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Original Article

O COTIDIANO DE TRABALHO NA ESTRATÉGIA SAÚDE DA FAMÍLIA: ENTRE O REAL E O IDEAL

THE DAILY WORK IN THE FAMILY HEALTH STRATEGY: BETWEEN THE REAL AND THE IDEAL

EL TRABAJO COTIDIANO EN LA ESTRATEGIA SALUD DE LA FAMILIA: ENTRE EL REAL Y EL IDEAL

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RESUMO

Objetivo: Analisar o cotidiano do trabalho de equipes da Estratégia Saúde da Família. **Método:** Estudo de caso de abordagem qualitativa, realizado em 10 equipes da Estratégia Saúde da Família em um município de Minas Gerais com 39 profissionais. A coleta de dados ocorreu por meio de entrevista semiestruturada. Utilizou-se a análise de conteúdo na modalidade temática. **Resultados:** O trabalho em saúde, no cenário estudado, está fragmentado, reproduz o modelo médico-centrado e restringe o escopo de ações da Estratégia Saúde da Família. Destaca-se o vínculo, as ações orientadas à comunidade e formação profissional voltada para as novas necessidades do trabalho em saúde como elementos que podem qualificar o atendimento na Atenção Primária à Saúde. **Conclusão:** Apesar da implantação da Estratégia Saúde da Família, no município estudado, há quase duas décadas, sua função de reestruturadora do modelo de atenção ainda apresenta fragilidades. Os agentes do trabalho reconhecem a necessidade de mudança, mas mantêm articulação das ações cotidianas sem transformações de ordens simbólicas. Há evidências de práticas exitosas que, se incorporadas às práticas de atenção à saúde, contribuirão para a qualificação da assistência e mudança do modelo de atenção à saúde.

Descritores: Estratégia Saúde da Família; Atenção Primária à Saúde; Sistema Único de Saúde.

ABSTRACT

Objective: To analyze the daily work of Family Health Strategy teams. **Method:** Case study with qualitative approach, performed in 10 Family Health Strategy teams in a municipality of Minas Gerais with 39 professionals. Data were collected through semi-structured interviews. Content analysis in the thematic modality was used. **Results:** The healthcare work, in the studied scenario, is fragmented, reproduces the medical-centered model and restricts the scope of actions of the Family Health Strategy. The bond, the community-oriented actions and professional training geared to the new needs of healthcare work stand out as elements that can qualify the care in Primary Health Care. **Conclusion:** Despite the implementation of the Family Health Strategy in the studied city, for almost two decades, its care model restructuring function still has weaknesses. The labor agents recognize the need for change, but maintain articulation of everyday actions without symbolic transformations. There is evidence of successful practices that, if incorporated into the healthcare practice, will contribute to the qualification of assistance and change of the health care model.

Descriptors: Family Health Strategy; Primary Health Care; Unified Health System.

RESUMEN

Objetivo: Analizar la labor diaria de los equipos de la Estrategia de Salud Familiar. **Método:** Estudio de caso de enfoque cualitativo, realizado en 10 equipos de la Estrategia de Salud Familiar en un municipio de Minas Gerais con 39 profesionales. Los datos fueron recolectados por medio de entrevistas. Se utilizó análisis de contenido en la modalidad temática. **Resultados:** La labor en el cuidado de la salud, en el caso estudiado, está fragmentado, reproduce el modelo médico-centrado y limita el alcance de las acciones de la Estrategia de Salud Familiar. Se destacan el vínculo, las acciones orientadas a la comunidad y la formación profesional adaptada a las nuevas necesidades del trabajo en salud como elementos que pueden calificar la asistencia en la Atención Primaria de la Salud. **Conclusión:** A pesar de la aplicación de la Estrategia de Salud Familiar en la ciudad estudiada, durante casi dos décadas, su función de reestructuradora del modelo de atención aún tiene debilidades. Los agentes de trabajo reconocen la necesidad de cambio, pero mantienen la articulación de acciones diarias sin transformaciones de órdenes simbólicos. Hay pruebas de prácticas exitosas que, si se incorporan a la práctica de la atención a la salud, contribuirán a la calificación de la asistencia y el cambio del modelo de atención de la salud.

Descriptores: Estrategia de Salud Familiar; Atención Primaria de Salud; Sistema Único de Salud.

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INTRODUCTION

The Primary Health Care (PHC) is characterized by a "set of individual, family and collective health actions that involve promotion, prevention, protection, diagnosis, treatment, rehabilitation, harm reduction, palliative care and health surveillance". It must be the preference of the health care system, acting as care organizer and coordinator, with the Family Health Strategy (FHS) as a priority, to reorient the health care model, following its guidelines and the principles of the Unified Health System (UHS)[1-2].

In the current context of the FHS, it is possible to observe the reproduction of healthcare practices focused on the disease, from the fragmented work model, even noting that the care integrality conducts the process of change for the breakdown of traditional values in health[3]. To establish transforming practices, health work, in the PHC, should be re-adapted, which requires, from workers, managers and users, greater ability for analysis, intervention and autonomy so that actions focused on procedures give place to the model of attention focused on the uniqueness of users[4].

The work of FHS teams "should be based on the implementation of activities prioritizing solution of the users' problems and their problem solving with responsibility"[5]. Workers' ability to act "is dialectically related to the context of the network of services, with the management type, with the general conditions of work at PHC units and with their ability of subjective mobilization to each work situation" [5].

Based on the experience as a Nursing intern in Primary Care and insertion, in the current PHC context, having FHS as a practical field, its role of re-organizer of the healthcare model is still incipient in the studied municipality.

This work is justified by the importance of analyzing the daily work in the FHS and its experiences, beliefs and actions of individuals in their environments of relations[6]. Thus, it is necessary to be attentive to the 'same things' and its internal logic. Therefore, it is necessary to understand the popular culture that keeps a magical relationship with its natural environment, with the world of objects and with the interactivity established with the material world constitutive of everyday life[7].

In this context, the following question arises: how is the daily work of FHS teams? Faced with the need to deepen this theme, and considering the importance of the qualification of the PHC, this study aims to analyze the daily work of Family Health Strategy teams.

METHODS

This is a case study[8], with qualitative approach, grounded in Symbolic Interactionism, which "constitutes a theoretical perspective that enables understanding how individuals interpret the objects and other people with whom they interact and how this process of interpretation affects the individual behavior in specific situations"[9].

The study was conducted in a mid-sized municipality in Minas Gerais, which, in June 2016, presented a FHS coverage of 46.33%[10]. To define the eligible scenarios in the study, only FHS teams whose medical and nursing professionals had been working for at least one year at the current unit were selected for random draw, being this time of experience estimated by the authors as feasible to create bond with the team and with the population of the area of coverage.

The survey was conducted at 10 FHS, the number of units that participated in the study was not defined a priori, and data collection was interrupted by data saturation. Saturation is when the researcher manages to understand, in the field, the internal logic of the group under study[11], thus managing to get the answers to his/her research problem.

All doctors, nurses and nursing technicians, community health agents (CHA) and the dental surgeons of the oral health teams linked to the FHS randomly selected were invited to participate in the study. Eligible professionals who were on regular vacation or medical leave were excluded from the study.

To approach the study participants, the researchers sent a letter of invitation to the selected team and held the personal approach of each member. Upon agreement for participation in the study and signing the Informed Consent Form (ICF), the data collection occurred through semi-structured interviews, carried out by a single researcher, in their own workplace, individually and in a reserved place, by means of a semi-structured guide composed of questions of characterization of the interviewee and questions about the daily work in the FHS. The data collection guide was subjected to a pre-test, in order to verify the adequacy of the questions and their understanding by the interviewees, two nurses, one CHA, a doctor and a nursing

technician, belonging to the non-eligible FHS teams for the study.

After adjustments in the guide, the interviews occurred in the period from March to June 2016, with 39 professionals, being 10 CHA, six dental surgeons, nine nurses, six doctors and eight nursing technicians. All participants agreed with the audio recording, and the average duration of the interviews was 21 minutes. The field diary was used only to record losses of participants, which were seven refusals and four professional absences due to vacation or medical leave.

The Content Analysis in the thematic modality was used, considered appropriate for health qualitative researches since its purpose is to discover the meaning cores and provide a significant communication to reach the proposed objectives[11].

For data organization, the interviews were fully transcribed, and to guarantee the participants' anonymity, they were identified by the letter I (interviewee) with the respective number of the interview, followed by the letter S of scenario with the respective number of the scenario (example: I1S1, I2S1, I1S2, I2S2...). The transcribed interviews were not returned to the participants of the study for corrections or comments. Still in the pre-analysis, the floating reading of the interviews was performed in order to deepen the content, allow for the encoding of the empirical material and identify units of record.

Then, the context units with similar themes were organized into empirical categories: health work in the routine of FHS teams; facilitating and complicating factors. However, as the symbolic interactionism allows for the analysis of empirical reality, in a dialectical approach[9], the authors chose to present the results in a text without the structuring by categories elucidated in the thematic content analysis. In the stage of data treatment and interpretation, relations between the data found and the scientific literature were established.

Data collection began after the project approval by the Ethics Committee, under opinion n. 1.377.807/2016, CAAE 49972715.2.0000.5545, in accordance with the Brazilian ethical rules.

RESULTS AND DISCUSSION

Of the 39 professionals who participated in this study, 31 were female. The average time of participants' experience, at PHC services, was 10 years and two months, and the average time of insertion in the current FHS was four years and 10 months.

Of the higher education professionals, 13 had *latu sensu* post-graduation in the family health area, and seven, in other areas. The time since graduation in the study scenarios, in the FHS modality, ranged from one to 18 years, with an average of nine years and 11 months, with five FHS as practical fields of Nurses linked to a *latu sensu* postgraduate program in the modality of Residency.

The first empirical category, "Health work in the routine of FHS teams", reveals that the health work involves, firstly, the recognition of its object by the agents. "Everyone knows what to do, then (...) you don't need to tell them what to do, everyone already knows what they have to do, it's eighteen years, huh? So, everybody is well trained to do their service" (I1S3).

The health work aims to develop comprehensive care that affects the health status and autonomy of individuals and health determinants and conditioning of collectives[1]. As a work object, the human body is proposed, with its individual and collective dimensions, considering the expanded health concept. The means for carrying out the work are the instruments and technical knowledge, which, used by professionals, result in the health care itself[12].

The research participants identify the "disease" as main object, in daily work, reproducing the cure-focused care model. "Prevention, we have few things, which would be vaccines,... few projects for hypertensive, diabetic patients (...) then our care is cure-focused and medical-centered for disease, without prevention" (I3S8). "We still work with this healthcare model, no matter how much we want it, we still work with a "health-post" model: if I get sick, I go there and pick up a medical chart (I1S2).

This observation is justified by the first premise of Symbolic Interactionism, which establishes that people's actions in the world are based on the meanings that this world offers them. And these assigned meanings, according to the second premise, are sustained by a lasting action and human interaction[9]. The cure-focused health care maintains the medical-centered division of labor. The other professionals complement the medical act, when developing isolated actions, without integration with other

team members and without recognition of the final outcome of the work[13]. Therefore, the meaning of the function assigned by the research participants to the work object in the FHS cannot be ignored, because it is essential in the behavioral formation.

A study about health care and work models showed that the demands of users of health services directly reflect on the choice of the work object of PHC professionals[13]. In order to meet the health needs of the population of the study scenario, FHS professionals organized the work process in a fragmented manner, according to the skills and competencies of each professional. "So, their services [CHA] are basically the requests and the active searches, huh? So, it is basically in the field. The nurse works with child care and pap smear, huh? Cervical pap smear (...) she makes screening and the remaining visits along with me, like, now she is vaccinating, helping me when I need to do other things. But the nurse's basic service is, in addition to coordinating the unit (...), the screening (...) the doctor performs household visits, prenatal care, results of tests and routine appointments (...)The dentist meets the demand from dental treatment, the assistant, her basic service is to assist the dentist and, whenever possible, she helps me here, usually separating records, organizing records, these things (...).I vaccinate, ah...the nurse makes dressings as well. Now I vaccinate, make dressings, pre-consultation, post-consultation, what more? [laughs]. Everything that comes" (I3S1).

The technical and social division of labor, as evidenced in this study, has its roots in the capitalist system, which secretes the work conception from its actual implementation. Another study also showed that the PHC professional practice is predominantly fragmented, focused on the biomedical model, which points to the need for a practice of integral care that goes beyond the mere implementation of procedures and techniques[4].

In view of the Symbolic Interactionism, the meaning is produced from human interaction[9], and the study participants recognize that the work organization, based on the spontaneous demand, contributes to and reinforces the reproduction of the doctor-centered healthcare model, restricts the scope of the actions of the FHS and hinders the identification of priorities for the health of the territory. "We still treat more than we promote health, our focus is the disease, right? (...) you can see it through our agenda. Ninety per cent of our appointments focus on the patient's complaint (...) And medicating the patient. Most of those who come here are seeking medication." (I3S2). "It is the work process in here, we try to organize according to the spontaneous demand, right? We don't know perfectly the reality even in our area of coverage" (I2S1).

Only few interviewees in scenarios 7, 9 and 10 cited the use of Local Diagnosis as a tool for planning health actions. "A diagnosis to raise what we've managed to do, to have, on the graph, what has improved and what hasn't. And work with goals, so we raise problems, outline priorities (...) you manage to work more directed" (I2S7).

The situation pointed out by the participants, referring to the predominance of assistance, from spontaneous demand, may possibly result from the lack of structuring of the health work, in favor of users' needs, associated with the absence of effective programmatic actions. According to the interactionist perspective, health professionals are actors that define their roles and adopt only those actions that have meaning to them, and this meaning emerges from the interaction with people and the environment[9]. In this way, it is necessary to develop an "epidemiological look" at the population, which will be able to reveal risks and health problems not perceived or not valued by professionals and encourage the provision of services beyond restricted areas and focused on medical care[14].

Such a need to develop skills and competencies that are conducive to both the work process as the expansion and consolidation of the FHS was experienced, in the study scenario, as the speech below: "We make a home visit, in Cuba, promoting, preventing and here, only what the patient needs, only one day, only in the afternoon, you can't do with them all (...) we lack experience, working only with promotion, prevention. We treat more than we promote and prevent (...) they [the population] search for treatment, not seeking prevention" (I2S9). "People are like, ah, there should be more doctors. I don't think we need more doctors, I think we should have more health care professionals to the human being, right? (...) I learned so much with the Cuban doctors (...) we see the differential, because they really go to the disease outbreak" (I1S2).

The "*Mais Médicos para o Brasil*" Program pointed out positive interventions in the Brazilian scenario, since the education of these professionals focuses on the integral care to users and community[15]. Other studies[16-17] also showed satisfactory results of this Program, such as the improved access and performance of PHC services, as demand from municipalities, which suggests these professionals as potential re-structurers of care practices in the FHS.

Since the 1970's, there has been a search for changes in health-related training in Brazil, from attempts, albeit not very effective, of teaching-service integration. In 2001, with the deployment of the National Curricular Guidelines, it became possible to approach health training to the principles of the UHS, which represented a milestone in the reorientation of health-related training due to its direct influences from the Ministry of Health (MoH)[18].

In the study scenario, the development of other modes of thinking and producing health[19] was caused by the nurses from a residency program in family health. "The arrival of the intern greatly facilitated our life (...) I don't see the team without the presence of an intern anymore (...) In fact, there are two nurses working, right? So this part of prevention, health promotion, home visits, improved a lot (...) we look at the intern who left, if we list on a paper the differences he made, it's great. So I think (...) it's a very positive factor and very motivating for the team" (I2S3).

The presence of an intern, according to the Symbolic Interactionism, produces a new interactive process between the agents of labor in the family health team. Thus, new symbolic interactions are established and constitute the process that will result in a behavioral change[9].

The interviewees of the FHS, which are fields of activity of the Nurse Intern in Family Health, characterized this training as a facilitator of the organization of the health work process, since it contributes to increasing the scope of actions of the teams. "The intern is a great partner. He comes with other opinions, other knowledge and manages to develop, along with the team, some actions sometimes forgotten, for example, women's health. The pre-natal was something I had no intention of doing. With the arrival of the intern, we organized and realized we could do. So, he is a link between theory and practice. (...) I've been here in the FHS for six years, but, sometimes, due to our timeless routine, we forget some things that are important, then the intern comes with this new look, this new knowledge, and helps us get in line according to the reality of the population we work with, right?" (I2S5). "The intern arrives euphorically, seeking changes, improvements, making us seek more study. For example, we want to deploy the group of pregnant women, to start pre-natal care, I'll start with appointments for hypertensive and diabetic patient, which I used not to do" (I1S9).

A study corroborates that the intern is stimulated, at every moment, to propose and develop together with the work team new activities, such as nursing consultations to priority groups that are not commonly performed by nurses, including prenatal, hypertensive and diabetic patients, patients with Leprosy and Tuberculosis; implementation of the nursing care systematization; educational groups with the population and the establishment of intersectoral partnerships in the area of coverage of the FHS[20]. That is, in the light of Symbolic Interactionism[9], it is clear that the activities developed and stimulated by the presence of an intern constitute positive factors for the construction of new behaviors by members of the Family Health Team.

As expected, FHS teams develop actions for the prevention of diseases and health promotion, some respondents pointed out the execution of these actions on their territory of coverage. "Four years ago we founded a group (...) it has no age, we accept everyone and we seek overall health themes. (...) we are in the 32nd meeting (...) we treat everyone equally and, with this, we establish a link (...) The entire team currently goes to this group (...) I am happy, because it's at 2 p.m., whether with rain or sun, they are there (...). So the population is steady and strong. This is gratifying" (I1S2). "We make waiting room or specific groups, according to the needs: hypertensive, diabetic patient, pregnant women, children, mothers in child care, women's group" (I2S3).

However, due to several reasons, even inherent to the organization of the work process of the teams, it is not always possible to follow these actions. "We organize some groups of hypertensive, diabetic patients, we also have a non-smoking group (...) it works a period, stops, because of employees, lack of organization of the team, we can't keep this" (I3S8)

It is important to highlight the recognition, on the part of the respondents, of the essential attributes of PHC, such as the bond, first contact access and longitudinality; and the derivatives, such as community guidelines and cultural competence, can "trigger" practices guided by principles and guidelines of the PHC. In some locations, appointments, educational groups and activities at schools are held in the evening or Saturday mornings, to meet the population that is not able to attend the usual time of operation of the units. "One of the pillars of the family health is the longitudinality. Everyone is old here, so you recognize the person by her voice. You know everything about her (...) an interaction with the community depends on the time you've been here (...) When I arrived here, I used to treat the father and the mother, then, the father, the mother and the child, today I treat the grandchildren. So I think it is a facilitator, because I've known the family for three generations" (I1S3). "The population didn't even know what the municipal health council was (...) it was the result of this work we developed in the community, and the community began to learn and see what is important and has been supporting" (I1S2). "We have some groups, not during the working hours, for example, on Saturday morning, during the night, we tried to do as the population needs, especially those patients who couldn't participate normally, so we did it" (I4S2).

Among many challenges, it is important to maintain efforts to improve the quality of health services, through the search for different strategies and modes of action that aim "to deconstruct the hegemonic mode of health production"[14] and go beyond the medicalization. The meeting with the users, whether in the territories, at home or in different spaces, favors the extended look of the professional, who begins to consider them from their life story and not just as subject to illness[4,14].

North American countries had to redesign their health systems in order to reduce the inequalities of access, expand health services and meet the needs of its users. To do this, they emphasized the interprofessional work, expanding, especially, the nursing roles. Giving autonomy to nursing work proved to be a powerful strategy in care continuity. It was also possible to check the reduction in the demand for specialized medical appointments, by greater adherence to the established treatment, mainly, of non-communicable chronic diseases[21].

The turnover of professionals in teams, due to temporary contracts of employment, was cited as a complicating factor of the health work, as well as the incomplete staff, uncovered micro-areas, or also the population under the responsibility of the FHS that extrapolates the recommendations of the National Primary Care Policy (BANP). "Because our contract is ending, it won't be renewed (...) what we have now, the trust of the population will be broken (...) So, who gets here, will have to build all the way again. Everything will have to be redone" (I2S2). "It is a disorganized FHS, not only by the team (...) poorly formed, isn't it? We should have all CHA, we don't have the registered area, our FHS has two community agents, it should have five, we don't know our population" (I3S8).

The Management of the municipality is far from the reality of the work developed by the professionals in the FHS teams, enhances productivity, at the expense of the quality of services (I1S5), which corroborates the practice of the doctor-centered care model. "As we are talking about FHS and primary care, emphasizing the managers, right? In my assessment, the Health Department staff could have a greater dialog with the units. Carefully, to see how each specific reality is, of the units and, indeed, it doesn't exist" (I1S1). "But what is happening is that we have no FHS, it's a "big health post"! (...) nor do we have a car to make home visits" (E1C4).

The speeches allow for demonstrating that the care model adopted by the municipality has affected the meaning participants give to the aspects of everyday life that negatively affect the work process of the team. This can be understood in the light of the theoretical framework adopted in the present study, which states that the meanings are formed and transformed positively or negatively in the process of human interaction[9].

The establishment of a bond between professional and user, by means of relations of trust and co-responsibility, enables the development of user-centered care and collaborates to the development of new ways of producing health[13]. The bond, therefore, configures itself as a light technology that allows for constructions that generate positive impacts on health problems of users[11].

The poor knowledge of the population about the FHS, its objectives and its purpose, hinders the organization of work, especially in the newly trained FHS teams. "We have difficulties with the population, because we had two gynecologists, but currently, we have none, due to the criteria of strategy (...) the population doesn't accept" (I1S4). "Even today it focuses on the doctor (...) it's complicated to work prevention in a community that only thought in cure until recently" (I1S5)

Thus, regarding cure-focused health care, participants pointed out that the FHS has not fulfilled its reorganizing role of the current health care model and works as a traditional unit, popularly known as "health post": "The FHS has not ceased to be a big health post, a basic unit, because the characteristic of our population here, unfortunately, is prescription (...) a lot of medications, so this part of promotion, prevention, work on health information, FHS that is the family care, in the general context, we still have to work very hard to improve it" (I1S4).

The professionals reproduce the health care model, "big health post" (I1S2), once they recognize that there is no personal and/or collective directing for the reorganization of the health work. This fact also occurs because they are "trained to come, make your service" (I1S3). Nonetheless, the participants recognize the need for permanent health education: "I think we need it, my college focused on the issue of organization of the work process. I think we lack knowledge, I think that's it (...)" (I1S9). "I think what could also improve is the work process, perhaps some permanent education, which I think sometimes lacks a bit, right? Something to empower us also to be acting according to those obvious problems we have. I think that this could also improve a little" (I2S1).

In this context, it is possible to infer that the training of human resources, focused on the UHS and teamwork, are elements that can qualify the care in the PHC. The professional qualification constitutes an important tool, in order to restructure the care model, regarding the need to restore assertive care practices that allow for the recognition and effective action on the health conditions and their determinants[13,22].

In countries with advanced primary health care, such as Canada, where there is a search for the strengthening of primary care and community focus on health care, there is evidence that the interdisciplinary performance and team work favors the quality of service[23].

Due to these considerations, the Symbolic Interactionism allowed for knowing the complexity and ambiguity of the meanings attributed by the actors involved in the daily work of the Family Healthcare Team. The current challenge of the FHS is to restructure the work of teams in the perspective to construct a new healthcare model. In this way, the organization, the planning of services and professional preparation are priorities for achieving such goals[24]. As shown in the speech of the interviewees, each location has its reality and health needs, which demand different ways of organizing work, to improve the health conditions of the users.

Thus, it is important to highlight that, in a context that reproduces traditional techniques of biomedical-centered health care, there still arise professionals who recognize the real meaning of the PHC and try to express this meaning in their practices. "The Family Health Strategy is the first contact that person has with the health care system, it's the primary care (...). It is more important to prevent than curing and prevention is directly related to primary health care (...).The purpose of my work is prevention and health promotion, which I think are the purpose of all primary care. The curative part also (...), because the primary care includes everything. I am saying that the most important thing of primary care is the prevention and promotion, although you focus on cure, do whatever you have to do" (I1S10).

Researchers say that the health care model corresponds to how the technologies and knowledge are organized into a system to meet the health needs of the population[13]. The successful experiences evidenced, in the study scenario, indicate the need to develop actions focused on care integrality. The health work should be accomplished in a team, by means of the complementarity of actions and movement between types of knowledge, because, acting together, the actors in this process builds the path to be followed based on policies and assumptions that underpin the FHS and the UHS[3]. Nonetheless, health work does not always work, based solely on standards and guidelines, as workers, and even their own daily work, require constant reinterpretations and reinventions in order to produce health[25]. According to the third premise of Symbolic

Interactionism, by means of human interactions, the meanings of actions can be maintained or modified by individuals[9].

In this perspective, the workers - protagonists of the process of change of health work should receive permanent qualification, so that, from the dialog with users of the services and with the team itself, anchored in a critical reflection on their actions, can recognize the difficulties in everyday services and incorporate effective practices for qualification of health care[26-27].

CONCLUSION

After more than two decades of deployment of the FHS, in Brazil and nearly two decades, in the municipality of study, its restructuring role of the care model still has weaknesses. Workers recognize the need for change, but they maintain articulation of everyday actions without symbolic changes. There was evidence of practices and successful experiences, focusing on the user and his/her needs, which may be considered situations capable of modifying the meanings of daily work in the PHC and, thus, reorganize the work of teams.

However, factors such as the predominance of the cure-focused model, fragmented health actions aimed to spontaneous demand, high turnover of professionals and the lack of knowledge of the population about the FHS are recognized as obstacles to advances in health care. These points should be discussed, reduced or modified, in order to reach the ultimate goal of the PHC: qualification of health assistance and improvement of the quality of life of users.

There is importance of a training geared to the rupture of the biomedical-centered practice, in particular, the Nursing Residency Program, which aims to strengthen assumptions and substantiate the implementation of the UHS as health policy, by means of the articulation between the worlds of work and education and, thus, train professionals capable of performing a quality care based on the principles and guidelines of this System.

In this way, as evidenced in this study, the presence of Nursing interns, in the daily work of the teams, approaches the real to the ideal, because, in addition to encouraging the team to aspire to build practices consistent with the restructuring proposal of the FHS, also constitutes as labor force to operate such changes and face the biomedical model, still so entrenched in PHC health practices.

There is no suitable formula of the path to be followed - perhaps this is the factor that most favors the lack of organization of work by the teams, generating different configurations of everyday work. In this sense, studies about successful practices for the FHS work organization become important, as well as those that inhibit this process, in order to allow for achieving the proposed objective, which is the construction of a new way to produce health.

A limitation of this study is its development in a municipality with FHS coverage of around 40%, which suggests difficulties of municipal management implementing the policy of reorganization of the PHC. Therefore, the refusals to participate in the study would not affect the empirical reality, as evidenced by the professionals and, in this way, thus bringing contributions to the practice of nursing and other health professionals.

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