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Limites e possibilidades do trabalho do enfermeiro na estratégia saúde da família: em busca da autonomia
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ORIGINAL ARTICLE

The limitations and possibilities of nurses' work in the family health strategy: in the search for autonomy*

LIMITES E POSSIBILIDADES DO TRABALHO DO ENFERMEIRO NA ESTRATÉGIA SAÚDE DA FAMÍLIA: EM BUSCA DA AUTONOMIA

LÍMITES Y POSIBILIDADES DEL TRABAJO DEL ENFERMERO EN LA ESTRATEGIA SALUD DE LA FAMILIA: EN BÚSQUEDA DE LA AUTONOMÍA

Maria Raquel Gomes Maia Pires[1]

ABSTRACT

The paper addresses how nurses can contribute to the consolidation of the Family Health Strategy (FHS) within the Brazilian National Health System (*Sistema Único de Saúde* - SUS), in the search for professional autonomy. Objectives: To discuss the limitations and possibilities of nursing work in the FHS aimint at the consolidation of the SUS; evaluate the available nursing appointments carried out by the FHS in Belo Horizonte (BH); reflect on the political aspects of nurses' autonomy on job positions. This is a quanti-qualitative stud study. We evaluated the availablitiy of nursing appointments in basic Health Units (BHs) based on secondary data and official parameters as indicators of autonomy. Subsequently, through focal groups, we analyzed nurses' autonomy in the FHS. Nurses can strengthen the FHS for the consolidation of the SUS, as long as they improve their understanding of the socio-historical context of nursing, the ambiguity of power relationships and social practice of the profession, improving it criticism, collectively and creatively.

DESCRIPTORS

Nursing
Professional autonomy
Professional practice
Family Health Program

RESUMO

Questiona-se de que forma o enfermeiro pode contribuir para a consolidação da Estratégia Saúde da Família (ESF), no âmbito do Sistema Único de Saúde (SUS), na busca da autonomia profissional. Discutem-se os limites e as possibilidades do trabalho do enfermeiro na ESF para a consolidação do SUS; avalia-se a oferta de consultas de enfermagem realizadas pela ESF de Belo Horizonte (BH); reflete-se sobre a face política da autonomia nos posicionamentos dos enfermeiros. Estudo de caso de natureza quanti-qualitativa. Foi avaliada a oferta de consultas de enfermagem em Unidades Básicas de Saúde (UBS) a partir de dados secundários e parâmetros oficiais, como indicativos de autonomia. Em seguida, analisou-se a autonomia no trabalho da ESF por meio de grupos focais. O enfermeiro pode fortalecer a ESF para a consolidação do SUS, se melhor compreender o contexto sócio-histórico, a ambiguidade das relações de poder e a prática social da profissão, aperfeiçoando-a crítica, coletiva e criativamente.

DESCRITORES

Enfermagem
Autonomia profissional
Prática profissional
Programa Saúde da Família

RESUMEN

Se cuestiona de qué forma el enfermero puede contribuir para consolidar la Estrategia Salud de la Familia (ESF), en el ámbito del Sistema Único de Salud (SUS), en búsqueda de la autonomía profesional. Se discuten los límites y posibilidades del trabajo del enfermero en la ESF para consolidación del SUS; evaluar oferta de consultas de enfermería realizadas por la ESF Belo Horizonte (BH); reflexionar sobre la faz política de autonomía en la posición del enfermero; Estudio de caso cuanti-cualitativo. Se evaluó oferta de consultas de enfermería en Unidades Básicas de Salud (UBS) desde datos secundarios y parámetros oficiales, como indicativos de autonomía. Luego, se analizó la autonomía de trabajo de la ESF mediante grupos focales. El enfermero puede fortalecer la ESF para consolidación del SUS, comprendiendo mejor el contexto socio-histórico, la ambigüedad de relaciones de poder y la práctica social de la profesión, perfeccionándola crítica, colectiva y creativamente.

DESCRIPTORES

Enfermería
Autonomia profesional
Práctica profesional
Programa de Salud Familiar

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INTRODUCTION

The Family Health Strategy (FHS), a form of priority organization of the primary healthcare policy of the Brazilian National Health System (SUS)[1], defines an important field of activity for the nurse, particularly due to the managerial, educational and care skills assumed by this professional. However, the work of the nurse in primary healthcare is not necessarily new for Brazilian nursing, originating from the need for the State to organize public health in the 1920s[2]. Similar to the fragile construction of Brazilian citizenship, the public policies, including those of health, from which emerges the constitution of professional nursing, originate from the tensions between the State and the market, with little participation of civil society[3]. Any analysis of the nursing practice must take into account this national scenario for the desired changes.

The critical production that analyzes the emergence of professional nursing in Brazil tends to highlight the passive character of its origin, linked to the interests of the State, and not the social agents that performed at the time, with a challenge to autonomy[4-6]. That is, in the model of Nightingalian professionalism, based in modernity, the formation of the nurse ideologically masked the reality that constituted the nursing care in the early twentieth century, performed by lay practitioners, the religious, prostitutes, slaves - people from poor social class or with behavior seen as inappropriate for the Catholic and bourgeois morality of the middle class.

The attempt to raise the *status* of the nurse, the social and technical division of labor, the denial of the social practice of its agents, the scientificism, the ideology surrounding the founding myths - of sacralized, asexual and vocational images - conform the archetype of the profession. These issues need critical recognition if the contradictions that hamper the achievement of technical and political autonomy of the profession, as expressed in their care, are to be overcome[7-8].

The political autonomy, able to face the contradictions of the practice, inherently articulates with the technical dimension of doing, giving it argumentative strength and cohesion of subjects around common ideals. It is the ability to make one's own history, to recreate possibilities, to conquer and be opportunities for life[9]. The hegemony of the technical dimension of the work is predominant in the profile of nurses in the representations that they make in their practice[10]. However, for the conquest of political autonomy, there is a need to deepen the understanding that it is not enough to advance in the technical dimension of scientific knowledge, disconnected from the ability to critically reflect and modify realities[7-9].

The political autonomy, able to face the contradictions of the practice, inherently articulates with the technical dimension of doing, giving it argumentative strength and cohesion of subjects around common ideals.

In this theoretical ambience, the exercise of the freedom of choice and of decision-making regarding the practices, linked to scientific knowledge, is immersed in ambivalent relationships of power that constitute the subject[11], which require greater reconstructive comprehension. To remove the political face of the knowledge, which feeds the autonomous actions of the nurse, is to become vulnerable to manipulation for the interests of others - whether the professionals, managers, representatives of the market, or the government, within the health policy. It is expected that the physician of the team, the manager of the service, the secretary or the minister of health confirm the recognition and freedom of action that is so required in the profession. To wait for rewards or to complain, without the appropriate broad analysis of the context and of the power relationships in which the professional work is inserted, is political fragility that must be overcome.

In order to exercise the protagonism sought by nursing, with emphasis on the nurse as the team-forming agent, it is useful to slightly reverse the logic of the questions that have always been made about the work of this professional in the SUS. That is, for the political dimension of the autonomy that is sought, it is little to ask for the spaces of action offered in Family Healthcare, by the government, in the historically observed tendency[2,4-6]. It is now worth questioning, in an authorial and purposeful way, how the nurse can contribute to the consolidation of this strategy of change in the Primary Healthcare area of the SUS.

With this problematization, the aims are to discuss the limits and possibilities of the work of the nurse in the Family Health Strategy for the consolidation of the SUS, in light of autonomy; to evaluate the offer of nursing consultations performed in primary healthcare units (PHUs) in Belo Horizonte (BH) as indicative of the autonomy of the profession; to reflect on the political face of the autonomy in the positioning of these nurses.

METHOD

This is a case study with a quantitative and qualitative approach, which analyzes the work of the nurse in the Family Health Strategy through a variety of research techniques, using triangulation of methods and data[12]. The study took place in two complementary steps, around which the techniques and information sources used are described. In the first step, the frequency of nursing consultations indicates possible evidence of autonomy by singularizing the private activity of the nurse in the healthcare services. The suitability of these consultations to the

local and national parameters of the primary healthcare/SUS was verified[13-14]. The secondary data base was used from the study *Evaluation of primary healthcare in Belo Horizonte: use, provision and accessibility of the services*[15-16], where the sources were the Healthcare System Network and the Fênix System of the Municipal Secretary of Health of Belo Horizonte (SMSA-BH), 2008 to 2009. The total number of nursing consultations were compared to the FHS consultations, in relation to that recommended, both in the general care and in the programmatic actions (child health, prenatal care and control of arterial hypertension), in a PHU in Belo Horizonte.

The qualitative deepening of the political autonomy occurred through the rereading of the statements from four focus groups conducted in the research cited, which also evaluated the organization of the work of the FHS[15]. The subjects of the research regarding the primary healthcare of BH were 30 professionals, 14 physicians and 16 nurses, all of the FHS teams of 10 PHUs of BH, randomly selected in the nine districts of the SMSA-BH. For the present study, the positions of the 16 nurses involved in these focus groups were analyzed. The investigation was approved by the research ethics committees of UFMG - Protocol 053/06 - and of SMSA-BH - Protocol 19/2006.

The analysis of the political autonomy of the nurse was based in formal quality references (or technique), and policies of the profession[7-8]. An examination was made regarding the proximity or distance of the statements concerning the characteristics: a) critical view of the reality and the social practice; b) questions about the inconsistencies of the profession; c) inclusion of the political face of the knowledge in the arguments; d) contextualized understandings of the autonomy and power unit; e) the concept of themselves as historical subjects. The statements were analyzed in the light of depth hermeneutics (DH)[17] - a method that reveals how the symbolic forms (significant constructions that require interpretation) are employed to maintain power relationships (*ideology*).

RESULTS AND DISCUSSION

a) Evaluation of the production of the nursing consultation in the PHU in Belo Horizonte

The Family Health Strategy of Belo Horizonte covers approximately 75% of the population of the city. The basic network has professionals who offer support for the actions of the FHS teams in the PHU itself, such as the support team (pediatricians, clinical practitioners, gynecologists, social workers), the mental health teams, oral health teams and the rehabilitation nucleus[14].

The mean number of consultations of the nurse in the programmatic activities was 35%; the remainder (65%) comes from the spontaneous demand of the PHU[a]. However, the mean number of consultations was not distributed evenly among the 10 PHUs, ranging from 15% to 67% for programmatic activities and 33% to 85% for the spontaneous demand, which provides diversity in the practice of the nurse in the FHS. The mean number of consultations offered by the nurse was 13.2% in relation to the total of the FHS, however, this percentage varied from 8.4% to 18.9% between the 10 PHUs, with a standard deviation of 2.9% and median of 12.3%.

In monitoring the growth and development in children under one year of age (Table 1), the mean of nursing consultations was little more than a quarter (26.1%), when the parameter recommends more than half (57%)[14], ranging from 9% (UBS 5) to 47.8% (UBS 3). The pediatrician assumes a major part of the consultations of the children in the PHU (mean 56.3%, recommended 29%)[14]. The performance of the pre-natal consultations follows the trend of low performance of nursing consultations when the mean is observed (23.6%; parameter 42.5%), however, compliance above that recommended occurred in UBS 10 (45%) and was well below the mean (12%) in UBS 9. It was verified that the gynecologist assumes the majority of the provision of prenatal consultations (mean 45.9%), three times higher than that directed by the local policies (parameter 15%), to the detriment of the consultations of the general practitioner (30.4 %), which, on average, is also lower than expected (parameter 43.5%). In three PHUs (1, 3, 9) the consultations of the general practitioner were within the recommended levels. Monitoring the hypertensive patients through nursing consultations in the PHU corresponds to a mean of 5.8%, when it should be 50% for the users who need this care. The majority of the consultations are assumed by the general practitioner of the FHS (79.3%), reaching close to 100% in some PHUs (97.2% PHU 3; 96.2% PHU 2; 94% PHU 6).

The low production of nursing consultations of the FHS of BH, both in the total of the PHU and within the programmatic actions, indicates worrying repercussions, both for the primary care policy and for the autonomous practice of the profession. In the context of the policy, it can be seen that the heterogeneity of scenarios complicates any linear evaluation, without taking into account the context of the practices and the reality of each healthcare service. For nursing, the scenario of low production of consultations can mean a retreat from the clinical in the work of the profession, necessary for the autonomy that is sought[10,18-19]. Other studies show that the precarious conditions of work of the FHS, the quotidian stress, the risk of illness through the work, and the conflictual relationships in the healthcare team accentuate the difficulties to be overcome[20-21].

[a] In the guidelines for the organization of the Primary Healthcare in Belo Horizonte, it is expected that the FHS teams designate 25% of their time for meeting the spontaneous demand and 75% for planned activities, and programmatic actions[14].

Table 1 - Percentage of consultations offered by nurses, general practitioners and support physicians in the programmatic actions in the PHUs investigated - Belo Horizonte, 2008-2009.

	PRIMARY HEALTH UNITS (PHUs)										
Professional	1	2	3	4	5	6	7	8	9	10	**MEAN**
	%	%	%	%	%	%	%	%	%	%	**%**
Child Health - GD monitoring of the child under one year of age											
(Parameter[14]: Nurse 57%; General Practitioner 14%; Pediatrician 29%)											
Nurse	26	28,6	47,8	39,1	9	31,8	11,9	33,7	13	20,3	**26,12**
General Practitioner	24,9	14,6	10,2	12,9	40,7	18,8	3,4	22	21,4	6,1	**17,5**
Pediatrician	49,1	56,8	42	48	50,3	49,4	84,7	44,3	65,6	73,6	**56,38**
Women's Health - prenatal care											
(Parameter[14]: Nurse 42.5%; General Practitioner 43.5%. Gynecologist 15%)											
Nurse	35	27,8	35,4	14,6	16,2	15,7	20,8	14,4	12	45	**23,69**
General Practitioner	44,5	16,5	45,9	0,4	26,2	35	31	29,9	52,7	22	**30,41**
Gynecologist	20,5	55,7	18,7	85	57,6	49,3	48,2	55,7	35,3	33	**45,9**
Adult Health - control of arterial hypertension											
(Parameter [14]: Nurse 50%; General Practitioner 50%; Clinical Practitioner 50%)											
Nurse	0,8	2,3	2,8	8,6	6,8	3,8	1,4	14,3	15,4	2,1	**5,83**
General Practitioner	75,6	96,2	97,2	66,4	74,8	94	88,1	80,1	59,7	61	**79,31**
Clinical Practitioner	23,6	1,5	0	25	18,4	2,2	10,5	5,6	24,9	36,9	**14,86**

GD: Growth and Development
Source: Health Management Network System/GEEPI/SMSA-BH[15-16]

b) Autonomy in the positioning of the nurse in the FHS in Belo Horizonte

Although the production of nursing consultations is an indicator to gauge the situation of autonomy of the nurse, it is insufficient to express the potentiality of their work in the FHS. The list of practices cataloged in the International Classification of Public Health Practices (CIPESC), in the dimensions of management, care, education and research, highlights the breadth of the actions of this professional[18-19]. Therefore, it was sought to reveal the autonomy of the nurse from the socio-historical context, of the characteristics of the work in the PHU and of the political meanings produced by their discourses.

The categories that summarize the socio-historical context of the nurses, originating from the statements, are: a) family relationships, motherhood and painful situations with the users; b) political correctness: little explanation of what one thinks; c) Family Health, let's struggle: some examples reproduced the official discourse of change of practices through the FHS uncritically, compromising more dialogical attitudes.

The nurses, in general women, chose stories of the personal life, considered remarkable, to present themselves. The centrality of the affect predominated in the contextualization of those interviewed, both in the significant events of life and work, as well as in the pictures chosen. In some professionals, the statements either tended to either side, or revealed a distancing from the proactive postures of change, faced with the scenario of the working practices. In other cases, the official discourse of Family Healthcare was reproduced, vigorously, with primacy of the technical dimension of doing. Although the small amount of critical reflection is indicated as a trait of the political fragility[7-8], the value of engagement for the required changes should be highlighted. One of the representatives of this category, ambiguously, revealed a high degree of determination and commitment to everything carried out; showed professional security and performed constant self-evaluation practices, more deeply reflecting on the situations. With regard to the work of the nurse in the PHU, it was found that, when they carry out the clinical dimension and the management of the teamwork process better, there is a positive impact on the organization of the actions in the PHU, this being one of the potential actions expected for the public health[18].

A close look at the socio-historical context of nurses indicates the influence of gender, of social class and of the formation regarding the profile they present. There is a certain non-homogeneous tendency towards conservatism of the statements, whether in relation to social traditions, to the role of men and women in society, or to the centrality of the biomedical model in the care. The excessively technical formation inhibits a deepening of the ethi-

cal, political and social reflection, with a tendency to superficiality in the analysis, in some of the discourses. The majority of the nurses demonstrated difficulty in analyzing the ambiguity of the power relationships in the team, in the service or in the health policy, compromising the political nature of their activity[7-9].

Between the extremes, or in the gaps, there were the ways out, the utopias or the new possibilities, inherent in the process of change that is being sought with Family Healthcare, and the autonomous action of the nurse. Those subjects closest to the political autonomy made explicit the critical analyses of their own work, of the team and of the PHU, highlighting the limitations and the advances of the FHS; saw more clearly the tensions and contradictions of the practice; demonstrated, in a certain way, the knowledge that they are able do better, detailing anxieties faced with the structural challenges of the practice. The majority of the nurses presented fragility in the political autonomy, tending to avoid the responsibility of the social actor, with little comprehension of the context of the health policy, of the power relationships of the healthcare team and of the nursing. Those who showed proximity with the political autonomy, in the minority, criticized the context and the professional practice, saw more clearly the ambiguity of the power relations in the team, although with little analytical depth, and placed themselves as social agents of the changes, even though *exhausted* in the midst of quotidian pressures for results and care[20-21].

CONCLUSION

The nurse finds an important space of actuation in the Family Health Strategy and can strengthen it for the consolidation of the SUS, to better comprehend the socio-historical context and the ambiguity of the power relationships in the social practice of the profession, improving it critically, collectively and creatively. The possibilities of this contribution for consolidating the principles of the FHS, with repercussions for the SUS, include the centrality of this professional in the formation and organization of the nursing workforce in the healthcare services; the potential for teamwork and the organization of the services in the PHU, characteristic of their doing; the diversity of actions developed in public healthcare, arising from their formation and practice; the use of the CIPESC for the diagnosis and reflection-action regarding the social practice of its agents and the strategic spaces they occupy in the health policy, whether in management, education, care, or in research. As a limitation to advances in the autonomy of the nurse and in the primary healthcare policy of the SUS the following can be highlighted, the fragility of its political discourse; the small amount of appropriation regarding the historicity of the profession; the attachment to idealized images of nursing that do not correspond to the reality of the social practice; and the precariousness of the relationships and working conditions in the Family Health Strategy. A critical culture of reflection has to be developed regarding the political fragilities of nursing, so that the quest for autonomy is a quality exercise of their doing and of commitment to the changes of the care model.

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