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Original articles

Challenges in the work process in the Family Health Strategy

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ABSTRACT

Purpose: to analyze the work process of the Family Health teams in the municipality of Caxias do Sul, in Rio Grande do Sul State, Brazil.

Methods: this is a qualitative, descriptive and exploratory research conducted in four Family Health Strategy (FHS) units, with the participation of 22 health professionals. The data were collected through a semi-structured interview and analyzed through the theme content analysis, aided by the Atlas.ti software.

Results: the results were organized in three categories: (1) Roles, reality and idealization of working in the FHS, in which health prevention and curative practices appeared as the focus of the work process; (2) Elements of working in the FHS, which dealt with the purpose of the work connected to health prevention, related instruments, hard technologies and work object, in relation to professional specificities; and (3) Challenges and perspectives of working in the FHS, which emphasizes the fragilities, due to the shortage of professionals and the need for managerial improvement, as well as commitment and teamwork as potentialities.

Conclusion: in the work process in health, the preventive professional actions with curative focus were predominant. The challenges were centered on redirecting the work process toward the Family Health approach.

Keywords: Public Health; Public Health Care System; Family Health Strategy; Workflow

INTRODUCTION

Various international movements in history have sought to oppose the Flexnerian biomedical model, which is centered on specialized practices, focused on the existing disease and in fragmented action as its attention core and care guide. The influence of the biomedical model was widespread based on the Flexner Report, which evaluated the medical schools in the United States and Canada at the beginning of the 20th century, influencing, until today, the health practices in many Western countries[1].

In Brazil, the most promising experience of incorporating the logic of comprehensive health care and health promotion is the Family Health Strategy (FHS), which presents principles and guidelines to ensure the people's access to health and reconfigure the health care model[2]. As the main representative of primary health care (PHC), the FHS began in 1994 characterized as a program; however, its effectiveness made it rise to the status of strategy, as it furnished considerable improvements in health indicators[3].

The role of the FHS is to coordinate health care, centering on the users and communities in the context where they live[4]. Its expansion has been evaluated by a growing number of studies published in national and international journals, as well as in congresses and other events, both in Brazil and abroad[3,5]. Hence, the FHS is recognized as an alternative to bring about changes in the assistive model and redirect the hegemonic health care practices, through interprofessional actions envisaging health promotion, preventing aggravations, aiming at diagnoses, treatment and rehabilitation[2-6].

Nonetheless, in the PHC context in some places, particularly in the FHS, a strong influence of the biomedical (Flexnerian)[1] model is still noticed. Studies in the field of health training reveal that such dissonance sometimes occurs due to the training still being grounded in a fragmented model, whose actions in the training process do not mobilize toward integrated care, nor the broadened clinic, the interdisciplinarity, the teamwork and the related technologies as instruments in health care[7,8]. Thus, professional practices without integrating the members of a team, nor these professionals with the population, are still seen in day-to-day assistance. Moreover, they are still centered on diseases and their complications[8,9]. These aspects need to be overcome for the FHS to become effective in many regions of the country.

Given these facts, this study aimed at analyzing the work process of the Family Health teams in the municipality of Caxias do Sul, RS, Brazil.

METHODS

The research complied with all the current legislative guidelines and was approved by the Human Research Ethics Committee of the Universidade do Extremo Sul Catarinense, under number 2625621. The anonymity of the participants was ensured through alphanumeric code, structured as their profession's abbreviation followed by cardinal numbers, e.g., NUR1 for nurse and so on.

This is an exploratory descriptive study with a qualitative approach, conducted at four community health centers (UBS, as abbreviated in Portuguese), where Family Health teams (FHT) work. The inclusion criterion was their being assessed on the second assessment cycle of the Basic Health Care Quality and Access Improvement Program (PMAQ, as abbreviated in Portuguese) in the municipality of Caxias do Sul, which is an integral part of the fifth Regional Health Coordination of Rio Grande do Sul, Brazil, which encompasses 49 municipalities.

The participants in the study comprised 22 professionals with at least one year of professional experience working in FHS, namely: five community health agents (CHA), four nurse assistants, three oral health assistants, four nurses, three dentists, and three physicians.

Most of the participants were females hired in the statutory system; only the CHA had been hired under the Consolidation of Labor Laws (CLT, in Portuguese). The professionals' training was adequate for their position. Some professionals had a higher education degree while others had a postgraduate degree; however, their jobs are at a medium or technical level.

The data collection was conducted through semi-structured interviews from February to June 2018. It consisted of closed-ended questions, for the identification of the participants' profile; and open-ended questions, which comprised the main investigative focus of this study.

The data were submitted to the theme content analysis technique[10], composed of three stages: pre-analysis, material exploration, and results' treatment and interpretation. This analytical process was aided by

the Atlas.ti software, version 8.0, and anchored on the theoretical look of the authors that promote reflections about the work[11,12] and work process in health[2,13-16].

It was decided for presenting the organized results as tables, developed from the analysis made with the assistance of the Atlas.ti software. Nevertheless, to better express the relationship between the theory and the researchers' perception, some narrative excerpts will be highlighted in the discussion section.

RESULTS

The results were obtained from the analysis of 22 documents (transcribed interviews) which produced 275 narrative excerpts, linked to 31 codes, distributed in eight subcategories. These, in turn, were grouped into three categories: "Roles, reality and idealization of working in the FHS"; "Elements of working in the FHS"; and "Challenges and perspective of working in the FHS". The following table describes these findings.

Table 1. Listing of categories and subcategories by the number of codes referring to the work process in the Family Health Strategy, in Caxias do Sul, RS, Brazil

Categories	Subcategories	n	%
Roles, reality and idealiza-tion of working in the FHS	Actual work in the FHS	39	14.2
	Roles of the FHS	23	8.3
	Work idealized for FHS	21	7.6
Elements of working in the FHS	Purpose of the work	30	10.9
	Working instruments	25	9.1
	Work object	22	8
Challenges and perspective of working in the FHS	Fragilities of the work in the FHS	80	29.1
	Potentialities of working in the FHS	35	12.8
Total		275	100

Source: Data bank of the research, 2019.
Legend: FHS – Family Health Strategy; RS - Rio Grande do Sul

The "Roles, reality and idealization of working in the FHS" category is demonstrated in Table 2, which revealed the work focused on preventing the users' complications and diseases, bringing to light the reality of the assistance practice under the perspective of curative attention and based on the multiprofessional work. The following table presents this category.

Table 2. Listing of the number of narratives by codes and subcategories related to the "Roles, reality and idealization of working in the Family Health Strategy" category, in Caxias do Sul, RS, Brazil

Subcategories	Codes	n	%
Roles of the FHS	Preventing complications	16	19.3
	Care coordinator	07	8.4
Work idealized for FHS	Multidisciplinary	09	10.8
	Health prevention	08	9.6
	Humanized	04	4.8
Actual work in the FHS	Curative	18	21.6
	Health prevention	11	13.2
	Multidisciplinary	06	7.2
	Physician-centered	04	4.8
Total		83	100

Source: Data bank of the research, 2019.
Legend: FHS – Family Health Strategy; RS - Rio Grande do Su

The "Elements of working in the FHS" category is presented in Table 3, which shows that the finality of the work is linked to preventing complications and diseases. The hard technologies prevail among the working instruments, and the work object is centralized on the professional practices in a perspective that is at the same time multiprofessional and specific of each area, with a curative focus as well.

Table 3. Listing of the number of narratives by codes and subcategories related to the "Elements of working in the Family Health Strategy" category, in Caxias do Sul, RS, Brazil

Subcategories	Codes	n	%
Purpose of the work	Health prevention	13	16.9
	Specific of the profession	11	14.3
	Multidisciplinary in the FHS	06	7.8
Working instruments	Hard technologies	17	22.1
	Soft technologies	04	5.2
	Soft-hard technologies	04	5.2
Work object	Specific of the profession	08	10.4
	Multidisciplinary in the FHS	08	10.4
	Curative actions	06	7.8
Total		77	100

Source: Data bank of the research, 2019.
Legend: FHS – Family Health Strategy; RS - Rio Grande do Su

Lastly, the "Challenges and perspective of working in the FHS" category is presented in Table 4. This category shows that the weaknesses in working in the FHS have to do with the lack of professionals and the need for improvements in the institutional management. Nonetheless, the potentialities are mostly related to the professionals' dedication and teamwork.

Table 4. Listing of the number of narratives by codes and subcategories related to the "Challenges and perspective of working in the Family Health Strategy" category, in Caxias do Sul, RS, Brazil

Subcategories	Codes	n	%
Fragilities of the work in the FHS	Lack of professionals	27	23.6
	Institutional managerial support	21	18.3
	Working materials	07	6.2
	Curative culture	05	4.3
	Physical structure	05	4.3
	Autonomy	05	4.3
	Humanization	04	3.4
	Social	04	3.4
	Motivation	02	1.8
Potentialities of working in the FHS	Personal commitment	14	12.2
	Teamwork	14	12.2
	Multidisciplinary work	04	3.4
	Relationship with the com-munity	03	2.6
Total		115	100

Source: Data bank of the research, 2019.
Legend: FHS – Family Health Strategy; RS - Rio Grande do Sul

DISCUSSION

Roles, reality and idealization of working in the Family Health Strategy

The subcategory "roles of the FHS" expresses an interconnection between practice and theory, as knowing the role of the FHS leads to the knowledge of what is recommended and what is done in the daily work process at the PHC.

Understanding the role of the FHS as a health care coordinator is the starting point in comprehending the health work process. This reiterates the perception of the Brazilian Ministry of Health, as well as the state and municipal governments, that the FHS is an extension, qualification and consolidation strategy of the PHC, as it favors the redirection of the work process with greater potential to deepen the principles, guidelines and fundamentals in this level of assistance. Furthermore, it broadens the resolvability and the impact on the people's and communities' health situation and provides an important cost-effectiveness[17].

The following excerpt expresses what is the function of the FHS:

> [...] In my opinion, the Family Health Strategy is essential in organizing health care. The basic points are the prevention of diseases and, as its name says, the work along with the family, the community; so, it is a physician's role, but also a sociologist's, as part of the community and the family too (PHY2).

This narrative corroborates the point of the FHS being considered as the PHC model's reorientation driving force, as it proposes continuous attention to a population within a specific region. It is up to the professionals to commit to providing comprehensive health care to the families through the interdisciplinary work in a multiprofessional team[2].

Preventing health complications is part of the daily practices in the FHS. It is also commonly stated by those who work at the PHC, as expressed in the following narrative:

> [...] The role of the strategy is prevention, working with prevention. I see the work of the Family Health Strategy always as a focus on the community, thinking of preventing the diseases before they happen, through educative activities. That is what is in the law, so to speak, but it is not what we see in practical terms. That's my point of view, what we strive to get accomplished every day (NUR1)

Preventing complications is an important factor when comprehensiveness is the goal. Thus, the work efforts must also be guided by such a premise. Although the FHS is configured as an important change-mobilizing instrument, it must be seen as a field of possibilities, more than a structured model to be uncritically incorporated nationwide. This means overcoming the concept of forming ideal health models, defending comprehensiveness as a privileged principle to reorganize practices and revert the model[2].

The "work idealized for FHS" indicates what the participants should do in terms of differentiated work, but they still have difficulties in accomplishing. This relationship between precept and what is actually done is associated with a concept of the true work[12], which has to do with issues like failure and subjectivity of the work process, either idealized or not, and at great risk of causing feelings of frustration.

The aspects of humanization and multiprofessional practice indicate what the ideal work would be like in the FHS. The following narrative expresses a coherence that is linked to both associated codes.

> [...] I believe this is how the health care should work: the physicians, nurses, assistants, community agents, the whole team, each should take care of those people who were theirs. It is very clear to me; when I first came to work here, the other time, that is how it worked. We had much more connection with the people. So, each nurse welcomed the people who were from their team, and many times the person would feel connected to the nurse, the assistant; sometimes, they did not even need the physician's appointment. They end up being broken, the team breaks up. So, the work process should be like this: the user connected to their team (NUR2).

The National Humanization Policy (PNH, in Portuguese)[18] advocates the qualification in health and management work process. Such improvement in health practices includes receiving patients by classification of risk and having broadened clinic and environment. These new perspectives aim to work more humanely and rationally on the principles and guidelines of the *Sistema Único de Saúde* (SUS – the Brazilian National Health System), aiding in health care and the user's general well-being.

The core of the abovementioned thought pattern brought the ideal of a multidisciplinary team and revealed the importance of an assistive model centered

on interprofessional teams to work at the PHC, for the practice to be conducted following the precepts of comprehensiveness.

The results indicate a connection between idealized work and preventive logic. This leads to reflecting on these workers' training process, as they consider strengthening the preventive actions as a purpose of the work in the FHS, to the detriment of the health promotion precepts, which was not intensely materialized in the participants' narratives.

Anyhow, the organization of the PHC health services through the FHS comprehensively and longitudinally prioritizes health promotion, protection and recovery actions. It is expected that it will be able to approach the individuals' health-disease process uniquely and articulately in the home and community context[14].

The "actual work in the FHS" subcategory reports the actions experienced in daily practice, performed based on autonomy (or its absence) to solve problems faced daily, and even to plan the actions. The situation expressed in the actual work arises to bring to light what actually happens, presenting what the participating health professionals do in their work process.

The actual work can have varied tendencies. The work centered on curative principles is recognized as a traditional, physician-centered model. In it, prevention is put aside in detriment of healing, as the preventive actions are not put into effect due to the great effort of the curative work. On the other hand, there is an eagerness to work in the FHS as it is meant to be. This model, as constantly perceived in the health work process, was expressed in the following testimony:

> [...] Every day, we notice that the practice is all about the disease, treating it, prescribing medications. And many times, some treatments do not require medications, but we have to give them some; they will go home frustrated because they want some medication. I would like them, though, to make use of other things, like teas, alternative medicine, other things that are not so aggressive, and that are well supported by evidence. So, we work on the disease, but I would like to work more on health prevention, promotion and instruction. Also, it is difficult to make them accept; we speak and explain, but sometimes they do not grasp it. I do believe one of the ways to take is instructing them about health and quality of life; this would indeed avoid an increase in their attendance and public expenses we have (PHY3).

It was verified in the findings that there is a disparage between the professionals' work and their understanding of what it should be like and how it should be carried out. The actual physician-centered work makes the daily actions to be directed to the physician's practice. However, such an understanding is often restated by the conduct of other FHS workers. This fact is expressed in the narrative below:

> [...] I cannot tell for sure, I do not know if this is what it is, but we hear a lot in the complaints about the delays, both in making an appointment here so to speak and in the professional's delay, in making a cardiologist's appointment. So, everything is too slow; I would like it to go faster. If there were more physicians at the community health center, more openings for physicians, that is what we would need. We used to have four, now we have two [...]. So, I think if we had more physicians, more openings, there would be fewer complaints. That is what I think (CHA1).

This testimony reports the view reinforced by some FHS workers regarding the importance of the physician in health care. Thus, it disqualifies the need for multidisciplinary work, whose goal is that all FHS workers be autonomous, potentializing the resolvability in offering care with quality and comprehensiveness. This is based on the teamwork approach, instead of the physician's conduct approach, aspects that are sometimes not valued by the workers themselves in the sense of making the population aware of this logic in health care.

On the other hand, it is believed that the multidisciplinarity is increasingly incorporated in the daily practices of the FHS, which is of great importance for the quality of the assistance in the PHC. Hence, the work process based on the premise of interprofessional practice brings resolvability and broadened access. In the following narrative, this description is made evident:

> [...] We have the teams, the micro[area] meetings, in which we plan our actions; we try to work with the multidisciplinary team. There are some groups at the unit where we participate, we have the support from the Family Health Broadened Center (NASF, in Portuguese) to assist in the part of promotion, [...] we have the prenatal schedule, childcare, quick tests; these are not done by the team, it is for the whole unit. The groups are not by team either (NUR5).

The teamwork[6] shows the impact of the FHS and the success of the comprehensive approach, which

articulates disease prevention and health promotion and recovery actions. This teamwork requires integrated and collaborative practices of a broad team of health professionals, including community health agents, nurses, physicians, nurse assistants and auxiliaries, dental surgeons, oral health assistants and auxiliaries. Moreover, there are the professionals who work at the Family Health and Primary Care Broadened Center (NASF-AB, in Portuguese), as the physiotherapists, speech-language-hearing therapists, nutritionists, occupational therapists, physical educators, psychologists, among others. Thus, there is an eminently multiprofessional character in health care and in the training of the professionals who work in this context.

The work focused on disease prevention is a paramount aspect in the FHS, actions that are an effort toward a health care model that thinks and acts comprehensively, making it essential to make changes that demonstrate the transforming potential in preventive health practices.

> [...] I really like working in the FHS. I used to work in the FHS in another city and in 2011 I came to Caxias do Sul. My opinion is that it is much better organized here. We work with prevention, attending those who look for care on their own, with urgencies and priority care, that is, the children, pregnant women, older adults and patients with chronic diseases (DEN1).

This account demonstrates an effort to actually put into effect the work process that seeks disease prevention and health promotion. Acting within the parameters of comprehensiveness, understood as a broad spectrum of services available and offered by the PHC services, both from the standpoint of the biopsychosocial character of the health-disease process and the promotion, prevention, cure and rehabilitation actions. And even referrals for medical, hospital and other specialties[3].

Elements of working in health in the FHS

The work is perceived as a process, as it comprises interrelated phenomena and involves the object, instruments and energy expenditure to carry out an intentional humane action that will lead to a product[12]. The "purpose of the work" expresses the activity adequate to a purpose[11], translates what is work in its essence and is linked to their specific work and role as a member of the team, as described below:

> [...] My work is more related to receiving the patient and hearing them, the dental patient, that is. I also have to organize the office, proceed wit its asepsis, discard all the residues, properly cleanse and sterilize the instruments, everything a dental office needs to attend the user adequately. I help/aid the dental surgeon in the examinations, educative speeches, instructions; we can give speeches and instructions, supervise toothbrushing, apply fluorine, always under the supervision of the dentist. But, yes, we do participate (OHA2).

Another perspective identified is the attempt to make the multidisciplinary work important, which must be a goal in order to strengthen the work in the PHC.

The multidisciplinary work is a prerogative of the work process in the FHS[15], which was seen by the participants as interaction within the team. However, it is not limited to that; multidisciplinary work is more than being together and sharing the same space[9], it is understanding the practice of the multidisciplinary work as an act that strives for comprehensiveness in the health actions.

The preventive actions are once again reinforced in the findings linked to the purpose of the work. The following account shows such perception:

> [...] I would like to [...] teach them ways to keep healthy for life and work more with promoting and preventing, tell them not to intake much salt, to practice physical activities, not to smoke; then they would pass it on. This way, we would be able to establish a better quality of life. I would like to teach them how to avoid diseases; that would be my goal (PHY3).

The workers' understanding and assimilating the concept of health needs contribute to the development of practices that go beyond in the biological bodies, as the interventions focus on the various aspects that characterize the complexity of the human life[12].

Concerning the "working instruments" subcategory, these are the workers' means to perform their profession and transform their work[11]. The findings indicate the predominant use of hard technologies, although soft and soft-hard technologies are also present[15].

In the following narrative, the use of hard technology in carrying out the professional's duties is identified:

> [...] I use all those I look for in my training and practice; I look for instruments, from books to electronic instruments. I use them, but that is

> something we do not have. You can see here, we only have the desk; we do not even have the scale in the family doctor's office, there is no child scale, for example. So, basically, in this community health center, we have to share one, two or three scales between all the professionals. So, from this point of view, I can say that I use all the instruments, but I do not have all of them (PHY2).

The productive restructuring process can be verified in the FHS, which in many cases changes the way of producing without changing the work process centered on hard technologies. Training the team, moving the workplace to where people are, and encouraging health surveillance suggest that there are changes in the way health is produced. Nevertheless, the work organization micropolicy reveals, particularly in clinical practice, a care core that continues operating a process centered on the instrumental health-producing logic[19].

The soft technologies have the greatest connection with the work process in the FHS because through them it is possible to put in action the work based on human relations. This perspective makes the worker their own working instrument[15,19].

The soft technologies are present in the work's relational space and are materialized in the subjects' attitudes; hence, they can be called relational technologies. These comprise the welcoming, integration and bonding, the spaces for getting together and listening, respecting and valuing autonomy, cooperating and sharing responsibility, using communicative abilities for the proper verbal expression, good mood, empathy and ethical stance[8].

The soft-hard technologies, in their turn, are the structured knowledge that is materialized, for instance, in a professional instruction guide, flows, etc.

The following narrative illustrates the use of soft and soft-hard technologies permeated with the dialogical process and guided by structured clinical thinking firmed on the nursing process [consultation].

> [...] I use nursing consultation, individualized attention, more often. Sometimes the person does not understand, they are not educated enough to understand what we are saying, more difficult words; so, I usually draw a lot, tell stories for people to understand. I believe we sometimes have to touch the person's heart to achieve something, to make the person conscious of their own health. I consider nursing consultation paramount; it is the best resource we have to get to the user (NUR2).

Using technologies in the work process, especially the soft ones, bring benefits to health production, which is the object to be worked at by the professionals. Historically, training in the assistive health model was centered on hard and soft-hard technologies, as there were corporate interests, especially of economic groups that deal with health[7,15,19].

The "work object" subcategory encompasses that which the worker must produce in their work process; that object is the "raw material" to be transformed[11]. The work object in health means producing health, whose transformation results from the whole work process in health.

The curative actions are an integral part of this object work process in the participating FHT; the following statement expresses such manner of reflecting.

> [...] Our action here is basically curative. We certainly try to work on prevention, but most of the patients come here to cure some already existing problem. Of course, we attend the patients encouraging prevention; we go to schools to bring people here for a check-up before any damage occurs. However, most of them come only when they start hurting, or when a problem already exists. Unfortunately, that is why our action is mostly curative (DEN1).

Unfortunately, the curative actions as the work object are still a predominant practice in the routine of the FHS. As for the specificity of a profession, it is revealed when the reflection is based on their isolated work practice. The narrative that follows reveals this statement.

> [...] My role is to attend the population, attend the family from the comprehensive and the individual standpoint; that which has to do with comprehensiveness we deal with as a group, and the individual problems we solve individually. Then I often bridge the individual to the most specialized professional. Most of all, I am only part of the bridge, but my main role as a family health physician is to work with the community (PHY2).

Another item maintained as a work object is the specificities of the health teamwork, given its character of providing services and, especially, of the work process in health. In this context, it is worth highlighting the complexity of the intervention objects, the intersubjectivity, as the work always takes place when the professional and users meet, through interdisciplinarity and interprofessionality, characteristics that require the assistance and care in health organized in the logic of

teamwork in place of the isolated, independent professional work[6,16].

The following narrative upholds aspects related to multidisciplinary work.

> [...] My focus in work is to minimize the complications the users might have, at least those who come to me, or when we have a group discussion about some case. It is always to minimize the user's problem, trying to solve them, making use of the Family Health Broadened Center (NASF) and other services where we can have the person's health kept in order; not only the physical health but the mental and social, too (NUR2).

Challenges and perspectives of working in the FHS

The "fragilities of the work in the FHS" subcategory is related to the negative aspects related to the work process, in which the problems hindering the quality of the service are presented. They interfere and cause frustration because the professionals cannot come to a solution when they have to deal with the situations faced in their daily work.

The participants demonstrated that there are fragilities based on the short-termist biomedical model (hegemonic model). The health actions taken in a biomedical approach, anchored on a curative culture, reflect user's practices also based on such perspective[13]. The excerpt from the following interview illustrates such a statement.

> [...] The greatest fragility is our population's curative culture, in spite of the public health care system (SUS) looking good in theory, this idea of preventing diseases, of working before the disease appears. There are the chronic diseases that are most recurrent, killing people every day, proving us unquestionably that it does not work, because our population does not adhere to the SUS' working method. Our population has a curative mentality, and they expect the physician to tell them what to do [...], to prescribe them pills (NUR1).

Regarding the physical structure, the Humanizing National Policy (PNH, in Portuguese)[18] has it as one of its guidelines to value the environment, organizing healthy and welcoming workspaces. Based on the idea of cross-sectional and inseparable attention and management, of comanaged environment projects as a device to contribute to changes in work relationships[12].

The notes of FHS workers concerning physical structure demonstrates that the workplaces are somehow hindering the work process. The environment humanizes the service and increases the probability of the actions being successful. The following interview excerpt reveals aspects related to the physical structure.

> [...] I think there is not enough support from the Department of Health. We struggle a lot with a lack of material and physical structure. I notice that the community health care center here is very old; part of the structure is falling apart. In some offices, the walls are moldy, the paint is peeling, the wiring is unsafe. I believe the greatest problem here in our work process is the physical structure. Other aspects that make the process difficult are the long lines waiting for an appointment with the specialists; many times, the patient ends up abandoning the treatment. We need more back up and a supporting structure that will allow more effective health care (DEN1).

One of the ways valuing the professional is to give them an adequate working place. Currently, the Ministry of Health has specific construction and renovation norms for the community health care centers, for the work to be executed with adequacy and quality. This issue of adequate physical structure does not ensure that the quality of work will be the best, but it helps in the work process and makes both professionals and users feel welcomed in the health units.

When speaking of professional autonomy, it has to do with interdisciplinary work; however, when the fragility is not being autonomous, the concern becomes greater. This is seen in the account that expresses a wish for professional autonomy.

> [...] I perceive some weaknesses. I practice nurse consultation; I'm trained for that. Until recently, the Department of Health would not allow us to prescribe vitamin D, rash ointment, saline nose drops. Now we were given autonomy to order mammography; since we conduct the breast exam, why can we not order it? Why can we not sign the exam that we... Anyway... The nurse with all these responsibilities has to depend on the physician; it is not fair; it is not right. Why can I not order a beta-HCG test? ... Will I be iatrogenic? Will I harm this person in any way? No. We have to stop having such a restrictive view of certain things. Why can other professionals not take action when necessary? This is something we are delayed in, and it needs to be thought over. Some things hinder our work process. They take away our autonomy, and this is one of those things (NUR1).

These descriptions demonstrate that, for them to attend with quality, a greater protagonism of the professional categories is necessary, encompassing aspects of care and conduct that can be interprofessional. This is the key to excellence in PHC work[6]. Favoring everyone's protagonism also furnishes a better way to speed and optimize health care. The existing lack of professional autonomy – which the professionals report being the case – is, in great part, a matter of management, not in the microspace, but as the absence of a proposed macroplanning in health, respecting professional autonomy, disconnecting from the predominant biomedical model, taking on work processes based on the protocol for PHC, which enable different professionals to have the support to work in the comprehensive care of the users.

When dealing with the lack of humanization, the fragility appears in the participants' accounts as a connection with how the users are being attended in their workplaces. They can be harmed by the lack of time for health actions, even medical appointments. It needs to be understood that a humanized public health care system (SUS) recognizes each person as legitimate, a citizen with their rights; it values and encourages their participation in producing health[18].

The instruments reported exist, but they are considered an important fragility for health workers. The reports properly describe the need for instruments for the work process in the FHS.

> [...] I see that we should have more time to go out and visit the patients at home. We have a problem with transportation. We waste too much time visiting them on foot. We need a car to visit them. For me, this is a very negative point, this issue of transportation (NAS3)

The factors related to work management are very much associated with the working conditions, which encompasses many elements related to the environment where the work takes place. It includes the workforce, considering number, qualification and role performed in the production process; contractual relations, wage, workday, labor benefits, and rules related to safety at work. Furthermore, there are the working conditions, enough working instruments in terms of quality and quantity, besides the institutional conditions and the knowledge to operate them[20].

The lack of motivation arises as an important fragility, as it reveals the professional's dissatisfaction with their reality in the work process. All the accounts report a feeling of discouragement.

> [...] I am the one who has to motivate the team most of the time because we are always the same ones. The management may change, but we are still here. We end up a little discouraged. Then we go on vacation and come back motivated. The team needs to be more motivated! Seeing those people here every day... they do not help; as much as we try, they do not help. Then we end up thinking: "Why am I going to talk about it, anyway?". "Look, you cannot eat this, let us try to improve it" but they do not care; they only want medication. Their education needs to change. Going more to the schools, speaking to the children. It has to begin at an early age; it is a way to do it. I think the team lacks motivation. Now that we have material it is alright, but when we run out of everything – now we are lacking nurses – how are we going to do things? (NAS4).

Valuing work is paramount for satisfactory work and must deal with the professional's efforts, doubts, frustrations and discouragements[20]. The lack of professionals is fragility in any institution; however, such a problem in health can interfere with the quality of the service offered in PHC. The following excerpt indicates this situation.

> [...] I notice that we have a hard time having a team 100% present. There is always a workmate absent or on leave. Another difficulty is having a tight schedule for each appointment, having to do each one in 15 minutes. This often complicates a lot. We know each person is unique, they have their particularities. We can attend some in five minutes, while others take 20 or 30 minutes (PHY1).

The results express that the lack of professionals causes difficulties to the FHS members, given that the work is multidisciplinarily complemented and the absence of one link harms the work process. This disadvantage in the relationship is crucial to a certain point, as it generates frustrations and dissatisfactions to both professionals and users[12]. The feasibility of an innovative proposal, as the FHS, depends on working conditions, including teams in sufficient quantity and quality[21].

As for the managerial issues, the limited support given by the management of the municipal system is a fragility felt and reported in the professionals' accounts. The wish for institutional support is sharply identified.

Such support, or the lack thereof, interferes in how the work process will be conducted.

> [...] So, as for these resources we never have there, we have to invent; it is a group, two for each team. If it cannot be on the same day, we have to share more resources; we do not have anything. We have to pay for things there; I mean, we have to pay for the snacks; I have to take the things I am going to work with. "Well, today I am going to make a cake"; I take or buy for myself; if there is any left, everybody eats; everyone does what they want. The girls also take things to work; it has to be like that. There is no other way; instead of giving, they take from us. So, what can we do? But we always talk, we always do something (CHA3).

The institutional support to the participants in a certain situation of the work process is harmed due to the management's inaction. It is felt that there is a movement that pushes toward taking action; however, it is noticed instead that this motivation is struck due to the solitary initiatives of the teams.

Regarding the social attribution described in the results, it is important to highlight that in Brazil health is the responsibility of the State. Hence, the idea of professional disclaiming is extremely dangerous, as it hurts the principles of universality. Anyhow, it was identified that this fragility is connected to people's deficient education, interfering with self-care and the mentality of healthy eating habits. People's education interferes with the work process in health, as in the following description.

> [...] The population puts on the professional the responsibility for their health, a responsibility that belongs to themselves. My health is not your responsibility, it is not the municipality's, nor the mayor's; it is mine. And our population does not have that culture. They think the government has to provide. And we, who work for the municipality, have the obligation to provide. I see this every day. I think that is the greatest deficiency, the fragility of the public health care system, both in this unit and in general (NUR1).

Autonomy can be either connected or not to the social condition, but health education is directly connected. Therefore, it is an important fragility, perceived by the participants as a hindrance in health attention.

In the opposite subcategory, "potentialities of working in the FHS", the challenges of working in the FHS are emphasized, these potentialities indicate the way to be taken to improve the actions in the PHC context.

The relationship with the community indicates a potentiality to be developed in the work in the FHS. Potentialities demonstrate the participants' positive perceptions. In the following report, the participant reveals their thoughts concerning the community, considering it as a potential in the work process.

> [...] Our community is very big. It has a huge potential for grand things. We could work with teenagers, children, older adults, young adults. You know, things about sexuality, nutrition, everything we wanted to do, everything there is in the primary care notebooks, if we wanted to work here in the community, we could (NAS1).

Therefore, it is considered that the potentiality reported in the participants' account is relevant and demonstrates that the user-professional contact transforms the work process. The proximity leads to accepting the issues that permeate between professional practice and empathy, the guiding aspect in a community relationship.

This mutual respect and consideration between those involved make the work easier, both for the professionals and users in care, which favors access to health. The relationships established between health professionals and users are among the most challenging subjects in reorganizing health services. Thus, they are essential to the full implementation of the public health care system (SUS)[21].

Concerning personal commitment, a committed team reflects on the way they work. In the description below, commitment is presented as a potentiality.

> [...] Persistence is the potentiality. Persisting despite everything; doing our best always, never expecting so much that we will be paid for it or always receive recognition. Doing our job well done. The potentiality would be more in the sense of persevering, continuing despite the difficulties, and being able to offer health and well-being to the people. Provide the system's deficiencies somehow, either through talk, multiprofessional attention, or working overtime. I think the goal is always the patient, reestablishing the patient's health (PHY1).

In a counter-hegemonic movement in face of the individualizing injunctions of the current atomized society model, broadening spaces for bioethical debate seems to reinforce the possibility of dialoguing between

patients, community, professionals and service, as well as stimulating changes in values, incorporating bondage, commitment and solidarity[21,22].

The following finding describes the importance and the existence of the teamwork.

> [...] The team is closely united, there is a lot of affection in the team itself. When the user is aggressive, we help each other. I see this as a positive point in the team. The issue of taking on the care for children, the childcare itself, sure has some aspects we cannot solve. But we have had some advances, in the sense of prescribing those protocol medications. I think it is very good and valid; the bruises program is very good. The municipality gives us the autonomy to conduct the treatment. We can see results; I have seen many results, which make me very satisfied. We can see we were important at that moment, having helped to improve a lesion (NUR4).

Currently, there is a consensus about teamwork in health; however, there is still a persistent and predominant notion of team restricted to the coexistence of various professionals in the same workplace, sharing the same physical space and clientele. This causes difficulties for the teams' practices, as they need integration, fellowship, group responsibility, respect and ethics to ensure the comprehensiveness of health attention[9].

Lastly, the interprofessional practice in the FHS demonstrates a reflection on the relationship with the other professionals and how important that is to the team.

> [...] Great. I get along well with everyone. We have two oral health teams in the unit, which is very good, too. I think it is nice to exchange ideas; we help each other a lot. If I have any questions, I talk to my workmate and we interact. There are two dentists here, and my relationship with the physicians, the nurses is generally good with everyone (DEN1).

In the work process in health, the subjects of the action, the teams' professionals, are the agents responsible for integrating the activities of the elements constituting this process, intermediating the relationships between the instruments and the subjects-objects of the intervention, and thus, conducting a project that is at the same time socially defined and mediated by the intersubjectivity of the subjects involved[23].

The limitations of the study were attributed to the participants' diversity of schooling, which can have influenced the structuring of the results. Since there was a significant number having concluded only high school, they did not have deeper discussions about certain topics that are naturally brought up in the university context.

Moreover, the study results from a master's dissertation. Thus, in order not to lose all the research, it was decided to maintain the three categories. These deal with different debates but have converging themes, which may have given the reader the impression of repeated discussion. Nonetheless, this cooperated for validating the findings, which agrees with the guidelines for qualitative studies.

CONCLUSION

By analyzing the work process in health in the municipality of Caxias do Sul, RS, Brazil, it was verified that the most predominant actions were the preventive ones with a curative focus and physician-centered perspective, though idealizing a work as that prescribed by political in health for the FHS.

The analysis of the work process in the FHS made it possible to identify that it is necessary to invest in the professional and managerial improvement, to conduct a more collective and interdisciplinary work. However, the findings cannot be generalized due to the limits of the contexts investigated, so, it is important to conduct a continuing study nationwide in different FHSs and at the community health centers (UBS).

The findings also reveal the importance of improving the work in the FHS, with the need to respect the local dynamics, fomenting and making possible the professional initiatives, so that a greater assurance of comprehensiveness in health care can be envisaged.

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