

The Production of Care in Primary Health Care: An Analysis of Workers' Perceptions

A Produção do Cuidado na Atenção Primária à Saúde: Uma Análise das Percepções dos Trabalhadores

La Producción de Cuidados en la Atención Primaria de Salud: Un Análisis de las Percepciones de los Trabajadores

RESUMO

O estudo destaca que o cuidado em saúde é marcado pela dimensão afetiva, com trabalhadores valorizando a empatia, o vínculo e a subjetividade nas interações com pacientes. A Terapia Comunitária de Adalberto Barreto é citada como exemplo de prática que integra afeto e diálogo. **Objetivo:** investigar os processos de trabalho na atenção primária à saúde à luz das relações de trabalho e da produção de cuidado. Para tanto, propusemo-nos a verificar como o trabalhador se percebe na produção de cuidado e analisar os processos de trabalho em saúde, implicados nessa produção. **Método:** tratou-se de uma pesquisa-ação, com abordagem qualitativa, realizada com 17 profissionais de saúde de uma unidade de atenção primária em Fortaleza, Ceará. A coleta das informações aconteceu entre agosto e setembro de 2015, em três encontros conduzidos através do uso de círculos de cultura. **Resultados:** os discursos aferidos nos revelam que o trabalhador da saúde encontra seus processos de trabalho fundamentados em ações produtoras de dados para parametrização de atividades e tomada de decisões de saúde. No entanto, não se percebem com autonomia para planejar as ações de saúde necessárias às suas comunidades e aos seus territórios. **Conclusão:** os trabalhadores se mostraram disponíveis para novas produções e encontros mediados por círculos de cultura, entendidos como espaços de trocas e aprendizados por meio da criticidade. Consideramos, por fim, que o ato de cuidar se expôs marcado pelo afeto.

DESCRIPTORES: Atenção Primária à Saúde; Análise das percepções; Trabalhadores em saúde; Saúde Coletiva.

ABSTRACT

The study highlights that healthcare is marked by an affective dimension, with workers valuing empathy, connection, and subjectivity in their interactions with patients. Adalberto Barreto's Community Therapy is cited as an example of a practice that integrates affection and dialogue. **Objective:** to investigate work processes in primary health care considering work relationships and the production of care. To this end, we set out to verify how workers perceive themselves in the production of care and to analyze the health work processes involved in this production. **Method:** this was an action research study with a qualitative approach, conducted with 17 health professionals from a primary care unit in Fortaleza, Ceará. Data collection took place between August and September 2015, in three meetings conducted using culture circles. **Results:** the speeches assessed reveal that healthcare workers find their work processes based on actions that produce data for parameterizing activities and making healthcare decisions. However, they do not feel they have the autonomy to plan the healthcare actions necessary for their communities and territories. **Conclusion:** workers showed themselves to be open to new productions and encounters mediated by culture circles, understood as spaces for exchange and learning through critical thinking. Finally, we consider that the act of caring was marked by affection.

DESCRIPTORS: Primary Health Care; Analysis of perceptions; Health workers; Collective Health.

RESUMEN

El estudio destaca que la atención sanitaria se caracteriza por su dimensión afectiva, ya que los trabajadores valoran la empatía, el vínculo y la subjetividad en las interacciones con los pacientes. La Terapia Comunitaria de Adalberto Barreto se cita como ejemplo de práctica que integra afecto y diálogo. **Objetivo:** investigar los procesos de trabajo en la atención primaria de salud a la luz de las relaciones laborales y la producción de cuidados. Para ello, nos propusimos verificar cómo se percibe el traba-

jador en la producción de cuidados y analizar los procesos de trabajo en salud implicados en dicha producción. **Método:** se trató de una investigación-acción, con enfoque cualitativo, realizada con 17 profesionales de la salud de una unidad de atención primaria en Fortaleza, Ceará. La recopilación de información se llevó a cabo entre agosto y septiembre de 2015, en tres encuentros realizados mediante el uso de círculos de cultura. **Resultados:** los discursos evaluados nos revelan que los trabajadores de la salud basan sus procesos de trabajo en acciones que generan datos para parametrizar actividades y tomar decisiones en materia de salud. Sin embargo, no se perciben con autonomía para planificar las acciones de salud necesarias para sus comunidades y sus territorios. **Conclusión:** los trabajadores se mostraron dispuestos a nuevas producciones y encuentros mediados por círculos de cultura, entendidos como espacios de intercambio y aprendizaje a través de la crítica. Consideramos, por último, que el acto de cuidar se expuso marcado por el afecto.

DESCRIPTORES: Atención primaria de salud; Análisis de percepciones; Trabajadores de la salud; Salud colectiva.

RECEIVED: 09/13/2025 APPROVED: 10/01/2025

How to cite this article: Oliveira CMS, Nunes GP, Oliveira MN, Pordeus MP. The Production of Care in Primary Health Care: An Analysis of Workers' Perceptions. *Saúde Coletiva* (Edição Brasileira) [Internet]. 2025 [acesso ano mês dia];16(101):17502-17519. Disponível em: DOI: 10.36489/saudecoletiva.2025v16i101p17502-17519



Camila Marques da Silva Oliveira

Nurse graduated from the State University of Ceará (UECE). Specialist in Family and Community Health and Master in Public Health, both from UECE. Public servant and assistant nurse in the Family Health Strategy of the Municipal Government of Fortaleza. Technical member of the Research Group on Flows, Networks, and Care (GP-FRIDA) at the State University of Ceará. ORCID: <https://orcid.org/0000-0003-3254-8954>



Glaucilândia Pereira Nunes

Bachelor's degree in Nursing from the Federal University of Ceará (UFC, 2004). Specialist in Clinical Nursing (UECE, 2006) and in Family and Community Health (UECE, 2009). Master's degree in Public Health from the State University of Ceará (UECE, 2018). Currently a nurse in the Family Health Program (PSF) of the Municipal Government of Fortaleza. Experienced in Public Health, with an emphasis on Primary Health Care. ORCID: <https://orcid.org/0000-0002-0132-0044>



Mariana Nascimento de Oliveira

Bachelor's degree in Nursing from the University of Fortaleza (2016) and in Physical Education from the State University of Ceará (2010). ORCID: <https://orcid.org/0009-0002-6376-6911>



Marcel Pereira Pordeus

Ph.D. candidate and Master's degree holder in Public Policy from the State University of Ceará (UECE). Specialist in Brazilian History from the Federal University of Piauí (UFPI). Bachelor's degree in Portuguese Language and Literature from the Federal University of Ceará (UFC). Member of the Research Group on Democracy, Parties, and Public Policies (UECE). Member of GETEME/PPGL (Textual Genres: Theoretical and Methodological Perspectives) at the Federal University of Ceará. Associate Researcher at the Latin American Center for Cultural Studies (CLAEC), focusing on the study of Theories and Methods of Human and Social Sciences. ORCID: <https://orcid.org/0000-0003-4317-0619>

INTRODUCTION

The production of knowledge based on lived experience has been a constant topic of public health debate among universities and health systems and services. The proposal for techno-assistance and healthcare models that promote the

guarantee of health rights has generated important discussions and recent proposals¹⁰.

For the Ministry of Health (MH)⁵, The technological aspect is not limited to the choice of scientific and technical resources, but is shaped by the approximation of reality with social needs and contact with local diversi-

ty. Meanwhile, according to the Ministry of Health⁴, care modalities do not refer solely to outpatient/hospital care options, but "the set of concepts used to care for, treat, and listen to healthcare needs and rights, and the focus of work proposals."

We emphasize, in light of this information, that the choice of tech-

no-assistance models that best respond to health demands must adhere to the SUS principles of ensuring universal access; comprehensive care; decentralization of management; regionalization of care; high resolution in each service or in its articulation in an intercomplementary network; intersectoral integration; [...] social control and continuing education³.

Among the proposals for reforming health services, some aspects remain a consensus, namely: the notion of territory; the broad concept of health; the pursuit of systematic knowledge of the population's health situations; the planning of interventions and the assessment of their impact on identified problems; the review of the concepts of hierarchical organization of health services; and the democratization of management. With this information in hand, I highlight what we experience in the daily life of primary health care in Fortaleza.

A nurse in the Family Health Strategy of Fortaleza, Ceará, and a public servant since 2006, I have long sought to understand the health work processes involved in the production of care. Under a previous municipal administration, the technical assistance activities developed were programmatic and aligned with the ESF (Family Health Strategy). The goal was to build, promote, and expand comprehensiveness through an emphasis on health promotion¹². The ESF was established with the goal of transforming the ways health care is handled and delivered, aiming to overcome the biomedical, curative, individual model, disconnected from the territorial/social context. Yes, the logic of the model, focused on the health center, was reversed to give visibility to the territory and its potential for health and care.

Silva, Pontes and Silveira¹⁸ reveal the limitations of the Family Health Strategy (ESF) in serving the territory's population beyond its planned

programs and meeting spontaneous demand. In their studies at the Fortaleza ESF, the authors noted a lack of services available to users seeking the health center, difficulties in establishing relationships between the various stakeholders, and a strong emphasis on a care model guided by Cartesian medical logic (centered medical decision-making, rationalization of health care, and medicalization of the body). Workers and users noted that the care provided at the Family Health Center proved to be a space for sharing affections, but also for medicalized actions and a dehumanizing factor in the workplace¹⁸.

In the current municipal management of health services, with the application of a new techno-assistance model, strongly based on patient care in spontaneous demand, we find, empirically, obstacles in health promotion and disease prevention activities, as well as deficiencies in the articulation of typical programmatic activities of the ESF as a form of primary health care.

In light of the observation of my praxis¹, in light of new work processes attempting to deliver care, I wonder if emergency care in primary care, also called reception, leads to discontinuity of care, limiting the impact on chronic diseases and favoring reduced adherence to health promotion strategies by users. Furthermore, I perceive serious difficulties in effective teamwork, with evidence of reduced health accountability, difficulties in team coordination across time and space, and a loss of the caring dimension in health care actions.

Healthcare workers find themselves forced to provide health care based on the biomedical model, where the patient seeks health and the professional offers treatment,

rather than care¹⁹. This model should have been overcome by now, given the many struggles for health in Brazil, especially the Health Reform.

That said, in this research, I believe it was essential to promote a discussion about healthcare workers' perceptions of their own healthcare work processes, specifically in Primary Health Care (PHC). This fact was relevant when we realized how essential it is for healthcare workers to feel a sense of belonging and involvement in their work, as well as to understand the concrete nature of their health-promoting actions. We also saw that this field of research offered us the opportunity to analyze how current healthcare services function, how care is delivered, and how to support the development of new arrangements for organizing care, making them fair, equitable, and comprehensive. Without aiming to generalize processes, we delved deeper into issues in a primary care unit to contribute to a project to raise awareness and enhance their work.

Primary Health Care (PHC) should be based on health care for individuals, families, and communities, with full participation and at costs that the local community and the country can bear. PHC, therefore, would correspond to the core of the country's health system and would evolve in tandem with its economic and social development¹⁶.

PHC arose from a translation of the English expression primary health care and conveys the idea of a patient's first contact with the health service, based on an initial need. Didactically, Giovanella¹³ states that there is no consensus on the concept of PHC, but highlights three axes of conceptual circulation: 1) a focused and selective program, with a re-

¹ We understand praxis as the meaning of concrete action acquired through reflection on the political, economic, social, and moral space-time.

stricted basket of services; 2) one of the levels of care that corresponds to non-specialized first-contact medical outpatient services, whether or not including a broad spectrum of public health actions and clinical services aimed at the entire population; 3) comprehensively, a conception of a care model and organization of the health system¹³.

In Brazil, the APS adapted relatively comfortably, mainly because it was in harmony with the principles of the struggle for Health Reform. Giovanella¹³ reveals that the use of scientifically proven and socially accepted technologies was promoted, with an emphasis on community participation and the democratization of knowledge, including traditional health practices, midwives, and community workers, reducing the paradigm of medical knowledge.

Long after the first waves of democratic-health movements in Brazil, in the 2000s, it was only after the establishment of appropriate aspirations for Brazilian PHC that it became possible to solidify the desired outcomes for Brazilian PHC, such as reducing infant mortality and connecting communities to health centers. These health work methods allowed the adaptation of PHC proposals to the Brazilian socioeconomic and cultural reality.

In his work, Starfield²² contributed to defining the scope of PHC as it is understood today. Starfield continues to develop a series of concepts that, as we have seen today, form the pillars of a health system widely applied throughout Brazil, the Family Health Strategy. The PHC emerged in the mid-1990s from a paradigmatic tension provoked by the discourse of the Health Reform Movement and the practice generated by the implementation of health care models that were alternatives to the privatized medical care model. In principle, it was easy, especially in remote areas

of Northeast Brazil, to implement a techno-care model that followed the guiding principles of the SUS and was not centered on the physician¹.

The ESF encompasses changes in the organizational dimension of the care model when it establishes the multidisciplinary family health team responsible for providing health care to the population of a given territory. It defines the generalist as the primary care medical professional; it establishes new professionals, Community Health Agents (CHAs), nurses and, subsequently, dentists, focused on community work, thus expanding the team's role in the determinants of the health-disease process^{1,3,18}.

This initial idea of a multidisciplinary team lasted for some time, due to the integration with the CHA, who, at the time, were already working in the field, and the supervision of nurses, through the Community Health Agents Program (PACS - Programa Agentes Comunitários de Saúde); until, following market demands, the central presence of the medical professional figure was strained¹.

Andrade¹ further emphasizes that, despite the significant improvements in health indicators among the population benefiting from the Program, the strategy's success or failure cannot be generalized. This is because: the ESF found in the most diverse Brazilian communities is the result of the process of local adaptation of the family primary care model proposed and initially funded by the federal government. In our view, this diversity of ESF experiences in Brazilian cities is primarily a result of the varying implementation times, professional training, managerial commitment, funding stability, and level of community empowerment¹.

In Fortaleza, Brazil's fifth-largest capital in urban density, according to 2014 IBGE data, the ESF (Family Health Strategy) has given way to

healthcare networks, with a primary focus on acute complaints. The traditional healthcare delivery system is understood to be centered on medical knowledge and a biologically based clinic, where work processes are centered on prescriptive acts, acting more as "producers of procedures" than "of care" *per se*¹⁴. As we have seen, inverting the care model presupposes significant changes in the way we conceive of a new way of acting in health. A multidisciplinary work process is required and, more than that, a change in current work technologies.

With these concepts in mind, the study aimed to investigate the work processes developed in Primary Health Care, in light of work relationships and care delivery, and to analyze the health work processes in PHC involved in care delivery.

METHOD

In Minayo¹⁵, we learned that research is motivated by the relationship between the investigating subject and the investigated subject, involved in the process of construction, deconstruction, and reconstruction of knowledge, in which they are historically connected. For this research, in which we set out to investigate the work processes and production of care in PHC, the use of qualitative research, with a focus on action research, seemed coherent.

This research was conducted in the municipality of Fortaleza, Ceará; more specifically, at a Primary Health Care Unit in the Bom Sucesso neighborhood, which is part of the geographic coverage area of Regional Secretariat 3. It is important to describe the location of this research. Fortaleza, the capital of Ceará and the most populous city in the state, has 2,591,188 inhabitants and a population density of 7,7866 people per square kilometer, according to data from the Brazilian Institute of Geog-

raphy and Statistics (IBGE - Instituto Brasileiro de Geografia e Estatística) for 2015. The city also has five federal health facilities, 18 state facilities, 92 municipal facilities, and an estimated 426 private health facilities, according to 2013 data, also from IBGE.

For the purposes of knowledge production, in this research, we center the subject as an actor in the process of apprehending reality, thus preserving their humanness, without relegating them to the status of object. Considering this methodological way of acting and having as a guide the objectives of our work, we held three culture circles with groups that varied from 9 to 15 participants in each meeting.

The research subjects, who comprised the PHC workforce at this health unit where the interviews were collected, were included according to the following criteria:

a) Inclusion criteria: mid- and high-level workers from the aforementioned PHC unit, with any form of employment, who were directly involved in healthcare delivery and care delivery, who had worked with the team for at least one year, and who were willing to participate freely in the research;

b) Exclusion criteria were workers who were on vacation or leave during the data collection period.

At each meeting, the group was composed primarily of women, with one meeting with only one male participant. Participants ranged in age from 25 to 62. Average income ranged from one to eight times the minimum wage.

In all circles, the majority of participants were public servants, except for the dental health assistant, who had participated in the first and third circles. This employee, as well as the current nursing assistants and technicians, had no employment relationship with the Fortaleza City Hall at the time of data collection for this

research, and their monthly salary was received under the acronym RPA, which refers to "Receipt of Individual Payment." This year, a municipal public selection process was held to fill mid-level positions for these professional categories.

To avoid personal identification of the subjects, their names were suppressed. Their statements were generically identified by the capital letter T, which was intended to refer to the word "worker." Since our goal was not to measure the feelings, statements, and expressions by educational level, we dispensed with identifying the participants as "high school" or "higher education." To code the worker who made this statement, we organized them by number, which does not refer to any particular classification.

Thus, when organizing the statements, the participant who attended the first meeting was identified by the letter T and then, for example, the number 1. If this same participant attended the third meeting again, they remained identified as T1.

The statements produced in the first culture circle were designated C1, the second, C2, and the third, C3. This made it possible to identify the themes developed in each meeting.

As she is also a worker and member of the UAPS health team, with Recamonde Capelo for nine years, there is a sense of belonging, engagement, and connection with the space and the team. This certainly facilitated the researcher's entry, who was able to begin field research through systematic individual invitations and through a flannel board poster in the UAPS meeting room. She also provided, whenever asked, information about the topic to be discussed and the methodology to be developed.

We chose to keep a field diary to record the experiences we had during this research, as we realized we were searching for the insights of our re-

search subjects, drawn from our own field experience.

The group's statements were collected through voice and video recording with three devices placed in different positions in the meeting room, to minimize overlapping expressions and lost speech. Three meetings were held between August and September 2015. The physical space, a meeting room, despite the high local temperature, was well-ventilated and private, which prevented outside interference. There was a table approximately two meters long, which allowed all group members to sit at the table, along with the researcher.

To survey the vocabulary, we brought individual cards, which the participants used to write down the trigger question: What words come to mind when talking about producing care? Next, we identified the generating words that emerged from the observation and reading of these cards.

We transcribed the recordings and images produced by the group, as well as the field diary entries, which make up the research corpus. These were the first steps taken to process the data obtained. Bardin 2 called this phase pre-analysis.

We performed an initial reading of the transcribed information, allowing ourselves to be influenced by first impressions and orientations. Seeking to understand the strength of the statements, we entered the exploratory phase, which Bardin 2 defines as the stage in which systematic readings are conducted to seek connections and disconnections between the data and grasp the relationships obtained.

Throughout the preparation of this material, we maintained a commitment to respect what was postulated by Resolution No. 466, of December 12, 2012, of the National Health Council. This resolution addresses the maintenance of the principles of bioethics focused on the individual

and collectivities, namely, autonomy, non-maleficence, beneficence, justice and equity³. This Dissertation Project was submitted to the Research Ethics Committee (CEP) of the State University of Ceará (UECE) and was approved without pending issues with CAAE 42543015.3.00005534, whose CEP substantiated opinion number is 1,115,332.

RESULTS AND DISCUSSION

By carefully observing the images from the first culture circle, we noticed the researcher standing and constantly moving, away from the rectangular meeting table where the participants were seated. This distant and nervous manner of positioning herself in the scene gave way, over time, to a discreet movement of approaching and toward whomever the voice was directed. Eventually, the researcher appeared closer to the other participants.

Producing care to generate co-accountability—this first category—was identified by the perception that the initial question, posed in the first culture circle ("What comes to mind when we talk about producing care?") resonated in the subsequent meetings. The participants felt compelled to first conceptualize the production of care, so that, as the circles developed, they could seek to highlight their own ways of producing care in their work dynamics.

For me, it's about making people feel capable of taking care of themselves, of being responsible for their health [...] we have to encourage this responsibility in them, so they can feel like agents in the health process [...] of being responsible for their own self-care (T3 C1).

Our job, all of us, is to bring health through what? Guidance and information. But knowing that each person is truly respon-

sible for their own health (T6 C1).

They (the patient) are responsible for their health; our job is to educate (T15 C2).

Franco and Mehry⁹ reaffirm that the work processes in Family Health are, in themselves, its greatest challenge, since the production of health care occurs fundamentally through relational dynamics and their applicability, as well as through work technologies. The authors highlight the need for professionals who make up Family Health teams to relearn their work based on relational dynamics that enable the integration of diverse knowledge.

This is why we believe that the implementation of culture circles was advantageous in reactivating desired productions and promoting awareness of the ways in which work at the health center is being developed. As a starting point, we identified that UAPS RC workers perceive themselves as providing care to their patients when they instill in them self-esteem, self-confidence, self-care, and the certainty that they, the patient, are also responsible for their own health care. To promote individual autonomy and self-care, the SUS developed the PNH, which, among other elements, recognizes the need for this form of democratization of health services as a fundamental requirement for humanization. To this end, it provides for the transversality of social and health actions, the pursuit of autonomy, and the protagonism of collectives that make up the SUS, be they managers, workers, or patients³.

By verbalizing that they are concerned about the patient's ability to take care of and be responsible for their own health, and by educating them about self-care, workers are thinking about new ways of producing and circulating power in the

healthcare field¹⁹. Furthermore, we believe that they are seeking to act in line with what the PNH calls for: the construction of autonomy and protagonism of the subjects for whom the SUS is intended.

Campos⁷ validates this thinking when he states that a healthcare humanization project is impossible without considering the democratization of interpersonal relationships. The author advocates for democratic ways of working in institutions to increase the decision-making capacity of SUS users vis-à-vis health authorities. Building patient autonomy as a way of delivering care is a movement toward co-participatory management of healthcare actions. Similarly, we can say that it also involves sharing knowledge and practices that empower them to make choices that promote their own health.

Contributing to the development of SUS user autonomy presupposes providing the means for patients to assert themselves in the face of interventions designed for them by healthcare professionals, thus bringing their knowledge and potential for care to the care provided⁸.

The debate on institutional democratization of health and the principle of co-responsibility is more strongly present in the ESF guidelines than in traditional PHC. The ESF, as a unique PHC framework, focuses on the production of subjectivities, without assuming equivalence, lack of differentiation, or homogenization of individuals and communities. In traditional PHC models, however, paradigms prevail that homogenize primary care.

We cite a reflection article by Silva et al.²¹ in which the authors participated in the healthcare of a patient undergoing breast removal surgery due to cancer. In the article, the Family Health team visits the patient until she decides to discontinue her medication treatment. The patient

expressed gratitude for the team's care up until that point and revealed that her only sadness was the absence of her family at that time. The repercussions on the team were initially very negative. Later, in a group reframing process, it was possible to develop a new care strategy, focused on the patient's real needs: affection and family support. We learn from this article that care goes beyond the provision of health actions and services; it intersects health actions, social services, spirituality, and many others, to achieve the care that needs to be provided, regardless of what is expected.

It is important to always consider that, in healthcare, we deal with individuals, their ways of life, and their unique perspectives on care. We believe that healthcare cannot be subjugated to procedures, routines, and care protocols. In Family Health, the best care possible is provided by teams. Healthcare workers tend to share experiences to reduce distress and strengthen one another in the face of close contact with illness, pain, and death. Promoting shared healthcare actions for individuals and the community, as we will see below, allows our workers to navigate the interdisciplinary approach characteristic of the ESF:

I think providing care is about promoting health and preventing disease. So, we go to someone's home, find out about their health situation, and end up consulting them [laughs]. We become a doctor in that person's life: "Do this, do that, so your health improves" (T7 C1).

The worker believes that this approach creates bonds and promotes health. The democratization of medical know-how among the multiple health professions is undoubtedly, in theory, still a thorny issue in power and territorial disputes. The extremely competitive economic con-

text contributes to the establishment of reserved positions for those with medical knowledge. However, as we saw in her account, in practice, field experiences in health legitimize relationships between other health professions and patients to be more equal and closer, and therefore less hierarchical.

We now contrast the worker's position because we find in her thinking signs that the understanding of medical knowledge and practice is grounded, as ways of producing care, in medicalization and the prescription of healthy actions. Her account illustrates that, although they understand that they need to be guided by a dialogical production of care, workers externalize forms of work that tend to hierarchize knowledge and medicalize bodies.

It is therefore inconsistent to think about care delivery in a dialogical and democratic manner and then proceed to promote medicalizing, prescribing health actions. It is necessary to break with approaches to health actions that do not require reflection and only contribute to the cycle of excluding patients from the central role they hold in their life, health, and illness processes. This way, discourse will more closely align with practice.

To promote care for SUS users, Tavares et al. ²³ argue that it is important to value the principle of comprehensiveness. The authors consider the notion that it is essential to allow for the exchange of power and permeate the encounter between the various actors involved in the daily delivery of health actions, capable of producing

acceptance, connection, respect, and dignity.

In our work, it's crucial to feel empathy for others. To recognize in them what you are. To recognize in them what you could be (T17 C1).

Professionals tend to disregard certain rules and norms, guided by the nature of the illness/need relationship to provide their own form of health care and, as is essential in the ESF, to establish a participatory presence in the lives of that individual, family, or community. The connection between professionals and patients is perceived as a moment of care intertwined by affection and subjectivity. In this context, absolute knowledge and interventionist practices fall away. Silva et al. ²¹ argue that, beyond institutional and physical, the territory of care is affective and produces singularities.

Providing care means caring for others as if they were caring for me. Because, for a few years now, after I passed through the hands of Dr. Adalberto Barreto², I've been working this way: I care for people as I would like to be cared for (T8 C1).

This proximity results, according to the following workers, in the professional seeking to acquire knowledge, training and constant restructuring of their knowledge in health.

You have to be firm without being aggressive; speak to make them understand. And also speak when you're certain. Seek to improve, seek to train yourself so that the patient always trusts what you say (T17 C3).

² Adalberto Barreto holds a Ph.D. and is a professor at the Federal University of Ceará. He earned a doctorate in Psychiatry from the René Descartes University of Paris, France, and a doctorate in Anthropology from the Catholic University of Lyon, France. He developed the methodology of Community Therapy, in which the community itself, through a dialogical and methodological approach, can help treat individuals suffering from psychological and emotional disorders. Community Therapy combines traditional knowledge and scientific understanding to create spaces of healing where the main remedies are words and touch. In groups of 30 to 40 people, participants share experiences, stories, and challenges, learning together how to cope with their difficulties. Source: Adapted from the Lattes curriculum of Dr. Adalberto de Paula Barreto.

Seeking to care for people means seeking knowledge, both within and outside the territory. Because outside the territory, we seek techniques, we seek to improve. Whereas within [the territory] in the community, you learn through experience [...] everything in the territory is a learning experience (T2 C2).

The certainty of the information offered to generate less paternalistic care and a more conscious approach to promoting health care corroborates Freire's thinking,¹¹ which encourages workers to cultivate the various knowledge necessary for transformative educational practice. We believe that workers also realize that their relationships with each other and with patients still follow traditional healthcare models, such as the strong institutional intervention of the public sector and the technical-social division of labor. It was important for participants to engage in this critical reflection to develop the capacity to denaturalize what had been estab-

lished. Undoing what presents itself as "normal" is crucial to making room for creativity and the action of inventing new ways of providing healthcare.

Studying healthcare workers' perceptions about how they deliver care, whether in PHC, ESF, or any other care delivery system, is always unfinished because it is done by people and for people. We need to recognize ourselves as unfinished beings and, therefore, constantly challenged to learn. As such unfinished beings, we must seek to perceive the subtleties of our place in the world and constantly reframe it, to prevent the hardening of existence.

In this study, we learned that healthcare work is fundamentally relational and eminently ethical. We say it is relational because it is through the movement between professionals from multiple categories, SUS users, and administrators that the healthcare production process emerges. The work of delivering healthcare requires the encounter between individual or collective subjects and is a service consumed the moment it is produced.

This healthcare model, based on evidence-based medicine, emphasizes hard technologies to vertically integrate healthcare network nodes. The macrostructure uses information technology to connect users, healthcare professionals, and service providers. The model's proponents and advocates stipulate that all activities must be electronically recorded to generate data and assist in healthcare decision-making processes. The information that feeds this system must reflect the patient's journey through the healthcare system, schedule and analyze their needs, align them within clinical guidelines for care, evaluate outcomes, and provide information on the costs of the entire process. For the developers of this healthcare model, it is a mechanism that not only guides care flows but also advocates for a shift in the way healthcare is thought of, focusing less on empirical approaches and more on successful outcomes to improve health indicators.

REFERENCES

1. Andrade LMO, Barreto ICHC, Bezerra RC. Atenção primária à saúde e estratégia saúde da família. In: Campos GWS, et al., editors. Tratado de Saúde Coletiva. 2nd ed. São Paulo: Hucitec; 2012. p. 907.
2. Bardin L. Análise de conteúdo. Reto LA, translator. 1st ed. 2nd reprint. São Paulo: Edições 70; 2011. 279 p.
3. Brasil. Conselho Nacional de Saúde. Comissão Nacional de Ética em Pesquisa – CONESP. Normas para pesquisa envolvendo seres humanos. Resolução CONEP 466/2012. Brasília: Ministério da Saúde; 2012. 12 p.
4. Brasil. Ministério da Saúde. Curso de formação de facilitadores de educação permanente em saúde: unidade de aprendizagem - Trabalho e relações na produção do cuidado em saúde. Rio de Janeiro: Fiocruz; 2005. 104 p.
5. Brasil. Ministério da Saúde. Curso de formação de facilitadores de educação permanente em saúde: unidade de aprendizagem - Trabalho e relações na produção do cuidado em saúde. Livro 2. Rio de Janeiro: Fiocruz; 2005. 160 p.
6. Bourguignon JA. O processo da pesquisa e suas implicações teórico-metodológicas e sociais. Rev Emancipação. 2008;6(1):41-52.
7. Campos GWS, Cunha GT. Método Paidéia

para GO-gestão de coletivos organizados para o trabalho. *Rev ORG DEMO*. 2010;11(1):31-46.

8. Franco TB, Andrade CS, Ferreira VSC. A produção subjetiva do cuidado: cartografias da Estratégia Saúde da Família. São Paulo: Hucitec; 2009. 164 p.

9. Franco TB. A reestruturação produtiva e transição tecnológica na saúde: debate necessário para a compreensão do processo de "financeirização" do mercado da saúde. In: Franco TB, Mehry EE, editors. Trabalho, produção do cuidado e subjetividade em saúde. São Paulo: Hucitec; 2013. p. 361.

10. Feuerwerker LCM. Micropolítica e saúde: produção do cuidado, gestão e formação. Porto Alegre: Rede UNIDA; 2014. 174 p.

11. Freire P. Pedagogia da autonomia: saberes necessários à prática educativa. São Paulo: Paz e Terra; 2010. 148 p.

12. Fortaleza. Secretaria Municipal de Saúde. Relatório de Gestão de 2007 da Secretaria Municipal de Saúde de Fortaleza [Internet]. Fortaleza: Secretaria Municipal de Saúde; 2007 [cited 2014 Nov 27]. Available from: <http://fortaleza.ce.gov.br/sms/relatorios.download>

13. Giovanella L, Escorel S, et al. Políticas e sistema de saúde no Brasil. 2nd ed. Rio de Janeiro: Fiocruz; 2013. 1100 p.

14. Merhy EE. A perda da dimensão cuidadora na produção da saúde: uma discussão do modelo assistencial e da intervenção no seu modo de trabalhar a assistência. In: Malta DC, et al., editors. Sistema Único de Saúde em Belo Horizonte. Reescrevendo o público. São Paulo: Xamã; 1998. p. 103-20.

15. Minayo MCS. Pesquisa social: teoria, método e criatividade. 31st ed. Petrópolis: Vozes; 2012. 80 p.

16. PAHO. Conferência de Alma-Ata de 1978.

17. Pan American Health Organization/World Health Organization (PAHO/WHO). Renovação da Atenção Primária nas Américas. Documento de posicionamento da Opas [Internet]. Washington: PAHO; 2005 [cited 2014 Nov 27]. Available from: <http://www.opas.org.br>

18. Paim JS. Modelos de atenção à saúde no Brasil. In: Giovanella L, Escorel S, et al., editors. Políticas e sistema de saúde no Brasil. 2nd ed. Rio de Janeiro: Fiocruz; 2013. p. 547-73.

19. Pordeus MP, Pordeus CLV, Rolim FAR, Nunes KJO, e Silva EDS, Araújo AM, do Amaral MS, Alves SRM. Psicodinâmica do trabalho e sua implicância na saúde do trabalhador: contexto da reforma trabalhista. *Rev. Foco* [Internet]. 19º de junho de 2023 [citado 28º de agosto de 2025];16(6). Disponível em: <https://ojs.focopublicacoes.com.br/foco/article/view/2344>.

20. Silva MRF, Silveira LC, Pontes RJS, Vieira AN. O cuidado além da saúde: cartografia do vínculo, autonomia e território afetivo na saúde da família. *Rev Mineira Enferm*. 2015;19(1):249-54.

21. Silva MRF, Pontes RJS, Silveira LC. Acolhimento na Estratégia Saúde da Família: as vozes dos sujeitos do cotidiano. *Rev Enferm UERJ*. 2012;20(Spec No 2):784-8.

22. Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília: UNESCO/Ministério da Saúde; 2002. 726 p.

23. Tavares MFL, et al. Práticas em saúde no contexto de reorientação da atenção primária no Estado do Rio de Janeiro, Brasil, na visão das usuárias e dos profissionais de saúde. *Cad. Saúde Pública*. 2009; 25(5):1054-62.