

The contribution of the residency in family and community health to strengthening the Unified Health System

A residência em saúde da família e comunidade no fortalecimento do Sistema Único de Saúde

La residencia de salud familiar y comunitaria en el fortalecimiento del Sistema Único de Salud

ABSTRACT

Objective: to understand the way in which residency in family and community health acts as an instrument for strengthening and defending the Unified Health System from the perspective of nursing. **Method:** exploratory-descriptive study with a qualitative approach, developed with 13 resident nurses. In this study, data were collected remotely with semi-structured interviews, processed by the IRAMUTEQ software, and interpreted according to Bardin's content analysis. **Results:** the results indicate that residencies in the health area express themselves with political force, theoretical knowledge, and training in practice, essential to strengthen social control. **Conclusion:** the training of professionals must be guided from the principles/objectives of the SUS and the fight against imminent attacks, exemplified by low funding and poor management, must occur.

Descriptors: Unified Health System; Nursing; Public Policy; Training of Human Resources in Health; Health Residency.

RESUMO

Objetivo: compreender a maneira como a residência em saúde da família e comunidade atua como instrumento para o fortalecimento e a defesa do Sistema Único de Saúde sob a ótica da enfermagem. **Método:** estudo do tipo exploratório-descritivo com abordagem qualitativa, desenvolvido com 13 enfermeiros residentes. Neste estudo, os dados foram coletados de modo remoto por meio de entrevista semiestruturada, processados pelo software IRaMuTeQ e interpretados conforme análise de conteúdo de Bardin. **Resultados:** os resultados apontam que as residências na área da saúde se expressam com força política, conhecimento teórico e formação na prática, essenciais para fortalecer o controle social. **Conclusão:** faz-se necessário que a formação dos profissionais seja orientada a partir dos princípios/objetivos do SUS e que ocorra o combate aos ataques iminentes, exemplificados pelo baixo financiamento e má gestão.


Descritores: Sistema Único de Saúde; Enfermagem; Política Pública; Capacitação de Recursos Humanos em Saúde; Residência em Saúde.

RESUMEN


Objetivo: comprender el modo en que la residencia en salud familiar y comunitaria actúa como instrumento de fortalecimiento y defensa del Sistema Único de Salud (SUS) desde la perspectiva de la enfermería. **Método:** estudio exploratorio-descriptivo, con enfoque cualitativo, desarrollado con 13 enfermeras residentes. En este estudio, los datos se recolectaron de forma remota mediante entrevistas semiestructuradas, que, posteriormente, fueron procesadas por el software IRaMuTeQ e interpretadas de acuerdo con el análisis de contenido de Bardin. **Resultados:** las residencias en el área de la salud se desarrollan con fuerza política, conocimiento teórico y formación práctica, lo que es esencial para fortalecer el control social. **Conclusión:** es necesario que la formación de los profesionales se base en los principios/objetivos del SUS y que ocurra la lucha contra los inminentes ataques, ejemplificados por una baja financiación y mala gestión.

Descriptor: Sistema Único de Salud; Enfermería; Política Pública; Formación de Recursos Humanos en Salud; Residencia Sanitaria.


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INTRODUCTION

The idea of the right to health was elaborated at the 8th National Health Conference in 1986, since its consolidation is a result of the legal structure responsible for the formation of the Unified Health System (SUS), which includes Laws 8.080/1990 and 8.142/1990. However, such norms have suffered attacks that contradict the achievements listed by the health reform in Brazil. De-financing, mismanagement and the neoliberal political/economic wave that aims at health as a profit are not recent issues, but have generated over the years the consequent loss of recognition of SUS as a social justice project belonging to the people^{1,2}.

Since its creation, there has been no other historical moment in which SUS has been so recognized with regard to an essential and necessary right as in the period of the pandemic caused by covid-19, with a peak in the years 2020 to 2021. It is identified that it is not only society with a more positive view, but also the media itself, through the dissemination of news and production of serials that bring a different view of the poor quality stereotype³.

If we look at São Paulo, the largest city in the country in terms of population index, opinion polls conducted annually since 2015 show that, in 2021, SUS was chosen as the best health service in the city, growing from 2% to 13%⁴.

Based on the above, how to justify the maintenance of means that weaken and withdraw SUS funding? This is the case of Constitutional Amendment number 95 of 2016, which freezes SUS spending until 2036, proving to be a drastic measure, with the argument of fiscal austerity, responsible for stagnating investments in health, science and technology. We can also ask the following question: how to resist in times in which different types of crisis intersect? The health, social, political and economic crises were already outlined since 2014 and lead us to a long recession, increasing unemployment, generating greater national dependence on world economic relations and reducing the quality of life of the population⁵.

It is necessary to build paths that strengthen the SUS in the face of the growth of inflation, governments that encourage the private sector or the weakening of social policies, which, above all, corroborate the serious increase in hunger⁶.

In this sense, Castro, Silva and Vasconcelos (2022)⁷ state that residences contribute to the strengthening of the system, acting in the face of priority areas in an interdisciplinary and interprofessional manner, in health needs in areas of social inequality, in addition to integrating teams with few human resources.

This is a proposal for training in the SUS and for the SUS, which seeks to insert professionals in the health reality, strengthening the principles and guidelines developed since the health reform, the columnar aspects that support the ideas of dignified health for all and generate agents in addition to technicians, also political and social^{8,9}.

In the state of Ceará, the School of Public Health (SPH/CE) linked to the State Department of Health has been working since 1993 in the field of residences, initially with the medical area and, in the following years, in multiprofessional integrated residences, focusing on permanent and interprofessional education, for pedagogical and political qualification of subjects¹⁰.

Given the above, we have the following guiding question: what is the understanding of nursing residents about the contributions of family and community health residency to the strengthening and defense of SUS?

Therefore, this study is justified by the need to discuss strategies with potential to strengthening the SUS, such as health training through residency, aiming to interrupt disassembly cycles that have occurred over the years.

Thus, the objective is to understand how family and community health residency acts as an instrument for strengthening and defending of the SUS from the perspective of nursing residents.

METHOD

This was an exploratory-descriptive field study with a qualitative approach, developed

with 13 resident nurses who make up the multiprofessional emphasis on family and community health of the School of Public Health of Ceará (SPH/CE).

The criteria for inclusion of participants in the study were undergraduate nursing, being properly enrolled in the multi-professional residency program in family and community health of the SPH-CE and being in the second year of training. Residents who were on vacation or leave were excluded. Sampling was done intentionally, non-probabilistically and for convenience.

Data collection took place during November and December 2021, through a semi-structured interview conducted by a nurse with experience in the development of qualitative studies. It is noteworthy that the interviews followed a thematic script prepared by the researcher, based on the objectives of the study. Thus, we sought to broadly address the interviewees' understanding about the SUS and the contributions of family and community health residency and the role of the resident to strengthen this system.

Due to the Covid-19 pandemic scenario, collection was carried out remotely through the WhatsApp mobile application. In the first contact, an appointment was scheduled for the interview; in the second moment, the collection occurred synchronously through audios or video calls, in order to assist and allow greater attention to the dialogue. Respondents' answers lasted from 20 to 30 minutes and were archived and named by numerals to ensure anonymity. The end of the collection occurred through data saturation.

After collection, the data were organized, typed and stored in the Microsoft Word software, version 2016, forming the textual corpus. For speech processing, we used the software Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires (IRAMUTEQ), version 0.7, which allows statistical analysis of texts produced, from basic lexicography, calculating the frequency of words, to multivariate, as used in this study: Descending Hierarchical Classification

(DHC)¹¹, which resulted in three distinct classes, each formed by the most frequent terms. Class 1, with 36.16% of the text, called "Discussing the formation of the resident and his relationship with the maintenance of the SUS"; Class 2, with 15.25% of the text, entitled "Resident and territories: basic actors in the strengthening and defense of the SUS"; and Class 3, with 48.59% of the text, called "The political role of nursing and the mutual strengthening between the SUS and the profession".

As for the methodological guidance for interpreting the findings of this study, it was based on the content analysis proposed by Bardin (2016)¹². As recommended for the execution of this analytical technique, the interviews were initially pre-analyzed, followed by their deepening, that is, the exploration of the material, ending with the treatment and interpretation of the results from the inference technique.

The research participants expressed their interest in participating in the study through the agreement of the Informed Consent Form (ICF) and the Post-Enlightened Consent Form, thus meeting the ethical principles for research with human beings, according to Resolution 466/12 of the National Health Council (NHC) and Circular Letter number 2/2021/CONEP, which deals with the collection of virtual data.

The study was sent to the Ethics and Research Committee of SPH-CE through the Brazil Platform, being approved under opinion number 5.023.001 and CAAE: 51543521.2.0000.5037. As a strategy to ensure the anonymity of the participants, the researchers used the acronym NUR, followed by a number, assigned according to the order of the interviews.

RESULTS AND DISCUSSION

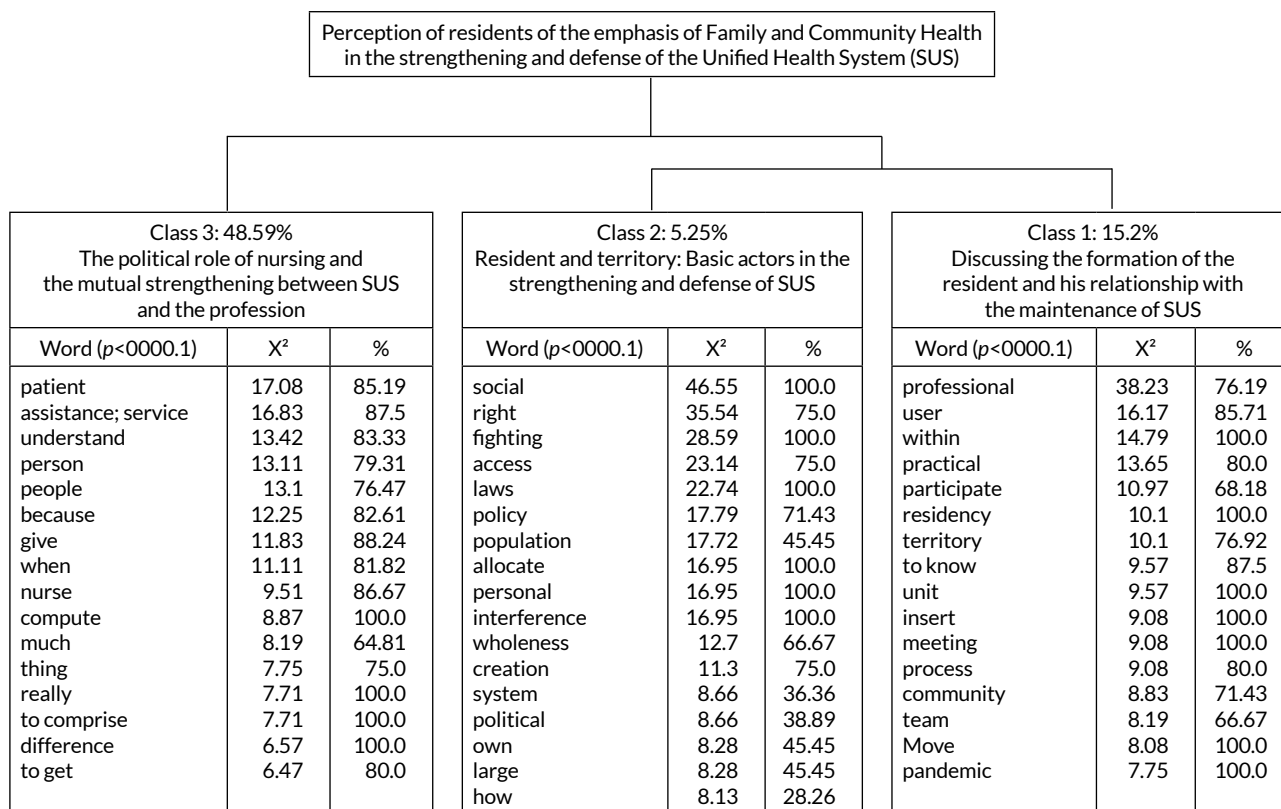
The interviewed residents were aged between 25 and 42 years, of which 38.5% were 25 years old, 23% were 26 years old and 38.5% were between 27 and 42 years old. All participants were female, with an undergraduate degree obtained between 2015 and 2020.

Hometowns varied between the states of Bahia, Tocantins and Ceará. Participants were SPH/CE residents located in the municipalities of Aracati, Crateús, Caucaia, Fortaleza, Guaiuba, Horizonte, Icapuí, Iguatu, Morada Nova and

Quixeramobim. Only three exercised residency in the same city they previously resided in.

The speeches processed by the IRAMUTEQ software generated the class categories shown in Figure 1.

Figure 1 – Dendrogram of the descending hierarchical classification obtained through the lexical analysis of the IRAMUTEQ software. Fortaleza, Brazil, 2022.



Source: Study data

The political role of nursing and the mutual strengthening between SUS and the profession

Before the SUS era, health services consisted of fragments and were composed only of physicians and nursing attendants. It was with the construction of a new health system that the multiprofessional team emerged, gaining prominence several professions, such as physical therapists, nutritionists, pharmacists, psychologists, among others. The SUS not only expanded health facilities, but also generated numerous jobs and transformed the concept of public health, expanding teams⁹, especially nursing, as described in the following statements:

“Nursing has a lot of confidence in the community because it is very active within it.” (NUR 2)

“Nursing is a very large and potent category, so it is strongly present in SUS”. (NUR 3)

“(…) this period only made me realize how great nursing is; how much our work is indispensable for the maintenance of the system. Without nursing, the BHU does not work, without nursing there is no SUS”. (NUR 13)

In this sense, while observing the statements, we recognize the presence of terms such as ‘patient’ and ‘nurse’ and we understand the inseparability of the themes. Weaving reflections on the SUS and its strengthening is

also to discuss the role of this immense category, both practically and politically.

Nursing professionals are 60% of workers who faced the scenario of the health crisis caused by covid-19. They are present in all states and municipalities, different levels of attention and in the most varied ways of life, as well as in science, research, teaching and social control¹³.

Despite its importance, nursing works with exhaustive workloads and low remuneration; growing unemployment can reach 20% in certain states. In addition, it suffers from the danger of violence and aggression in the workplace, as well as accidents and risks of the profession, such as progressive mental illness and sedentary lifestyle caused by lack of time and fatigue. Such problems plague nursing even before the pandemic¹⁴.

There is an urgent need to value the SUS, which, therefore, legitimizes nursing and adds value to the profession. If this is the largest class and the main pillar of health support in the country, its role is to understand the social context in which it is inserted and occupy the political and management spaces to change this oppressive reality.

Residency is one of the spaces that allows the construction of these debates and generates concerns on sensitive themes for SUS sustainability, such as popular participation, health training oriented to sanitary principles, the need for adequate funding and the ability of nursing to produce new views, studies, social and political movements in favor of public health^{15,16}.

The way society and politics are built in the country affects nursing individually, including the resident who works in the countryside; in general, the entire professional category; and, compulsorily, the way of working in the SUS. The more inclusive, defender of human rights and sanitary society is, the greater the value reaches the various fragile poles that involve the health field.

Resident and territory: basic actors in the strengthening and defense of SUS

The perception of the resident about the essence and what the SUS represents is of paramount

importance, given that the social, intellectual and regional formations within the residence are diverse. Understanding the political context of the theme “defense and strengthening of SUS” and how it is present in the territory of action/experiences allows us to identify the divergences and, mainly, the commonalities of what is understood about SUS. In addition to directly knowing the perception of the interviewee, we can identify, through what these professionals live in the act, the understanding of users in the territory. Therefore, we see from the perspective of these.

The SUS is undeniably the recognition of the right and access to health, in which the resident guarantees the integrality of care through a free care expressed in consultations and in its praxis. The presence of theoretical-conceptual value is highlighted in the following statements:

“SUS provides for the integrality of the care of actions of promotion, protection, recovery and rehabilitation of all, without any discrimination, without privileges.” (NUR 5)
 “(...) a comprehensive and complete system that guarantees universal access to health, as well as comprehensive care and equity, among many other principles”. (NUR 11)
 “It is a health system that aims to be universal and offer the integrality of health actions and services.” (NUR 3)
 “I am also enchanted by the competencies of the SUS, such as health surveillance, inspection and control of water, food, as well as the products we consume.” (NUR 8)

Another pillar is the political aspect, inherent in the system, as we observed in the combination of the following words: social, law and struggle, or even: access, legislation and politics. The resident understands the context of social struggle, realizes that weak legislation and political support make financing the main cause of the dismantling suffered by the SUS, by identifying scrapping due to lack of materials, weakened structure and inadequate remuneration. It also includes the inseparability of management and policy in this process:

“Due to the lack of appreciation and financing, the SUS cannot offer what it should, ending up in the capacity and lack of resources.” (NUR 2)
 “Politicians disagree and keep doing this de-financing, taking away funding from SUS and reducing actions, and real and effective professional actions, due to lack of funding, are taking away some of what SUS can offer”. (NUR 4)

“(…) in the municipality where I am allocated, the struggle is very great, because the politicians themselves do not value the system and much less value the performance of resident professionals, we have difficulty communicating with management, with workplace structure, with the lack of human resources, with inputs, with financial resources; we often take out of our pocket to carry out health actions; we have difficulty in the right to participate in internal meetings on health organization in the municipality”. (NUR 11)

The atypical situation and public calamity due to the covid-19 pandemic was the only reason why there was a modification/increase in transfers to Public Health Actions and Services (PHAS), previously defined by Complementary Law 141/2012. In 2019, the Federal Government recorded a total expenditure of R\$122.3 billion. In 2020, the budget of the Ministry of Health (MH), which accounted for R\$124.20 billion destined to the execution of PHAS, received an increase of R\$64.12 billion, reaching R\$31.73 billion in extraordinary credits directed to the National Health Fund¹⁷.

Such a specific and limited-time measure is necessary, but it does not solve the problem, since the Ministry of Health did not adequately allocate this amount, nor are there adequate resources in the long term to be allocated to the SUS, given that there was no revocation of Constitutional Amendment (CA) number 95/2016, instituted for fiscal management of public spending, which freezes the transfer of resources in an autocratic manner, without allowing remodeling until 2026 and without analyzing the implications for the

increase of inequality before so many families that depend on public services^{17,5}.

Despite being an essential service with more than 30 years and made for everyone without distinction, it suffers attacks that demonstrate the need to maintain a political and social struggle, as well as that occurred for its formation in health reform^{18,19}.

In the various territories in which the residents are inserted, it was perceived the need to value the SUS with statements that express the little and even non-existent performance and/or political understanding of service professionals and users of the community, in addition to the importance of the residency program:

“(…) as a professional I realized that we have a greater difficulty leaving, because the work routine is more exhausting and there is not much incentive on the part of the employer and the employee to participate in the movements, so it is as if they did not exist (…”. (NUR 3)

“(…) the residence brings a differential for that municipality, because it is a team of professionals different from the teams we already have and that have been plastered for years and always do the same thing”. (NUR 6)
 “Regarding patients, it is very difficult for you to see their political participation in the defense of SUS.” (NUR 9)

The lack of understanding of what the SUS represents and the lack of understanding of the need to strengthen this right to health directly imply fragile participation and social control, fundamental principles for its consolidation. Passive attitudes towards attacks on public health in our country compromise health care itself or even the non-valuation of SUS by users and professionals themselves, in addition to widening inequalities, thus weakening an essential instrument for the nation^{20,21}.

It is known that the popular stigma about SUS has changed due to the pandemic, with recognition of its role, mainly due to the media, which are sources of narratives for the population. As previously, such means associated the SUS with failures and problems, nowadays,

there is the insertion of public health even as a theme in the fictional series of recent years.

The fact is that derogatory perceptions, associated with media, are more present in those subjects who do not use SUS directly, as pointed out by the System of Social Perception Indicators (SSPI), informing that people who use it evaluate it better³.

Discussing the formation of the resident and its relationship with the maintenance of SUS

Resident training is based on collective activities, such as health promotion and education actions, use of active methodologies, study of theoretical modules on various topics, research, interventions in the territory, evaluations and experience of clinical practice within the territory in which it is inserted²².

It can be highlighted that most residents do not have experience or previous training in Primary Care, being encouraged to perform actions of planning and organization of the work process, as well as being matrix support, generating changes in health techniques, articulating theory and practice, in addition to forming a professional identity, while acting in an interdisciplinary way²².

Some fundamental aspects of the relationship between resident and territory were discussed in the previous topic and allow us to reflect on the possibilities of strengthening and defending SUS in the practice scenarios. For example, we observe the direct relationship between these actors in the day-to-day of their training, in which they live with the community exercising actions aimed at the daily and real needs experienced.

Such proximity means that the training modality produces skills to be developed by these professionals, both by the pedagogical and theoretical means inserted by the institution and by the imposed health reality. The stimulated political, social and practical understanding may, at times, not be present in managers of the city hall and in other professionals

of the municipalities, who are sometimes preceptors of both the professional core and the entire team, being responsible for directing the work in the field.

We can observe in the speeches of the residents of the different municipalities the difficulties faced due to this difference:

“There is a lot of the concept of political interest within municipalities, which, consequently, causes great impacts on health, which, in turn, selects professionals by “vote”, and not by professional competence, many of whom do not understand the work processes or do their competencies according to their wishes”. (NUR 1)

“(…) my tutor says that SUS is a makeup, but I never thought that SUS was a makeup, it only lacks a management to be strengthened, if it was a makeup, why things work out in some places?”. (NUR 6)

“(…) the struggle is very great, because the politicians themselves do not value the system and much less value the performance of resident professionals, we have difficulty communicating with management”. (NUR 11)

The preceptor is the reference professional and performs functions that directly interfere with the training of the resident, revealing the complexity in the teaching-learning process. Thus, being skilled in his professional practice does not necessarily reflect on the ability to perform pedagogical functions. There is also an understanding of the existence of challenges and difficulties to be learned and overcome by the preceptorship; however, it is necessary that there is at least a training profile that meets the health needs of SUS¹⁵.

The presence of the residency program generates changes in the service/territory inserted, which raise critical and reflective discussions regarding the strengthening and defense of the SUS, instigated by the reality and debates brought by the SPH, such as those presented in the following statements:

“It is present in the field and core rounds by residents and preceptors. This subject is widely discussed on almost every round.

Many recognize and know that they need to fight for the SUS.” (NUR 2)

“I only visualize this theme in the municipality from the residence.” (NUR 6)

“I see that they are similar, the SPH launches some discussions and we resemble what we experience in practice, in the territory. It is also similar in events.” (NUR 10)

The differentiated formation of the residence is what allows themes like this to reach varied spaces. It is these discussions, the formative process, the changes and even the discomforts in the territories that can promote the realization of the collective understanding of the ideals that formed the SUS.

One of the objectives of multiprofessional residency in family and community health is to qualify young people for work, acting in a decentralized manner, reaching various social realities and taking professionals, mostly recent graduates, to learn and contribute to SUS.

This exchange allows a continuous process of mutual strengthening, both of the professions that are inserted there, such as the study, nursing, and the specialization model by the immersion experienced during the two years of training, passing through the hegemony of medical residences and understanding the complexity of human needs, valuing, therefore, the various professions^{15,21}.

It should be noted that multi-professional residences, established by Law 11.129/2005, suffer from their own structural and organizational struggles. Therefore, there is a context to be exposed and there is no way to discuss the formation of the resident without elucidating the aspects that directly interfere in this process²³.

For example, the reduction of voice power given to residents in Interministerial Ordinance number 7, of September 16, 2021, which establishes the National Commission for Multiprofessional Residency in Health and reduces the representation of union entities, coordinators, preceptors and even the residents themselves in the decisions to be

taken in relation to their activities; in contrast, it increases government representatives, making greater submission to ministries of education and culture, denying the main actors¹⁷⁻²⁴.

In addition, several studies that bring the experience of residency in reports point out impacting weaknesses, such as the high number of moral harassment suffered, especially in hospital environments, psychological illness, high cases of leave due to covid-19, problems with exhaustive workload and the absence of isonomy with medical residences²⁴.

The intensive training of a professional/student brings with it stressors that generate physical and psychological signs due to work overload and curriculum. The high rates of *burnout*, the feeling of fear and lack of confidence, triggered by emotional exhaustion, sleep deprivation, lack of experience and skills, among others, show the need for strategies by programs and universities that result in better training quality²⁵.

In addition, it can be highlighted that the more anxious the resident is, the lower the resilience, which is extremely necessary in serious situations for public health such as during pandemic, because it is through it that one has the ability to readapt, confront and develop emotional, cognitive and socio-cultural skills²⁵. Such skills are necessary for the resident to be an agent in defense for the strengthening of SUS.

FINAL CONSIDERATIONS

Residency in family and community health is one of the social and formative instruments that contributes to the strengthening and defense of the SUS, because both its pedagogical aspects and the performance in the practice scenarios favor the development of potentialities that reaffirm the principles and humanitarian and sanitary guidelines.

The study reaffirms the role of nursing in the Brazilian health system, as well as the growth and mutual strengthening between SUS and the profession, presenting weaknesses/potentialities that are observed from the experience of nurses.

It was observed as a limitation in the construction of this study the scarce interest of a portion of professionals in discussing the subject and the little availability of time of the interviewees, which generated the need for a longer period to collect the data, plus the impossibility of face-to-face dialogues due to covid-19, which interferes with the interviewee's interaction and the interviewer's perception.

Thus, the main benefit of the study is the dissemination of the urgent need that social subjects must have in their performance so that the forces are correlated in favor of maintaining the SUS as a democratic right, resisting the measures that gradually corrode the legislation, discrediting it socially, weaken social control and are drivers of health plans and medical-centered hegemony.

It is necessary that residents can obtain an active voice and approach topics that are not discussed or perceived, but that directly interfere with their quality of life. For those who believe in the right to life, may they resist. The reformist movement that started in the 1980s persists until today. The SUS needs to be strengthened and defended by agents capable of generating transformations, in the search for a more humanitarian society, and that, as a single system, solidifies itself so that it lives independently of the political administrations that arise in Brazil.

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