

Occupational health in primary care: perceptions and practices in family health teams

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This study sought to recognize the perceptions of family health teams regarding work-health-illness relationships, and to identify strategies, facilities and difficulties relating to providing workers with healthcare. Focus groups were conducted among primary care professionals in three Brazilian cities: Palmas (TO), Sobral (CE), and Alpinópolis (MG). The Bardin technique for content analysis was used to organize and analyze the data. The results showed that the healthcare actions provided to workers were unsystematic and out of line with the guidelines and objectives of the Brazilian National Occupational Health Policy. The major problems identified were: work overload; unpreparedness among the teams regarding issues involving work-health-illness relationships; and lack of institutional support, among others. Central organizational support for healthcare teams, provided by occupational health reference centers and other parts of the Brazilian National Health System, was identified as a facilitator of actions.

Keywords: Occupational health. Unified Health System. Primary health care.

Introduction

In the current healthcare model of the Brazilian Unified Health System (SUS), the Primary Health Care (APS) is regarded as an organizer of the health care network and coordinator of comprehensive care^{1,2}.

This context may be interpreted as an opportunity to develop a special care to workers, incorporating the work contribution in determining health/illness processes by the Brazilian Unified Health System, which is a constitutional attribution regulated by the Health Organic Law and prescribed by the National Policy of Safety and Health at Work (PNSST)³.

The production of care to workers by the Primary Health Care (APS) gains relevance in the context of the ongoing economic transformations in the country. They are responsible for the increase and diversity of informality; work precarization; unemployment; bad labor conditions, with exposure to high psychosocial and physical loads; and fragile social protection. These are conditions that strengthen the workers' social vulnerability^{4,5}. Particularly regarding the informal work at home, the Primary Health Care has the possibility of breaking the invisibility of these workers' labor and health conditions, thus opening new perspectives of intervention and protection in health⁶.

The National Policy of Safety and Health at Work (PNSST) and, especially, the National Policy of Worker's Safety (PNST-SUS), offer the conceptual basis, principles, guidelines and strategies to provide comprehensive health care to workers. Among the strategies proposed by the PNST-SUS that involve the Primary Health Care (APS) are: the structuring of the National Network of Comprehensive Care to Worker's Health (RENAST) in the context of the Healthcare Network and the articulation with the worker's health surveillance, based on the analysis of the productive profile and on the workers' health status for the development of actions. Other highlighted issues are the strengthening and expansion of intersectoral articulation; the stimulus to the participation of workers and community in general; the training of Family Health (SF) teams; and the support to the development of studies and researches⁷.

In spite of the legal basis and the ethical-political justification, the implementation of systematic worker's health actions in the Primary Health Care presupposes the involvement of teams, thus demanding the need to know the labor organization as well as the main difficulties and facilitating factors which involve providing care to the working population.

The structural difficulties of the Primary Health Care are extensively researched and reported in the literature and should be considered in the process of incorporating actions of worker's health in the team's practices. Among them, stand out the precariousness of the physical network; the low level of connectivity and computerization of the Basic Healthcare Units (UBS); the care model focused on care actions; the low interaction degree among professionals; the huge spontaneous demand; the lack of technical preparation and high professionals' turnover; the little integration with the care network; and the work precarization^{8,9}.

Notwithstanding, studies conducted in the country show that the Family Health teams have to cope with daily problems arising from the work/health/illness relations, despite with limited responsiveness resulting from gaps in the education process of graduate courses; and lack of technical support, institutional support and support of well established care lines in the care network^{6,10,11}.

The need to develop effective tools and methodologies of pedagogical and technical support to the Family Health teams in order to provide workers' healthcare is appointed by several authors¹²⁻¹⁴. On the other hand, the fragile articulation of the Worker's Health Reference Centers (CEREST) with the Primary Care services was one of the factors shown in the situational diagnosis held in Minas Gerais state in 2007¹⁵.

Based on the aforementioned, this paper aims at discussing the perception of the Family Health teams on the work/health/illness relations and identifying the strategies developed to offer care to workers. Furthermore, it aims at showing the potentiating and limiting factors for care, as well as at proposing alternatives towards ensuring comprehensive care, considering the complex work/health/illness relations and the environment that unfolds in the areas where those teams operate.

Method

It is a qualitative, descriptive and exploratory research carried out with Family Health teams in three Brazilian cities: Palmas, in the state of Tocantins; Sobral, in the state of Ceará; and Alpinópolis, in the state of Minas Gerais, for knowing, in developed practices, how care is given to users-workers. Those three cities were chosen to meet the need of tackling distinct realities of the country. The following criteria were used: Family Health coverage over 50% and total records of accidents at work in the Information System of Primary Care (SIAB), in the year 2010, being the only indicator of worker's health prescribed for Primary Care.

The choice of the Basic Healthcare Units (UBS) to participate in the study was made based on interviews with the following key informants: the Primary Care coordinators; the Worker's Health Reference Centers (CEREST); and the state and municipal management. We have chosen to work with municipalities located in the area of a CEREST for taking into account its role in providing technical support to the Brazilian Unified Health System (SUS) network for actions of worker's health.

All professionals of the Family Health teams of the selected Basic Healthcare Units (UBS) were invited, making an average of eight professionals in each focus group. The number of participants was considered enough when the research data reflected the multiple dimensions of the object of this study and became repetitive¹⁶. The exclusion criterion was the refusal of not taking part in the research.

Focus groups were carried out with Family Health team members of the three previously mentioned cities, using the following guiding questions: How do you deal with demands and health problems related to work/health/illness process? What actions have been developed for users-workers' care? What instruments and approaches have been used? What are the facilitating factors and the main difficulties for developing these actions? Moreover, it was incorporated in the script the issue about the articulation between the Basic Healthcare Units (UBS) and the Worker's Health Reference Centers (CEREST).

From May to August 2011, focus groups were recorded and then transcribed, allowing an accurate information record. The participants were identified with codes according to professional categories: M for physicians; E for nurses; ACS for community health agents; and ACD for dental practice assistant. The real names of the participants were kept anonymous.

We used Bardin's¹⁷ method of thematic content analysis for systematizing and analyzing data. The initial information systematization collected in the groups allowed us to identify the main units of meaning which emerged in the field research, considering the speech regularities and the frequent and odd senses present in the speeches. Afterwards, the data were organized and classified according to the categories: a) Primary Care attributes and workers' health care; b) workers' health care organization; and c) recommendations. The empirical and analytical categories were compared, searching for relations between them. Next, those categories were subdivided into smaller components, into subcategories.

The discussion of results considered the foundations, principles and guidelines of the National Policy of Primary Care (PNAB) and the characteristics of the work process of the Family Health teams².

The research project was approved by the Research Ethics Committee of the Federal University of Minas Gerais (ETIC 459/08). The group participants signed the free and informed consent, according to the norms prescribed by the Resolution 196/96 of the National Health Council.

Results and discussion

The research findings were consolidated and they will be presented, considering the categories and subcategories, highlighting the specificities observed in the cities which were investigated.

Attributes of the Primary Health Care (APS) which favor workers' health care

The teams mentioned access, longitudinality and coordination of care as essential to the workers' care. Under the Directive 4279/2010, the Primary Health Care must be organized

according to the attributes: access, longitudinality, coordination, comprehensiveness, centrality in the family, family approach, and community orientation¹.

Access represents the preferred contact of users with the Brazilian Unified Health System (SUS). In the report of the Family Health teams, this attribute is present in the dimensions related to: temporal barrier, which is related to the opening hours of the Basic Healthcare Units (UBS); organizational barrier, which refers to the adscription characteristics of families per household of previously defined areas; and gender barrier, involving the healthcare use restriction by male users, primarily due to working hours.

In Alpinópolis, Minas Gerais state, the concern on broadening access resulted in extending the opening hours of the Basic Healthcare Units. The issue acquires a greater relevance in discussions about the implementation of the Brazilian Comprehensive Healthcare Policy for Men (PNAISH)^{18,19}.

We have nighttime health care to attend these people (workers). (E)

Nevertheless, some health professionals noted that the access to male users-workers is still limited, even with extended opening hours of the Basic Healthcare Units.

Men are very stubborn. They only go to the health center if they are already ill. (E)

We can work in the evenings, on holidays, on Saturdays, but they (the men) don't show up. (E)

In the studies carried out by Knauth, Couto, Figueiredo¹⁸ and Machin et. al²⁰, the work was appointed by the Primary Health Care professionals as one of the main factors that justifies the lack or difficulty of users' access to health care services.

Knauth, Couto and Figueiredo¹⁸ demonstrated that male workers, aged between 30 and 50 years old, constitute a minority group in health care due to some factors as: the insertion in the formal labor market; the fear of being penalized because of work absence; and the difficulties imposed by firms to justify work absence by a medical certificate.

It is important to highlight that the Brazilian Comprehensive Healthcare Policy for Men (PNAISH) proposes a male morbidity and mortality reduction through expanding and improving access to health actions and care, which necessarily implies the inclusion of the work issue in the discussion.

Another difficulty refers to the adopted criteria of families' adscription towards the health teams, using only the household criteria, limiting access and care to users who work but do not live in the area, as reported by a community health agent (ACS).

There are plenty of garages in my neighborhood, but the workers don't live here in this block. When there's an accident, they go to the Emergency Department or they look for the Basic Healthcare Unit (UBS) of their neighborhood. They are not from here; they just work here. [...] They don't seek the UBS because they're afraid of not being cared.
(ACS)

The difficulty of providing health care to workers, especially in the commuter towns of metropolitan regions, was identified in assessing the implementation of the Family Health strategy in ten large urban centers, carried out by the Ministry of Health in 2005. In order to solve the problem, the report recommends the study of the adscription possibility by workplace or by means of an individual entry at the Family Health Unit which is located near the workplace²¹. It is worth noting that the document of the International Conference on Primary Health Care, held in 1978, in Alma Alta, proposes healthcare to be offered by the closest Primary Health Care (APS) to where people live and work²².

Among the strategies observed in the study developed by the Family Health teams, aimed at making that the Primary Health Care (APS) actually constitutes the user's preferred contact with the Brazilian Unified Health System (SUS), it stands out: expanding the opening hours; visiting workplaces – being referred to in just one of the researched Units; and prioritization in scheduling an appointment.

When patients arrive because of the work, we arrange an appointment for them. I always schedule the appointment in the best times; I'm always rescheduling patients because of their work. (ACD)

Visits to a work environment located in the area were mentioned by the nurse of the Family Health team of Alpinópolis, in Minas Gerais state, and used for the development of educational activities. Among the developments, it was observed an increased demand for the Basic Healthcare Unit (UBS).

[...] we went to a clothing industry around here. We worked with the female workers regarding hypertension and diabetes. We tackled issues we had previously thought there were no doubts about; however, when we got there, we noticed that they had many doubts. [...] After that,

they went to the Unit, showing interest in finding out more about the subject. (E)

Among the difficulties related to visiting workplaces, it was highlighted the interference in the work routine, notably in situations where the worker has his/her income linked to productivity.

It's just that when we got there, [we found out that] everything is based on productivity. Then, as the head of the family, he needs such productivity. It's another concern of the worker. So, we were careful about not hindering his productivity and finding out if he was enjoying it. (E)

It is important to note that the attribute access is not limited to dimensions regarding organizational, cultural and physical barriers; rather, it includes availability, comfort and acceptability of service by users, which were aspects not mentioned by the teams.

The continuity of care was emphasized by the group and it can be included in the attribute longitudinality:

[...] a patient we had worked at the quarry for many years. He retired for having emphysema and soon afterwards was diagnosed with silicosis. In the beginning [...], he started an apex pneumonia treatment. I got worried about if he had something else. Then, I sent him to the Worker's Health Reference Center (CEREST), where he was supervised and guided [...]. He didn't get lost in the network. (M)

According to Starfield²³, the term longitudinality derives from the word longitudinal and requires from health professionals the ability to "deal with" the growth and changes of individuals or groups throughout a long period or life cycles. In the transcribed report, it can be observed the user-worker monitoring over time by a health professional of the Primary Health Care (APS), even after sending the worker to the Worker's Health Reference Center (CEREST). It draws attention the expression "He didn't get lost in the network" to denote the continuity of care.

Nevertheless, fragmentation and discontinuity of care were explained by another professional.

I, a person who has the longest serving and is older, spent my whole life frustrated. That's because you get a case, but then it goes somewhere else you don't know and it disappears [...]. (M)

It can be observed that professionals develop strategies to overcome structural lacks of the Brazilian Unified Health System (SUS) for ensuring the production of care. A study on the workers' perception regarding the Family Health strategy in the Federal District, about the work process and its repercussions on the health/illness process, showed that the constant unpredictability imposes on the worker a strong cognitive demand. Furthermore, the work load is increased by repetitive tasks, the accountability for results, the staff shortage, among other factors²⁴.

Managing care to users-workers, another attribute of the Primary Health Care (APS), emerged in the discussions; nevertheless, it was poorly explored. It requires sharing information between the APS team and professionals of other points of care about serving users and triggered actions, such as procedures, guidance and referrals made. The electronic medical record and the computerized systems are indicated as essential tools for managing care¹.

In the report presented below, the professional reveals knowing the procedures carried out by the technical team of the Worker's Health Reference Center (CEREST). Notwithstanding, he receives this information from the user-worker who is looking for the Basic Healthcare Unit (UBS).

And the most interesting we observe is that, even before arriving the counter-reference (of CEREST), the user himself/herself has the freedom to look for the Unit. [...] Even before the counter-reference arrives, we already know what's going on with the user. (E)

This issue shows the user's bond to the Basic Healthcare Unit (UBS), one of the principles of the Primary Care, and the maintenance of vertical relations, characteristic of bureaucratic and less dynamic systems, in which communication between specialists and the Family Health teams occurs through reference and counter-reference forms. Campos and Domitti²⁵ propose Matricial Support as a work methodology complementary to those adopted in the hierarchical system. Its application enhances the care management process by the Primary Health Care teams to the extent that it enables sharing different knowledge between reference and specialists.

Organizing care to workers' health

The "organization of care to users-workers" comprised the subcategories: recognition of users-workers and mapping productive activities of the area; notification of work-related injuries; medical report issuance; institutional and matricial support; intra and intersectoral articulation; work process characteristics; and workers' participation.

Users' recognition as workers starts on the registration of families by the community health agents (ACS) and continues in other interaction moments between users and the team, such as reception, clinic appointment, home visit, operative groups, among others.

The report below evidences the importance of including in the anamnesis questions pertaining to user's work in order to relate complaints and problems arising from the current and/or previous work.

When any problem happens, we ask if it was a work accident, an accident at the workplace... In anamnesis, at the appointment time, when we listen to the story of what has happened to the person [...], we ask him/her about his/her labor activity. (E)

When the user-worker comes to us with his/her complaint, an approach is made regarding what activity he/she exerts, for how long he/she performs it, if he/she performs any kind of physical effort, if he/she is exposed to any kind of risk. (E)

The information survey about health and living conditions of the population living in the area covered by the Primary Health Care (APS) teams is essential to the healthcare production. The community health agents (ACS), due to the bond they have and for living in the area they work, play a fundamental role in this process. The following excerpts show this assertion:

I believe we, who know people, start the thread. The first step is the identification, and we are the ones who do it. In my area, I think that 60% of men over 20 years old work in the quarry. And there are many cases of silicosis. (ACS)

[...] the girls are very important (ACS). They bring us the problems of each place. (M)

It was observed that most of the health professionals recognize that the community health agents (ACS) hold more qualified and accurate information on the area they work, as shown in the reports:

In relation to the identification of workers and mapping of productive activities, the ACS is undoubtedly one step ahead. They know better than anyone else the area of operation, the production processes, and the main activities of the community. (E)

I see the identification of the working population as an ACS's role. (E)

Despite having become evident that the community health agents (ACS) know who the workers are and what work activities they perform, they show facing difficulties when questioned about filling out the family registration record (form A) with the item occupation.

In the form A we filled out, we used to place “housewife” for women, but we didn’t mention the profession for men. Afterwards, we found out what it really was; we found out that information was important for starting the work. (ACS)

The community health agents (ACS) demonstrated that they realized the importance of filling out the field occupation; nevertheless, that data was not used in the actions planned and developed by the team. Some started to fill it out suitably after having understood how this data helps in the process of workers’ healthcare. This finding is corroborated in the study of Lacerda e Silva, Dias and Ribeiro¹⁴.

Reinforcing the fact that the community health agents (ACS) filled out the item occupation of the form A considering it only as a “bureaucratic” requirement, a nurse stressed:

We even have this mapping because the Information System of Primary Care (SIAB) does the typing, where it is required to mention the profession. The community health agents (ACS) know who the workers are in each micro-area, as you need that information when you type to register the family; however, the data stays there. It’s not worth for nothing else, but just to the register of SIAB. (E)

The teams should get pedagogical and technical support to overcome that difficulty in order to improve: the data collection and systematization process; the outline of the occupational profile of the population; and the discussions about the possible risks for the workers’ health.

Another important issue that emerged in the group is the recognition of informal workers in the area covered by the teams. The need of organizing health care actions towards these workers, notably the ones who develop their activities at home, increases in importance due to their frequency and diversity. Most of these workers get no labor and welfare protection and need the health care which is offered by the Brazilian Unified Health System (SUS), particularly by the Primary Health Care (APS) services that are closer to where they live.

There are many informal workers in my area. (E)

The complexity of health problems arising from risk factors exposure generated by the work and the situation of social vulnerability aggregate demands to the teams. Nevertheless, the teams are not prepared to solve most of these issues. To this end, it is necessary strong intra and intersectoral articulation.

Intra and intersectoral articulations reported by the teams are only focused on the Worker's Health Reference Center (CEREST) and on the Brazilian Social Security National Institute (INSS).

I've already referred many people to the CEREST, the INSS, and many of them were about to retire. (ACS)

We work a lot with the CEREST team. (E)

Wimmer and Figueiredo²⁶ emphasize the intersectorality as an integrative practice of actions of different sectors that complement themselves and interact for reaching a more complex approach to the problems.

On the other hand, the intra-sectoral articulation is essential to ensure care continuity and to the development of actions of the worker's health surveillance, articulated to epidemiological, environmental and/or health surveillance²⁷.

The Municipal Technical Reference in Worker's Health (RTMST), mentioned in just one of the cities studied, was stressed by the professionals as fundamental for strengthening intra-sectoral articulations:

Everything that comes to the Basic Healthcare Unit (UBS) and which is related to occupational disease [...] is reported to the Municipal Technical Reference in Worker's Health, which then contacts the Worker's Health Reference Center (CEREST). (E)

The Municipal Technical Reference in Worker's Health (RTMST) refers to the health professional who is graduated and responsible for supporting the Occupational Health Policy implementation, at the municipal level²⁸, and who was appointed by the team as the main mediator between the Worker's Health Reference Center (CEREST) and the Primary Health Care (APS).

The articulation with the CEREST for users-workers' care was strongly emphasized in the teams' reports, although the professionals responsible for the strategy of the Family Health of Palmas city, in Tocantins state, have pointed out that their relation with CEREST is still not systematic.

[...] we got in contact with CEREST on the day of the humanization lecture. And now, recently, the team was there, in the Unit, to develop a work as well [...]. (E)

The fragile articulation of the Primary Health Care (APS) with other points of care indicates the deficiency in the reference and counter-reference flows and the lack of structuring of care lines to workers.

As the work accidents are usually urgent, most of them are directed to the Emergency Department where the notification is made, but without a counter-reference to the Basic Healthcare Unit (UBS). Sometimes, we don't even know about it [...]. (M)

In spite of differences observed among the cities investigated regarding the intra and intersectoral articulation level for the resolution of the workers' health demands, the study showed the need to strengthen the workers' health care network, particularly the actions of worker's health surveillance.

Notification of work injuries is another relevant action in the production of workers' care, as it is essential for broadening knowledge about its profile of morbidity and mortality and allows this issue to be included in the political and technical agendas of managers and of the social control of the Brazilian Unified Health System (SUS).

Injuries regarding the notification work in the National Disease Surveillance Data System (SINAN) are disposed in the Directive 104/2011, mainly in the list of mandatory reporting diseases in sentinel units²⁹. The work diseases must be notified after confirmation, except in cases of exogenous intoxications.

According to the professionals, the need to confirm the relation between work and injuries and the lack of physicians at the Basic Healthcare Units (UBS) are some factors hampering the notification.

The notifications of work injuries are only made after the conclusion of the diagnosis, which is made by a physician. It's difficult for us to undertake the notification because, many times, the team doesn't have a physician. (E)

The lack of physicians at the Basic Healthcare Units (UBS) is a problem identified and discussed in the three management spheres of the Brazilian Unified Health System (SUS). Among the strategies developed by the Ministry of Health for coping with this issue, it can be highlighted: professional workload flexibilization, previously set at 40 hours a week, and the establishment of

the Program for Primary Care Enhancement (PROVAB), which offers incentives to the professionals who choose to work in the Family Health teams and in other forms of organization of the Primary Health Care (APS)³⁰.

Issuing medical reports for justifying work absence or work function change was another action required by the users-workers, as explained by the physician of the team:

[...] we prepare medical reports [...] I send a report, mentioning that the pregnant woman can't climb stairs, for example, and require she's given other work function [...] everything according to the specific demand.
(M)

Providing medical reports, opinions and medical examination reports is the duty of physicians attending workers, as stated by the Resolution No. 1940/2010 of the Federal Council of Medicine³¹.

The need of institutional support for organizing workers' care is clearly present in the groups. In the city where the Municipal Health Department had indicated a Technical Reference in Worker's Health, the professionals listed advantages for counting with a supportive instance on issues of the area.

[...] the Technical Reference in Worker's Health is aware of all the problems we have. It tries to solve the problem, look for an answer, forward the problem. (E)

I'm saying this as a physician: sometimes the medical examination was blank, not proving anything. Now, we can look for the Technical Reference in Worker's Health [...]. And they feel safer to bring the complaint. (M)

The medical report shows that the role of the Municipal Technical Reference in Worker's Health has eased the achievement of giving continuity to care. On the other hand, the lack of support to deal with workers' health issues is expressed in different ways by the teams of other cities:

We don't know what to do [...]. The patients have medical care, but we don't know what to do with them [...]. (ACS)

For the Family Health Program (PSF), there's neither an established protocol nor an orientation concerning work injuries. (M)

Still concerning the organization of workers' care within the Family Health Program (PSF), some characteristics of the labor process that limit the development of actions were underscored by the professionals:

The truth is that there were imposed so many targets for us to reach that one can't see other ways of working. You're obliged to meet the target. So, if they tell us that we must develop an action of the worker's health, somehow we'll develop it - not because we have the initiative and are willing to perform that job, but because we were strongly conditioned and the obligation is to meet the goal. (ACS)

In spite of the fact that the National Policy of Primary Care (PNAB) recommends that the programming and implementation of health care activities must be made taking into account the population health needs – through the prioritization of health and clinical interventions in health problems according to criteria of frequency, risk, vulnerability and resilience –, the aforementioned report expresses a work organization towards meeting the established targets set by the managers of different levels.

We develop many actions, but they are not systematic. The Health Department requests, and then adds them to the planning. We're going to implement men's health, but other actions to be set arrive [...], thus fragmenting people. (E)

The report above shows care fragmentation arising from the labor organization of the teams and, particularly, the fragmentation of people, thus contradicting the principle of comprehensive care. The National Policy of Primary Care (PNAB) recommends organizing the work agenda shared by all professionals, avoiding the traditional use of criteria of problems regarding health, sex and life cycles, which hamper comprehensiveness assimilation in the developed practices.

Meeting the imposed requirements within the management associated with other implementation problems of the Primary Health Care (APS) in Brazil impose limits on redirecting the care model grounded in the real health needs of the local population and which allows the performance of important functions of APS, such as managing care.

Regarding the workers' participation, essential in the processes of interventions formulation, planning, monitoring and evaluation on the conditions generating work injuries, the National Policy of Primary Care (PNAB) recommends that the Primary Health Care (APS) services

institute councils/collegiate bodies, composed by local managers, health professionals and users, in order to enable social participation in managing the Basic Healthcare Units (UBS)².

Our local council is very active and it was a gain concerning our municipal council. Previously, the community didn't have any type of social control guidance, but now, for example, it is making a petition to get an area to put the academy [...]. This mobilization is being made. (E)

The above report expresses the importance of the local council towards the community organization in the search of a common goal. Even though the community participation is still incipient in these spaces, some studies have shown the local population's adherence in task force activities, as for example: the local population's mobilization against dengue; claims about environmental issues, such as waste accumulation, environmental contamination due to productive processes in the areas, among others. In these processes, the community health agents (ACS) have been fundamental because of the leadership role they often play in the community¹⁴.

The health professionals highlighted that the little knowledge of the users-workers concerning their rights limits the participation on the Basic Healthcare Units (UBS) activities, including the social protection afforded by the Brazilian Unified Health System (SUS).

The community itself is also unaware of its rights [...]. When something happens, some kind of work accident, people don't know which rights they have and they also don't seek us to get some information. (ACS)

On the other hand, studies have demonstrated that the Primary Health Care (APS) teams do not feel themselves qualified to carry out guidelines with regard to welfare, labor and social rights^{10,13}. Chiavegatto¹³ states that only 22% of 358 APS professionals who participated in his study follow these instructions, in spite of 71% hold them as important. This work is developed by the social worker when there is one in the team.

In the same direction, the National Policy of Worker's Safety (PNST-SUS) document emphasizes the need to undertake efforts to reactivate and strengthen the participation of formal workers categories, as well as to ensure the representation and organization of informal workers in the Brazilian Unified Health System (SUS) management levels⁷.

Recommendations

With regard to the **recommendations** of the teams for the insertion of systematized workers' health actions in the Primary Health Care (APS), it is highlighted: the professionals' sensitization for issues involving the workers' health; the definition of actions to be developed; the

strengthening of the Worker's Health Reference Center (CEREST) while pedagogical and technical support; the incorporation of the topic in the processes of permanent education and the exchange of well-succeeded experiences.

It was emphasized the sensitization of the APS teams on issues involving the work/health/illness process, notably in respect to user's recognition as a worker in his/her labor practices.

The individual isn't seen as a worker, but as a person who arrives with a specific disease, a certain work injury. This is not unanimous in the team, but we know that there are some team members who are not sensitized on certain matters. (E)

According to the National Policy of Permanent Education in Health, the defining basis of the educational processes of the teams should be the problematization of the labor process and the collective and individual health needs. Thus, it is essential that professionals incorporate the role of the work in their approaches to determine the health/illness process³².

The need to further define the teams' attributions in relation to the worker's healthcare was also suggested by some professionals.

The first thing is the understanding of the team concerning what are the actions that should be developed towards worker's health. Actually, these actions should be presented to the team, and then we would identify if we've already developed some of them. [...] We can even develop some without knowing that they're worker's health actions. (E)

[...] It's not possible to suggest one or another action if you don't know well what the Ministry of Health establishes regarding worker's health, or what the state expects. (ACS)

With regard to the above mentioned report, it is worth noting the need to work with protocols and guidelines, in particular, recommended by the Ministry of Health. As previously announced, the Primary Health Care (APS) teams have traditionally been organizing themselves based on pre-established targets and protocols, thus limiting greatly the recognition of the transversal character of worker's health.

Furthermore, one can say that the fragmentation of actions developed by the Family Health teams reflects the Health Policy fragmentation, organized from different technical areas and specialized knowledge fields that escape the logic of health responsibility of a population inserted in

areas and contexts which influence and determine differently the disease and health processes of the groups.

Strengthening the Worker's Health Reference Center (CEREST) performance in pedagogical and technical support to the teams is another strategic recommendation when discussing the systematic insertion of worker's care actions in the Brazilian Unified Health System (SUS). In the document of the National Policy of Worker's Safety (PNST), CEREST was defined as one of the instances of Matricial Support.

[...] In order to improve this activity, it must be established a more intimate relation of the team with CEREST for offering this support [...]. We can't do everything alone as well. (E)

In this sense, the importance of exchanging experiences emerged from the groups, as shown in the following transcribed speech:

We also miss reports of other experiences, of knowing how to work, how to develop the worker's health actions. (E)

The principle of learning from whoever is acting and the engagement with socializing experiences considered successful have been systematically assumed by the Ministry of Health. Within worker's health, the creation of an Information Panel in Environmental Health and Worker's Health and of the online National Network of Comprehensive Care to Worker's Health (RENAST) are some of these initiatives.

Final remarks

The results showed that the professionals of the three Family Health teams of the surveyed cities often recognize the implications of the work/health/illness relations in their daily practices. Nevertheless, they have difficulty to develop intervention actions, whether in the context of health promotion, surveillance or care.

This difficulty has historical roots and reflects the lack of discussion that is more directed towards the theme in graduation courses and in the permanent education processes. Furthermore, it is strong the concept that the worker's health issues are inured to specialties, such as the Occupational Medicine and Safety Engineering, and the object of action of the Labor and Employment Ministry. This is a barrier to be overcome in order to accomplish the organization of worker's health actions in the Brazilian Unified Health System (SUS).

It was observed that the community health agents (ACS) find it easier to recognize the user-worker in his/her practices and relate complaints and diseases mentioned by users with the current or previous occupation. Notwithstanding, it was noticed that, many times, their knowledge about the area is not incorporated into the team's practices.

Overall, it was verified that the existing activities and the ones directed towards the users-workers are not systematic, in addition to being unarticulated with the guidelines and objectives proposed by the National Policy of Worker's Safety (PNST-SUS). Just one of the teams, based on visits to workplaces, reported the development of activities for promoting health and preventing work-related diseases involving actions of health education.

In spite of the fragility of actions, this study allowed to identify the difficulties related to the incorporation of worker's care in the Primary Health Care (APS). It also proposed recommendations for improving the process, emphasizing the strengthening of the Matricial Support in Worker's Health by the Worker's Health Reference Centers (CEREST), other instances of the Brazilian Unified Health System (SUS), and institutional support.

Collaborators

Thais Lacerda e Silva took responsibility for the revision of the literature, took part of the outline of the methodology, writing and text revision. Elizabeth Costa Dias took part of the outline of the methodology, of the coordination on the field study and of the writing of the manuscript. Vanira Matos Pessoa, Luisa da Matta Machado Fernandes and Edinalva Maria Gomes participated of the outline of the methodology, performed the field research and the final revision of the paper.

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