when slots are made available, residents in the area where the team works get priority. A high rate of unmet demand was seen, and great struggle for users to gain entry into dental care services. For example, we can cite the following statement:

*"...many problems for the community, who don't understand, that it is a process that takes a long time, there is only one dentist on the team to attend two different populations, here we have almost eight thousand people in Placido de Castro alone, this includes almost twice that, fifteen, sixteen thousand people among those outside the area, because when they come, there are two slots of emergencies, which are for extractions, and two slots for treatment..."* (Nurse, FHU 2)

Campos (2007) comments that:

[...] one of the important functions in Basic Care according to the configurations that the SUS has come to acquire is Receiving the demand and active search while assessing vulnerability: the patients need to be received at the time they demand. Without this, Basic Access to Health will never be a true point of entry into the system. The dimension of reception presupposes willingness, organization, and preparation of the team to receive, at varied times, a great variety of demands and assess the risks they imply, assuring service, seeking to resolve as much as possible. At the same time, through visits to the home, inclusion of the client and analysis of the health conditions in the community and the territory, a posture is expected that links people, families, and the community with the Basic Access teams and identifies the risks and vulnerability of these individuals, families, and segments of the community [...] (p. 6).

Through the observations which were recorded, some aspects can be identified which should be reconsidered by the team's professionals, so that reception can be the practice of qualified listening, where the needs which bring the user to the service are heard, guiding or referring according to professional competency. The type of listening developed by the professionals was clinical, with a focus on the complaints, with isolated interventions which were not purposeful and did not build any connections. If listening were conducted in a more ample manner, problems and needs beyond health services could be identified, which to be resolved require intersectorial connections, in other words, to seek partnership with other sectors outside of health care, in this way increasing community satisfaction; or, other fac-

tors could be seen which are not strictly biological that contribute to the problem in question; or other elements of personal life could be seen that contribute to the aggravation of that particular problem or which make "compliance" with the therapeutic propitions which are typically proposed, in other words, it would be possible to better understand the problems, beyond the complaint, and internally mobilize to face them together with the user.

## Day-to-day function at the Family Health units shows when the point of entry does not resolve the problem: disorganized service and work process

### Community Health Agents (ACS) and their daily routines

In the units under study, it was observed that each ACS defines who they will visit and when, with no team planning or orientation with regards to visit priorities. The nurse coordinators are not familiar with the "routes" of the agents' daily visits; the majority of agents go directly from their homes to visits, without going to the unit to give information about which families will be or were visited, which complicates the supervising nurses' monitoring work. Contacts with the families are not permanent, making it more difficult to create a connection and access the family and social context. Registrations are only updated when the Municipal Secretariat of Health's Department of Health Care (Departamento de Atenção à Saúde da Secretaria Municipal de Saúde: SEMSA) requests.

The only activities observed with relation to integration between the team and the population are some isolated information such as: if there is a doctor in the unit, if there are consultations with the dentist, on the days that there are PCCU, if they are monitoring the Bolsa Familia family assistance program. Orienting the families with regards to using the health services available is not part of the ACS's work routine. As not all units have a schedule of activities that is defined in conjunction with the team members, and do not use the data to analyze the territory's health situation, they adjust the time and the type of activity to be conducted according to the profile encountered.

It was observed that the average number of visits per agent per quarter did not meet the expected levels, seeing that the ACS has to visit the families in his or her territory (micro-area) at least once per month per household. It is possible to suggest that this occurs due to: lack of commitment by the professionals, lack of coordination, of shared management in the daily work environment, and the fact that some of the professionals are not prepared to carry out their assignments. Another important aspect to be considered is that there is a substantial number of people in the region covered who need more than one monthly visit, for example: if there are 81 hypertensive people registered in one unit, some of these will need more than one visit per month, which would guarantee more regular assistance to identify risks and prevent complications. This fact was proven when, in field visits to observe the home visits, the authors of this study had great difficulty, wasted a large amount of time, and at times had to make appointments with the ACS to register the home visits that, if they had occurred routinely, would not have been such an obstacle.

### The nursing team and their work routine

One-on-one interactions with patients were most observed during the collection of materials for cyto-pathological testing and pre-natal consultations. During some periods, the nurse remains in the unit and does not take part directly in any of the activities in question. The nurses conduct more administrative activities than direct care, in other words, the nurses' potential is not being fully utilized in the health services.

Because there is no planning which takes into consideration professional specialization and intervention for cases which require it, it was observed that the nursing team conducts few home visits. The nursing technicians conduct home visits only when the ACS requests they verify blood pressure, change dressings, or perform other procedures in patients who cannot get to the health unit.

The supervisory activities and assessment of the actions carried out by the ACS also were not ob-

served, although at various times, users expressed dissatisfaction with the way ACSs worked. Peduzzi (2001) "notes that systematic, external supervision practices are a possibility in terms of amplifying collective management and multi-professional teamwork" (p.106).

## Activities conducted by the doctors

Medical assistance is mainly oriented towards the diagnosis, treatment, and rehabilitation of sick individuals. The doctors do not participate in promotional activities (when they occur, for example in groups of older individuals), in administrative meetings, or in evaluation of the activities and the management of the inputs needed for the FHU to function.

Below are highlighted some statements of other professionals giving examples of how the doctors work:

*"...the doctor, she doesn't do home visits, she doesn't serve the patients well, she doesn't come to the unit, she comes when she wants to, sometimes there is an appointment scheduled, and she doesn't appear..."* (ACS1 FHU 1).

Inability to keep the work schedule creates dissatisfaction for users as well as for the team. The doctor does not participate in planning activities, and also does not grant educational activities performed by other team members the importance they deserve. Furthermore, it was observed that the greatest demand is for clinical consultations with the doctors, which contributes towards the lack of access to other services and to users being able to create a connection with a single team member. We can confirm, when noting the lack of activity in the unit when the doctor was absent, that what is characterized as the organization of the work process in the units under study is directed towards clinical demand, or that all those complaints and problems are translated into a biological problem to be diagnosed by the doctor, in other words, everything contributes to a doctor-centered service.

## Oral Health Teams

All the Oral Health Teams (Equipes de Saúde Bucal: ESB) studied attended the population of two units, and the clinic was located in one of these units. The ESB provides consultation slots for micro-areas of the ACS, who identify the people who require dental treatment and schedule this with the Dental Clinic Assistant (Auxiliar de Consultório Dentário: ACD). The majority of activities are clinical procedures; few activities promoted oral health, and families were not visited in their homes. When prevention activities were conducted, they were done in a manner that was not integrated with the other team members in any way.

During the interviews, some professionals spoke about how the oral health teams work:

*"With relation to working as a team, I think it is flawed, mainly in the interaction with oral health, I think there isn't a really good interaction..."* (Nurse, FHU 1)

*"...the dentist also doesn't plan, he comes here once a week, every Monday afternoon, he only meets with the health agents, sometimes I intrude a little bit and ask, can I participate in the meeting, and I go there and meddle a bit too..."* (Nurse, FHU 2)

We also confirmed that the work of the oral health teams is extremely independent from the unit's other activities, and has a high level of autonomy. Concerning this aspect, Mishima and Campos (2003) emphasize that:

[...] Family Health can open itself up to go beyond hierarchical technical work, to work with social interaction between workers, with greater horizontality and flexibility of the different powers, bringing about greater autonomy and creativity among the agents, and better team integration. This is one of the great challenges for health teams which are moving into Family Health. If this integration does not take place, we run the risk of repeating the model of dehumanized, fragmented care which is focused on individual biological healing and which has a rigid division of labor and unequal social value for the different tasks [...] (p. 129).

The work process needs to have a structure based on the team, and should establish a common project in which the specialized work of each professional is complemented and where they can construct interaction between the workers and the users.

However, in some of the units we observed that there is no collective responsibility and integration

of the professional in the organization of work; there is a fragmentation of activities and knowledge, and accordingly, there is no effective work as a team.

As the survey was conducted, situations of conflict arose among the team members. Among them were: personality styles, ways of interacting with others in various situations, terrible work conditions, internal conflicts, low salaries, variations in opinions and stances, situations which were difficult or which generated competition, low interaction between team members, lack of systematic supervision on the part of municipal coordination, and high turnover among professionals on the team.

During a focus group, a nurse commented:

*"...I think that the doctor's conduct doesn't correspond with a person who's a member of a team, he arrives and if you don't say good afternoon to him, he doesn't talk to you, he sits, does his appointments and leaves..."* (Nurse, FHS 2)

The absence of management regarding on-site monitoring of the teams' working processes for advising, evaluation and supervision makes it even more difficult for activities to be effective, since in the Family Health units there is no manager to coordinate the teams at the local level, and in this way there is a certain perpetuation of conflicts.

Araujo (2007) responds, saying that "The practice of teamwork in Family Health shows that reality involves conflicts, lack of training, inadequate profiles, disinterest and demotivation. Professional performance, based on the technical knowledge of each member, also requires that the team members have good interpersonal abilities. This means knowing how to deal with differences in professional and personal areas [...]" (pag. 463)

In the focus groups, when the teams were asked if they planned as a team, or even if there was community participation, the responses were as follows:

*"...the doctors don't like to plan. They don't sit down, the current one practically doesn't talk to us..."* (Nurse, FHU 2)

*"...To plan health actions, it has to happen before diseases occur, the decision has to come down from on high, and it has to work based on how the people at higher levels think, the municipality as a whole..."* (Doctor, FHU 3)

*"...We aren't planning, but if we decide to plan or evaluate a program, we have to hear every person's opinion..."* (ACS, FHU 3)

In the four Units, it was observed that the teams do not conduct diagnostics of the population's health situation, and do not collect the information present in the files of the Basic Care Information System (Sistema de Informação da Atenção Básica – SIAB) associating the mapping of risk areas, interviews with community leaders and other sources of information such as, for example: data from IBGE, from the health information systems and the press, to plan work and interventions with the population in a way which is done jointly, integrated, and complementary. Therefore, it is necessary to know the population's needs, identified through diagnostics and permanent monitoring of the families pertaining to the service, seeking improvement in health conditions and quality of life to the assisted population.

In general, the teams attribute this difficulty to the lack of an active coordination of management:

*"...I think that on every team, there has to be someone who says what to do, to coordinate the service, to plan with the team, here I am already at my limit extrapolating..."* (Doctor, FHU 3)

In the FHUs studied, it was observed that actions are coordinated verbally, based on day-to-day problems. The problems are resolved on demand, without systematization, which makes it difficult to assess and plan actions. The local planning depends on the professionals' level of training as well as other interests. The main mechanism of evaluating the Family Health teams is SIAB, which has the challenge of being more related to the commitments of municipal management than the organization of the process of working as a team

Another aspect identified regards the training that teams have to act in community health care. The difficulty the professionals have in educational practices in the basic health care space is obvious, in the community context, with regards to the technicians as well as those with more advanced training. On-the-job training should be prioritized, as it allows better adjustment between the requirements of educational training and the health needs of the population served. Continuing education should be-

gin from introductory team training, and use all the avenues of pedagogy and communication available, according to the realities of each context.

It was possible to perceive that the teams' work process is organized in a piecemeal and fragmented manner. Many workers make themselves available and demonstrate interest in what they do, but since they do not have specific training and find themselves in a space of conflict between what is proposed by Family Health and the legitimized hegemonic model, in which there is still a strong orientation towards traditional health, the workers are absorbed in activities of an immediate and non-resolving nature.

From the moment that there is an understanding of how the process of working in health is not realized in things or objects but instead in people, and that to construct a new model for health assistance which is focused on the user inserted in the family and social context, it is fundamental to rethink the work process, there will be opportunities for change. This should be oriented towards the principle of integrity, with tools like interdisciplinarity, intersectoriality, humanization of services, and the creation of links between the health team and the community.

## Final considerations

As this survey proposes to learn about and understand the reality of some Family Health units in the city of Rio Branco, reflecting on the role of these units as points of entry into the health system, it can be perceived that the Family Health Units are not effectively the port of entry into the municipal system. One of the problems we found was with the form of organizing the work process. The teams do not have a common project, do not conduct planning based on the local reality, identifying the common responsibilities and those specific to professionals; there is also no community participation, in other words, there is no collective responsibility in the organization of labor. It was evident that the teams' work activity is centered on the doctor and curative care, and that some professionals organize their work process in an individual and fragmented form, making teamwork difficult. The service is structured

and organized to meet its own needs and priorities, without any concern for the needs and satisfaction of the users.

The work process for the health teams should be oriented in a way that is closer to the community, with a deeper knowledge of the local reality, the presence of the community agent, home visits, supervision and nurse monitoring of the ACSs' work, as it is believed that these are some of the tools that the family health strategy provides to be an important difference in improving the quality of care.

Another obstacle we encountered was with the way people were received in the waiting room; initial contact is made by a professional who is not qualified to listen, to make referrals or to resolve complaints; the scheduled hours of operation are not observed; there is difficulty in accessing dental consultations; access to medical consultations is made more difficult due to the reduced number of available slots; long lines; large amounts of time spent in the waiting room; and disregard for working schedules.

In the daily routine of the units, the service was predominantly authoritarian, as the users were obliged to submit themselves to what was made available to them, with no consideration for their needs, which runs contrary to the principal of completeness. The units should organize their work based on the vulnerability of their users, with responsible and resolute monitoring of demands, including those that the team cannot resolve.

Another important factor to be considered is the lack of training professionals have to work according to the principles of basic care, specifically in family health. We suggest the implementation of a continuing education policy (at work) in order to better qualify the professionals who work in family health.

It is evident that the population that lives in the region studied requires a service in which there is a better link between the teams and the community. The Family Health Units are only used by the users in some specific situations and, at various times, facts were reported which indicated that users sought out other units to resolve their health problems; in other words, the port of entry is somewhere else.

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