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Original Article

Nurses and the Collective Care Practices Within the Family Health Strategy[1]

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This qualitative study identifies and analyzes the practices of nurses regarding collective care interventions in the context of the Family Health Strategy (FHS) and its knowledge development. Semi-structured interviews were held with nurses working in the FHS and thematic analysis was used to analyze data. The theoretical framework was based on the theories of institutional analysis and work processes. The results are arranged into two main themes: Conceptions that support collective care practices and Practices of nurses in collective care. The conclusion is that nurses actively participate both in proposing, coordinating, performing and monitoring these collective actions, though they are still predominantly guided by the traditional approach to health in general and specifically to health education.

Descriptors: Community Health Nursing; Family Health; Primary Health Care; Health Knowledge, Attitudes, Practice.

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O enfermeiro e as práticas de cuidados coletivos na estratégia saúde da família

Essa pesquisa qualitativa teve como objetivo identificar e analisar as práticas de cuidados coletivos do enfermeiro na estratégia saúde da família e seus conhecimentos estruturantes. Foram realizadas entrevistas semiestruturadas com enfermeiros da estratégia saúde da família e análise temática para tratamento dos dados. O referencial teórico metodológico baseou-se na análise institucional e no processo de trabalho. Os resultados estão dispostos em dois grandes temas: concepções que sustentam as práticas coletivas e práticas dos enfermeiros nos cuidados coletivos. Conclui-se que há participação ativa do trabalhador enfermeiro tanto na proposição como na coordenação, execução e acompanhamento dessas ações, mas ainda norteado, predominantemente, por saberes tradicionais da saúde e da educação.

Descritores: Enfermagem em Saúde Comunitária; Saúde da Família; Atenção Primária à Saúde; Conhecimentos, Atitudes e Prática em Saúde.

El enfermero y las prácticas de cuidados colectivos en la estrategia: salud de la familia

Esta investigación cualitativa tuvo como objetivo identificar y analizar las prácticas de cuidados colectivos del enfermero en la estrategia salud de la familia y sus conocimientos estructurales. Fueron realizadas entrevistas semiestructuradas con enfermeros de la estrategia Salud de la Familia y análisis temático para tratamiento de los datos. El referencial teórico metodológico se basó en el análisis institucional y en el proceso de trabajo. Los resultados se presentan en dos grandes temas: Concepciones que sustentan las prácticas colectivas y Prácticas de los enfermeros en los cuidados colectivos. Se concluye que hay participación activa del trabajador enfermero tanto en la proposición como en la coordinación, ejecución y acompañamiento de esas acciones, sin embargo más orientado, predominantemente, por conocimientos tradicionales de la salud y de la educación.

Descriptores: Enfermería en Salud Comunitaria; Salud de la Familia; Atención Primaria de Salud; Conocimientos, Actitudes y Práctica en Salud.

Introduction

This study addresses the production of collective care actions within the Family Health Strategy (FHS) emphasizing the work of nurses. Care actions, according to the hegemonic way of handling health, often require strategies to change behavior because these are still focused on curative actions centered at an individualist level and often disconnected from the populations' real health needs[1].

Actions in the history of health care have been opposed to those of collective care, having the clinical care traditionally based on *a priori* knowledge that classifies, diagnoses and provides care based on the logic of dysfunction. Collective care actions have been guided by a view that scans social spaces and risk behaviors, classifies common diseases, stratifies populations and proposes measures that are supposed to impact health indicators and consequently change living conditions[2].

Nonetheless, collective care actions cannot be regarded as being detached from clinical care. They can be powerful enough to investigate everyday health work and also allow re-launching promotion and prevention actions within the care context.

This study's theoretical framework is based on institutional analysis[3] and health work process in its micro-politics. From this theoretical perspective, the collective is considered as a multiple composition of

various connections, powers and breakages[4]. They are flows of life and desire that intersect with 'dams' that interrupt them; they are changing interconnections that can be singularized in matches and mismatches of affections, ways of living, and values[4].

Thus, a collective is not the sum of individuals with something in common. It is neither outside nor inside the Health Unit and interpretations of workers and users of the System. The collective is the "between": meaning that it is beyond dichotomies. It is among workers, work, users. It is in their ways of living together. It crosses and cuts across the so-called clinical practices and the so-called collective practices.

According to the adopted theoretical framework, collective care actions are understood as those that produce new assemblages of life and demand the emergence of other forms of subjectivity[3]. They contribute to quality of life, taking life *not* as adequacy given the standards of good living - with standardization of patterns of eating, dressing, loving, exercising - but as a permanent invention of oneself and of others.

For the purpose of this study, we will consider collective care actions to be those traditionally accepted in the field, such as the joint construction of the diagnosis in a specific area of intervention (territorial demarcation process), activities of health promotion, participation and social control, health education and inter-sector actions. Thus, we are departing from what is traditionally known to examine it from within and to be able to problematize it. We intend to bring out the strangeness of what is known, that is, scraping surfaces of records and control[5]: those that are presented as "being so", taken for granted, established and fixed[3,5].

The Ministry of health, aiming to implement changes in health practices, has launched, among other initiatives, the National Policy of Primary Care, indicating the Family Health Strategy (FHS) as one alternative[1].

In the FHS, the team has the challenge of developing collective and individual actions. One of the team members is the nurse, who performs his/her practice according to a certain work process organization.

Studies[6-9] addressing collective care activities within primary care corroborate some of the results found in this study, though this study presents a seldom investigated aspect that refers to the contribution of nurses to collective care based on the theoretical framework of institutional analysis and work process; hence this combination is seen as a possibility to contribute to the advancement of knowledge in this field.

Scholars[10-12] state that there are particularities in the work organization of family health teams that help questioning the ways of being and doing nursing, enabling one to question what is already established and give way to other types of logic, less dichotomous and more dialectical.

What are the current nurses' practices in the collective care actions of the FHS team? What are the theoretical foundations that support such practices? Are they in the direction intended to change the health care model?

This study's *objective* emerges from these questions, which is to identify and analyze the practices and conceptions that support the collective care actions of nurses in the health work process within the FHS.

Method

This is a qualitative[13] study in which the object (collective care actions) is in the sphere of entangled social, affective, economic, and subjective relationships.

The study was carried out in the West District of Ribeirão Preto, SP, Brazil, which composes the health district and approved by the local manager, universities and city health council.

The participants of this study were 11 nurses from FHS teams working in that specific district. Semi-structured interviews were conducted, recorded and then transcribed. The themes discussed were based on the description of the nurses' activities held the week before the interview. The participants were asked to list, among the actions they reported, those they considered to be collective care, describing in detail the nurses' work.

Core meanings emerged from the thematic analysis[13], which in turn produced the themes. All the transcribed reports were skimmed to note the grouping of similarities, recurrences and meanings, seeking different aspects that could give cues to other interpretations of collective care.

The research project was submitted to and approved by the Research Ethics Committee (protocol nº 251/2007). All the participants signed free and informed forms according to Resolution 196/96 of the National Council of Health.

Results

Two main themes were constructed through the thematic analysis. The first, *Conceptions that support*

collective care actions refers to the subject of care production and is composed of subthemes: Collective care as Practices performed outside the Unit; Collective care actions as implementation of groups; Collective Care as individual consultations capable of reaching various people; and Collective care actions: changes in history, life and production of autonomy.

The second theme – *Practices of nurses in collective care actions* – refers to the field of management devoted to the production of care, including the team and users. It is composed of the two subthemes: Organizing, making care viable, performing, monitoring and evaluating; and Weaving, spinning, sewing and becoming unnecessary as a health professional.

Conceptions that support collective care actions

Collective care as Practices performed outside the Unit: extramural

This theme includes the conceptions of nurses concerning collective care actions that include practices performed outside the Health Unit such as home visits, activities in schools within the unit's scope area, and reference of users to the health care network.

The excerpt shows that the work described is still predominantly mediated by the knowledge of hegemonic clinical practice, traditional health education and prevention of diseases with specific information and measures. *Ah, so I still have in my mind that collective action is that action that you go implement for external users, you know. So, it is the community that you go and visit, you have a group work, a lecture* (Nurse 5). *I guess that home visit is 'collective', right? Applying a dressing at home, it is… you provide individual care to that patient, so you are developing an activity at home and when you have a caregiver to provide some guidance related to care, you know (…)* (Nurse 2). The health need identified by the worker can be provided having a visit to the patients' home, taking care of an injury, in this case a dressing, due to the patient's inability to go to the unit, which involves family members in the performance of this practice. Another identified health need can be lack of information, hence the proposed action is a lecture.

Schools are identified as spaces to provide collective care, while actions are directed to traditional educational practices such as lectures to adolescents concerning undesirable pregnancies and preventive measures such as oral hygiene guidance. *Activities in schools are also collective care. We are not developing it right now, but we've already done it with a dentist from the unit, an educational activity concerning oral hygiene with children; we've already done activities in the community with children (...)* (Nurse 2).

The motto of educational actions is still the supply of information, which sees encouraging healthy ways of living in informed and sensitized individuals as feasible[6]. The economic, cultural, structural, relational complexity involved in all the situations is underestimated: *Collective care actions would be actions within a team as in the case here a health care team that takes place within a bounded physical area where the health team knows the population, the social devices, the economic difficulties, the difficulties concerning the transportation of students, and through this demand, it manages to change the history of this demand, I don't know, there're a lot of pubs on the corners, you know? The level of alcohol consumption is very high, the level of drugs is very high, because there are lots of people here selling drugs, so collective actions are those performed by the institutions jointly with human elements, able to identify and try to change that history* (Nurse 6).

Another form of the reproduction of the long-established collective care can be the way one interprets such demand, apart from the supply of actions, when in reality, they each produce the other[2]. What health services supply as care actions modulates demand and vice-versa.

Collective care actions as implementation of groups

The predominant point of reference adopted in the implementation of groups is still that in which people attend meetings to acquire knowledge and change their way of living in what, according to the team's conception, is not healthy or may cause harm.

Interviewer – *Which among all these actions that you develop during the entire week do you consider collective care actions?* (Nurse 10): *On Monday I have a group meeting, a group of diabetics and another of hypertensive individuals, it's … I work with a group of pregnant women also, I coordinate a semester course for pregnant women. In the first semester of the year I conduct the course and in the second semester I conduct another course where the pregnant women participate in four meetings for each course, and I also coordinate a course once per semester and a lecture on prevention related to getting tested for AIDS here in the school, I have a primary and secondary school in my area you know, so I work with AIDS prevention and prevention of pregnancy during adolescence in this specific school.*

The purpose and evaluation of the group disregards aspects such as otherness and the establishment of bonds to produce other forms of subjectivity[14]. It is centered on the logic of reducing symptoms by standardized

measures. *The diabetic patients, how do I know they achieved their goal? It is when I see that their glucose is under control, they are managing to lose the necessary weight in the case of obese individuals..., that they are adhering to the treatment, the results of exams, for instance, are within the parameters expected for them* (Nurse 10).

It seems that the perception of the group as a *dispositif*[14] able to consider and bring up the complexity of humans in their relationships and interactions and the interconnectivity of the subjects discussed, the people involved and the context in which they are involved, is still distant. This view - group as a *dispositif* – could enable caregivers to move participants from their histories and distressing experiences as something individually and isolated produced inside each individual and move towards a more relational understanding. The understanding of group work here is also as a space of the reproduction of hierarchies: within groups the professionals know and teach while users should listen and change.

Collective care as individual consultations capable of reaching various people

In this theme we consider the conceptions of collective care as a result of individual actions that are passed to other people or care provided that interferes in the family. *(...) I guess that all these actions are collective actions somehow, because I have a baby here and I'm dealing with the collective, right? I mean, being in his house if you think about it, but if I care for an elderly person, I also see myself doing for everyone (...) I guess that one by one, I'm making this change in the collective, you see?* (Nurse 1). *So, sometimes I have a hard time to think in the history of collective care action only in groups, you know. It is, because I guess that there are some things we do, and I guess that even, some guidance we provide ends up being collective care, you see? Because they are spread over, as a way of speaking, so let me see, guidance of this type (...)* (Nurse 9). *So, I said: "What it the matter people?" for me any action, you know... any, all actions that involve more than two people are collective actions for me, you see, because I guess that is it (...)* (Nurse 8). *Interviewer: why do you think we provide collective care, or what is its purpose?* (Nurse 5): *I guess that it'd be to improve people's quality of life, improve health as a whole, because the more people do good things, the better it gets you know, talking common sense, the idea is to really disseminate that.*

There is a notion that information is spread over and disseminated, so that it reaches the collective. The conception of collective is closer to the traditional assumption that guides public health, which is, a sum of people who should be reached to change their level of health.

The following excerpt indicates that people's interaction is a health need, therefore expanding the notion of territory to a *locus* of relationships, going beyond the opposition of individual and collective, constituting possibilities of change and making way for a new arrangement of care, though it includes the idea of equality among people. *I guess that these are actions that tend to care for a group of people, like, these aren't actions that focus on the individual, but we focus on the well being of all people living in this region, we try to improve the environment where they live, improve the interaction of one another, I guess that collective care is that, improving in the prevention of diseases, help people to care better of themselves (...)* (Nurse 4).

Collective care actions: changes in the history, life and the production of autonomy

This theme highlights the perspective of the construction of a collective care action that occurs "among" team workers, the social sphere and families. The participants discuss, taking into account the incompleteness of the work in health care and also the incompleteness of knowledge and practices within this sector to cope with people's living conditions. *I guess that collective care actions are those you plan, evaluate, discuss with the team, you know, and then you implement, to seek acceptance from the population, adherence from the population, so they have, facilitate life, because it's easier to talk about quality of life, but what is quality of life? You see? So they get fewer diseases, they have more opportunities to have a more dignified life, a good job, good housing, basic hygiene guidance, and they are able to plan their lives, not only children, but also expenditures, understand the fact that diseases are not only what they seem. It is to have access to information and the general care the unit can offer and should offer* (Nurse 7).

Even though this view is still incipient in the reports of nurses, it can enhance other ways of doing and knowing collective care, because it calls for a complexity of health needs and for a work process for which exchange of knowledge and co-responsabilization among the team, family, and other sectors is needed. The purpose of action shifts from the result to the process of the collective production: the June party*, for instance, moves diverse agreements and

* T.N.: Traditional Brazilian Folk Celebration

disagreements in its production, putting into motion possibilities to share, exchange and live together. *I guess that we take a lot of actions and then there're actions that are more… preventive you know, the vaccine, for instance, it is a preventive action you see… related to a specific disease… the flu among elderly people, German measles you know… The actions to create autonomy, like when we work with dengue issue, we don't go there just to collect the garbage of people for instance, we rather have to work with people and …sensitize, care, lead the person to participate in the process… So health care in the community, you know, I guess it is in this sense, actions we do to promote the encounter of people, you know… we never have activities for the sake of the activity itself…, so the June party is aimed to… what happens before the party is much bigger because it is the getting together moments to think about the details of the party. It is the group who prepares the ornaments for the party, so they get together over one or two months to make the arrangements and that is an opportunity to exchange, to talk, go out and meet other people, you know* (Nurse 11).

Practices of nurses in collective care actions

Organizing, making care viable, performing care, monitoring and evaluating:

We found practices that are told to be specific of nurses when discussing health needs that guide the proposed actions, in planning, mobilizing the team, performing the care, monitoring and evaluating. *I guess that it is the nurse work, the team helps also, but this thing of thinking in small details, of what can happen, we have the habit of thinking (laugh) about what will happen you know* (Nurse 11).

Nurse practice is linked to the social and historical development of this work since modern nursing was constituted through the technical social division of work, that separates and values manual and intellectual work differently[10].

Planning, supervision and control actions are attributed to nurses, as if they were managers of factories in the beginning of the past century. On the other hand, this worker and the remaining components of the nursing team establish themselves in the actions considered as practical, not clinical actions, assuming the latter is the property of hegemonic professions such as medicine. Among these non-clinical practices is the organization of work, actions traditionally recognized as collective care: vaccination, educational groups, blockades of disease based on epidemiological surveillance, etc.

Interviewer: *But there's that issue you mentioned earlier, the nurse as a leader or someone who…*(Nurse 5): *Pushes it*. Interviewer: *Pushes it? The nurse is the one who pushes the team to do these actions?* (Nurse 5): *Exactly. I guess.*

Pushing is related to calling the other workers for action, and also denotes the responsibility of nurses for triggering collective care.

Weaving, spinning, sewing and becoming unnecessary

Even though it is included in the report of a few interviewees, the nurses' practices in the collective care actions emerge as producer of a network, a net of knowledge, as actions among workers and users. We highlighted this perspective as engendering changes in health practices in the intended direction.

Yeah… I guess so… people do help but… they help to organize, but they do that and then if there is no one to get what was done and gather it again, get data and comments, for instance, look at the result of what everybody did and then discuss with them… that's what I use to do(..) We with the personnel from PIC (Community Integration Program), at the beginning I'd take care of the party organization, and I realized that each year I have distanced myself from it and the party goes on. It is like, in the beginning I'd take care of it, so we did it, organized each tent, person, who would be responsible for what, who would take care of this and that, I'd get extremely worried with the details, (…) I am impressed by how much the group has developed, already organized and done, you know. And taking this example, I guess the group is also becoming autonomous you know, really. I've done very little of the organization, and it's very nice, you know. (Nurse 11).

Hence, the work of nurses is focused on the production of other stakeholders both within the team and also users capable of realizing the structural organization and also producing encounters with creativity and power in a work regarding which they acknowledge themselves as authors.

We assert that the weaving with another unties hierarchical structures and reunites the power of co-creation, causing a new and revolutionary way of producing collective care to emerge.

Discussion

The two themes of analysis bring contemporary meanings of nursing knowledge and practice in relation to collective actions in health. The first theme addressed conceptions that support such actions. Despite the contribution of problematizing pedagogies in the health field, which advocate to the production of knowledge based

on experience, there is still a predominance of educational practices based on the 'banking'* concept[6,8,15]. Such proposals are based on the conception that consciousness should be awakened in another so this individual does what is right. Those who sensitize others define what is right. In the case of health, what is right has been already determined: healthy habits, healthy cities and prevention of abnormalities and imbalances.

Often, health needs are also addressed in a generic way, naturalizing unequal conditions of life inside the same territory. There is a disregard to the fact that needs are intrinsically related to social classes[16], to culture and to the context in which people live and relate to each other. Such naturalized concept ends up promoting educational actions in which people are gathered in groups and have their needs homogenized based on age ranges and diseases (children, women, family planning, prenatal care, AIDS).

On the other hand, the perspective adopted here views the group as a *locus* of encounter with "another" in the sense of another person and with "others" who would be "another" in a state of coming-to-be, of knowing both in production and in becoming. The group as place of the production of uncertainties, requires the destabilization of values and standards to create new histories and perspectives that do not depart from the production of either workers' or users' production or their needs[14].

Still from this perspective, we highlight that the complexity of group encounters is such that one does not know where they will end before experience them. They consist of multiplications and resonances of many feelings and affections, of many powers and questions. Hence, the worker needs to detach him/herself and abandon his/her centrality based on systematized and unequivocal knowledge. S/he needs to facilitate, produce encounters among people to allow the passage of flows, affections and desires.

We also argue that to acknowledge actions of this nature, one needs to decompose traditional epidemiology and clinical practice, which put the family health team in a process of dealing with its non-knowledge[17]. The purpose of work in this approach questions the rates of normality as values of central reference, shifting to the production of involvement and other forms of subjectivity, while "good encounter", relief and joy[18] are the perspectives of care sought.

The second theme of analysis gave visibility to practices that are performed by nurses in collective care actions. Nurses' historical place within the health team is an organizing place that triggers actions considered to be collective in nature. This established functioning could compromise a nurse's role within the team and consolidate a place of dependence on the part of workers and cement a centralizing role and at the same time lead to a doleful outlook given the overload of work.

On the other hand, the second subtheme indicates there is a concomitant movement that breaks with this habitual way of functioning, promoting relationships where there is less subjugation and more creative power. Such collective actions are capable of generating autonomy and co-responsibility of all those involved in the health care project.

Final considerations

Even though the FHS intends to change the traditional long-established health care model, its workers still perform most of their actions aligned with the biomedical knowledge model, by the opposition of collective and individual actions and further by the idea that the team has knowledge that will lead individuals to modify their non-healthy behavior and habits.

The nurse is an important actor in triggering collective care actions within family health care because usually nurses are those who propose, organize, develop and evaluate such actions. However, nurses are still predominantly guided by traditional knowledge of clinical practice, epidemiology and education.

Although not predominant yet, other forms of caring and doing, which focus on the autonomy of users and other workers and connects these subjects, are starting to be delineated. In such doings/knowledge one has to relinquish control, the property of actions as the purpose of care, because unique subjectivities and groups of subjects and creators can emerge.

Breaking with the dominant and established way of intervening in the health care field requires *dispositifs* that problematize its logic and expose its functioning, denaturalizing and destabilizing its arrangements and meanings, enabling the co-construction of new practices in health, new modes of production of subjectivity. In this process of co-construction, both workers and users can produce new subjectivities, impregnating their daily routine with new expressions linked to flows of life.

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* T.N.: Banking education is a metaphor that refers to students being empty recipients in which educators must deposit knowledge.

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