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Articles

User Embracement in the Family Health Strategy: analysis of implementation in a large municipality of Northeast Brazil

Acolhimento na Estratégia Saúde da Família: análise de sua implantação em município de grande porte do nordeste brasileiro (resumo: p. 13)

Acogida en la Estrategia Salud de la Familia: análisis de la implantación en un municipio de gran porte del Nordeste brasileño (resumen: p. 13)

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User embracement requires an ethical and political posture in the reorganization of the work process in Primary Health Care (PHC). The objective was to analyze the implementation of user embracement in a Family Health Unit (FHU) in a large municipality of northeast Brazil. Case study with a qualitative method using semi-structured interviews with ten professionals. Qualitative data submitted to content analysis, under the paradigm of social production of health. The positive perception of professionals emerged from categories related to: facilitating access to the FHU, resolutivity, optimized work process and humanization. The implementation provided significant and sustainable changes, with an impact on the management and care of the PHC.

Keywords: User embracement. Family Health Strategy. Health evaluation.

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Introduction

Since the consolidation of the Brazilian National Health System (SUS) in 1988, a new care paradigm organized by Primary Health Care (PHC) became part of governmental policies and actions, offering longitudinal care actions in the search for improving the health situation and expanding users' access to services[1,2].

As the main form of organization of PHC in Brazil, the Family Health Strategy (FHS) presents significant changes in the conformation of this level of care, by placing the integrality of care and family care at the center of its actions in the pursuit of institutional, political and social goals and objectives. FHS professionals are committed to the involvement of users by establishing a bond with them, also aiming to promote health humanization[3-7].

To implement the principle of comprehensive health care in a country with profound socioeconomic inequalities such as Brazil, challenges such as the expansion of quality access to health services and goods, the development of the co-responsibility process among workers, managers, and users, and the lack of preparation of professionals to deal with the subjective dimension in health care practices, present themselves to management and professionals, especially in PHC[5,6,8].

One of the strategies to improve the quality of health services provided to the population was the implementation of a crosscutting National Humanization Policy (NHP) in the SUS[9-11]. The NHP believes that some ways of organizing the health work processes facilitate the confrontation of problems and enhance their resolution, in a unique way in each context. To this end, it points out guidelines that orient and guide the policy, among them the user embracement[2,10,12].

Users' embracement is proposed in the NHP as a way to operate ethically and politically in the health work processes at all moments, in order to provide qualified listening and a citizen and humanized attitude to all users who seek health services. It is related both to the professional attitude capable of user embracement, facilitating listening, and seeking the resolution of their problems, and to the reorganization of the work process of workers and managers[13-15].

With the proposal of user embracement in PHC, the entrance door of the Family Health Unit (FHU) is optimized, facilitating access and guiding the user flows within the services. One of the characteristics of the work process in the FHU is to perform the embracement with qualified listening, risk classification, evaluation of health needs and vulnerability analysis, taking into account the responsibility of solving spontaneous demand and first response to emergencies[8,11,15,16].

Experiences of implementation of the user embracement in the FHS report this device as a facilitator of access, in the sense of ensuring care to all individuals seeking health services. Moreover, it improves the worker-user relationship through humanitarian, solidarity, and citizenship parameters, and enables the strengthening of bonds and co-responsibility in health production[17-19].

However, the conceptions about user embracement encompass different meanings that converge towards an understanding of it from the perspective of comprehensive care and the expanded concept of health. Thus, the user embracement should be a crosscutting feature to the development of promotion, prevention, rehabilitation, and cure actions, re-signifying it as a health surveillance instrument in the SUS under the paradigm of social production of health, in which this work is anchored[20].

As a counterpoint, a high proportion in the implementation of the user embracement may not effectively mean the reorientation of care practices centered on the user, but only an organization of triage and referral of cases, depending on the obstacles that qualified listening and resoluteness of the users' needs may encounter[21].

Thus, studies that bring to light a theoretical and epistemological reflection on the embracement based on experiences in the daily life of services, highlighting the perception of workers, users, and management, may favor a better understanding of this strategy for the production of integral care[20], safeguarding the universality and equity of access to health services in the SUS. For these reasons, this study aimed to analyze, from the perspective of professionals, the implementation of the host in the care management of a FHU in a large city in the Northeast of Brazil.

Methods

The implementation and respective analysis of the user embracement in the FHU in question are the result of an intervention project from an end-of-course work of the Professional Master's Degree in Family Health of the Northeast Training Network in Family Health - RENASF, executed and defended in 2019. The present work presents a cut of the intervention proposal for the implementation of the user embracement process at the mentioned service[22].

This is a case study, with the purpose of analyzing the implementation of the embracement from the perspective of professionals, through a qualitative approach.

The analysis of the implementation of the user embracement was carried out in a FHU belonging to the municipality of Jaboatão dos Guararapes, located in the metropolitan area of Recife-PE, with a total area of 258,694 km^2 and an estimated population of 697,636 people[23]. The municipal territory is divided into seven political-administrative regions, each containing a Regional Health Coordination[24]. The municipality has primary care coverage of 55.61%, considering the FHS has 50% coverage[25].

The FHU was established in June 2015, and is formed by a Family Health Team (FHT) composed of a doctor, a nurse, a dental surgeon, a nursing technician, an oral health assistant (OHA), five community health agents (CHA), an administrative assistant, and a general services assistant. It has in its coverage area five micro areas with approximately 3426 registered people and another uncovered area, totaling more than four thousand assisted people.

The research subjects were the FHU professionals, namely: doctor, nurse, nursing technician, oral health assistant, administrative assistant (receptionist), five CHAs, and a general services assistant. It was assumed that one of the pillars that sustains and gives viability to the proposal of the embracement is the improvement of the relationship among all these subjects involved.

After six months of the implementation of the user embracement, a qualitative evaluation was carried out with the professionals. Data collection was carried out by a trained team, two people with experience in qualitative research, who conducted interviews using a semi-structured script. After the day's user embracement, the professionals who participated in the process of implementing the FHU user embracement process were invited to participate in the interview, which took place in a reserved room in the FHU itself, free of external noise, with an average duration of fifteen minutes and with the help of two digital audio recording devices. Considering a universe of twelve FHU workers who participated in the implementation of the user embracement process, two interviews were carried out as a pilot to evaluate the viability of the research interview script.

Ten professionals were interviewed, being four CHAs, one general services assistant, one administrative assistant (receptionist), one nurse, one physician, one nursing technician and one OHA. The inclusion criteria for the recruitment of subjects were: professionals who worked in the FHU and who had participated in the process of implementing the user embracement. Professionals who were on vacation during the data collection period were excluded.

After data collection, the interviews were transcribed, assigning a code "P1" to the first professional interviewed, "P2" to the second, and so on, following the sequence of interviews. Interview data were qualitatively analyzed by content analysis with a thematic approach, with the perspective of user embracement under the paradigm of social production of health as a backdrop[20,26]. The aim was to identify the different meanings assigned to the user embracement by the professionals and their implication with the aforementioned process.

The project was submitted to the Ethics in Research Committee, and was approved by opinion # 2.946.949, following all the legal determinations for research with human beings.

Results and discussion

Most of the professionals interviewed were female (80%), between 36 and 45 years of age (40%), brown (60%), with six to ten years of professional experience (60%), and working in the FHS for six to ten years (50%).

From the interviews, it was perceived that the user embracement facilitated the users' access to the FHU, changed the team's work process, improved resolutivity, and strengthened the relationships between them and the users, as well as the relationships among themselves. The results were aggregated by the nuclei of meaning grouped into four thematic categories: access, work process, resolutivity, and humanization.

The definition of access, in its functional sense, refers to the use of services according to needs, i.e., the users have a guaranteed care whenever they understand they need it[27,28]. User embracement and access are articulated and complement each other when implementing practices in health services, from the perspective of comprehensive care[28,29]. Professionals reported that the user embracement facilitated the users' access to the health service.

> [...]. It changed mainly in terms of the waiting lines; it was better to get care here at the Unit [...]. (P1)

> [...]. How many people didn't come here because they couldn't afford to stand in line to schedule an appointment and now, they come [...] now we do it according to the risk, some people need it more than others. (P2)

> [...]. It prevented residents from arriving at dawn, brought benefits really for them that now have the week off, from Monday to Friday, to come and solve things without needing to expose themselves as they were coming early and now no longer need [...]. (P3)

According to the professionals, the user embracement has brought benefits in user access to the FHU by changing the organization of work, opening the agenda, providing qualified listening and facilitating the resolution of demands during all days of the week. It began to guide the work process by means of access criteria, in addition to a waiting line by risk or severity situation. It allowed users to express their feelings, providing a broader approach to the individual by the team and the realization of an interprofessional intervention.

The guarantee of access shows not only what is desirable by the population, but the guarantee of a quality PHC. Thus, access faces the challenge of complexity in its technical and organizational dimensions for its strengthening in PHC, requiring strategies for its reorganization and expansion of response capacity to the population's needs[30]. The user embracement may point out one of these possible measures, understanding access as a citizenship right and built by qualified, cooperative, and inclusive action of the teams with community participation[31].

The user embracement process is not limited to the act of receiving, but constitutes a sequence of a sequence of acts and modes that make up the work process in health, understood as a working tool that incorporates human relations[32].

Regarding the relationship between professionals and users, the participation of all involved should be valued, and there should be a union in order to offer the best that the service has to offer. In the FHU, due to the link with the community, the bonds become closer and favor familiarity and participation, as perceived by the professionals.

> [...] I think I started to understand the patient more because we have from the initial listening to the care itself and this ends up creating more bonds. (P9)

User embracement, when explored under the focus of a technology of the professional/user encounter, allows triggering a process of change in health practices, directing them based on soft technologies. The idea of embracement, in the sense of practical wisdom, when adopted by FHS enables the permeability between hard, soft and soft technologies, essential to the success of the care itself, overcoming work fragmentation and valuing teamwork[32,33].

The good relationship between professionals and users was also understood by the FHS from the perspective of modifications in the work process implied by the user embracement. This, as an organizing device, has the potential to trigger a change in which the center of care is no longer located in the medical consultation, but in the multidisciplinary team, and enables the expansion of the use of knowledge and technologies available to improve the quality of care focused on the user's needs[29,34].

> [...]. I consider that it did change the work process of both the team and myself. In relation to the team, I think it made this issue of the relationship between the patient and the team more flexible, so it brought the patient closer [...]. (P10)

> [...]. And it was much better for me, now we can work properly and listen to what the patient wants calmly, without being that tumult [...]. (P1)

> [...]. In my view, I think everyone can interact, the dentist, the technician, the doctor too, the health agents, I think everyone can do their best to help the patients, and we here to always improve their side [...] changed in the good part because we help, we listen [...]. (P4)

The consistency in the users' positive perception regarding the user embracement over the implementation time can be associated with the professionals' perception that the user embracement was related to service resolutivity.

> [...]. It sees the whole of the resident and brings him closer to his needs in his daily life to achieve what he wants, the goal of care, what he needs at the time he is looking for the Health Unit here. (P3)

> [...]. Many things the patient arrives and we manage to solve for him without having to return without any answer [...] there is always someone who can attend the patient and give him an answer, about something, so that he doesn't return without knowing anything. (P6)

Resolutivity is considered to be the satisfactory response that the health service offers to the user when he seeks care for some health need. This return does not exclusively involve curing diseases, but also alleviating or minimizing suffering and promoting and maintaining health[35]. Resolutivity can be achieved through a user embracement service, with accountability from the team's professionals, with creative and comprehensive conduct, based on the technologies available at each level of care[36].

Resolutivity is associated with the technical knowledge of professionals, as well as the user embracement action, the bond that is established with the user, the meaning that is given in the professional/user relationship, which suggests the meeting of subjects with the sense of acting on the health field and providing satisfaction. Several studies indicate that user satisfaction with PHC correlates with the resolution of their health problems[35,37,38].

Professionals have been appropriating the new work process, started to conduct the user embracement better and, consequently, this has been reflected in their conduct. From the understanding of the embracement as a posture, the perception of a higher qualification in the work and in the production of care is established, strengthening the link with the community and, consequently, a higher user satisfaction[39]. Thus, the user embracement process is not limited to a physical space, a certain time of day, or a specific professional; it extrapolates to an attitude change within the health service, through the sharing of knowledge and responsibilities[15].

Transversally, the results of the analysis of the implementation of the embracement were intertwined with health humanization, related to the reestablishment of human dignity, often compromised in the interactions within the scope of care. A reductionist care practice based exclusively on the techno-scientific logic and the automatism resulting from a certain way of organizing the work process would be factors that contribute to the disqualification of the relationships between people[40]. Thus, the professionals at the FHU perceived the user embracement as related to humanization[41].

> I think that it is a way to work in a more humanized way, more loving [...] to perform a qualified listening with the intention of really helping, solving. (P9)

> I think that the greeting is a process of humanization of care, that you aim to prioritize the needs of patients and try to solve what you can give priority [...]. (P10)

Studies indicate that the user embracement, as a humanization device, has the potential to reduce repressed demand, by offering greater access to services, making the whole team responsible for the care and satisfaction of the user, and generating a process of change in professional practices in health services[36,42].

One consideration regarding the perception of professionals is that unfavorable interprofessional relationships hinder the user embracement process, but the act of humanization should go beyond routine activities and be seen as something intrinsic to the practice of each professional[36].

> [...] I believe that seeing a process as a whole, there should be some adjustments, especially in the team's idea, that sometimes we get a little lost in relation to what should be done and how it should be done, because as I said, it is a difficult process [...]. (P10)

The user embracement process does not reach the goal of humanization if it is implemented as an isolated measure and without the necessary adjustments[36]. Thus, it is always necessary to qualify the way it is developed, because if it is worked in a disjointed way, it can be reduced to a triage activity and be deprived of its humanization function.

The limitations of the study were due to its qualitative nature and its impossibility of generalizations. However, it should be remarked the importance of the team's collective construction around the user embracement and of this evaluative process encompassing health professionals.

Final considerations

The positive analysis of the implementation of the user embracement of users by the professionals was related to the guarantee of access through the reorganization of the work process, which brought the team and users closer together.

There are factors observed by the professionals during the six months after the implementation of the user embracement, such as changes in the teamwork process, with the displacement of the medical centrality and the perception of greater resolutivity of actions.

The humanization of actions was transversal to the professionals' perception in all aspects related to the implementation of the embracement, and it is recommended as an important tool for the organization of the work process and care management in PHC, with consequent reduction of waiting lines and qualification of comprehensive care.

Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

Conflict of interest

The authors have no conflict of interest to declare.

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O acolhimento requer postura ética e política na reorganização do processo de trabalho na Atenção Primária à Saúde (APS). O estudo objetivou analisar a implantação do acolhimento em uma Unidade de Saúde da Família (USF) de um município de grande porte do nordeste brasileiro. Trata-se de um estudo de caso com método qualitativo realizado por meio de entrevista semiestruturada com dez profissionais. Os dados qualitativos foram submetidos à análise de conteúdo, sob o paradigma da produção social da saúde. Da percepção positiva dos profissionais emergiu categorias relacionadas a: facilitação do acesso à USF, resolutividade, processo de trabalho otimizado e humanização. A implantação do projeto proporcionou mudanças significativas e sustentáveis, com impacto na gestão e cuidado na APS.

Palavras-chave: Acolhimento. Estratégia Saúde da Família. Avaliação em Saúde.

La acogida requiere una postura ética y política en la reorganización del proceso de trabajo en la Atención Primaria de la Salud (APS). El objetivo fue analizar la implantación de la acogida en una Unidad de Salud de la Familia (USF) de un municipio de gran porte del Nordeste brasileño. Estudio de caso con método cualitativo por medio de entrevista semiestructurada con diez profesionales. Los datos cualitativos se sometieron al análisis de contenido, bajo el paradigma de la producción social de la salud. De la percepción positiva de los profesionales surgieron categorías relacionadas a la facilitación del acceso a la USF, resolución, proceso de trabajo optimizado y humanización. La implantación proporcionó cambios significativos y sostenibles, con impacto en la gestión y cuidado en la APS.

Palabras clave: Acogida. Estrategia Salud de la Familia. Evaluación en Salud.