From diagnosis to action: experiences in promoting physical activity and health

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The work process of the Physical Education professional in primary care in rural areas

Processo de trabalho do profissional de Educação Física na atenção básica em territórios rurais

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ABSTRACT

The aim of this study was to describe the work process of Physical Education professionals in primary health care in rural areas. This study is a systematized experience report from the experiences of resident professionals of Physical Education, inserted in primary health care in the rural areas of the municipalities of Garanhuns and Caruaru, cities of the *agreste* of the state of Pernambuco, with *quilombola* populations and settlers from agrarian reform territories, from January to August 2021. The work process of Physical Education professionals in rural areas is marked by agents, objects, means, products and results that characterize work in primary care, composed of nucleus and other comprehensive actions, in addition to the specificities of the area. It permeates individual and collective activities based on the reality and specific needs of the population of the countryside, contributing to health care, facilitating the coordination and continuity of care of this population.

Keywords: Primary health care; Rural population; Physical Education; Workflow; Continuing education.

RESUMO

O objetivo do estudo foi descrever o processo de trabalho do profissional de Educação Física na Atenção Primária à Saúde em territórios do campo. Estudo do tipo relato de experiência sistematizado a partir das vivências dos profissionais residentes de Educação Física, inseridos na Atenção Primária à Saúde nos territórios do campo dos municípios de Garanhuns e Caruaru, cidades do Agreste Pernambucano, com populações quilombolas e assentados de territórios de reforma agrária, no período de janeiro a agosto de 2021. O processo de trabalho dos profissionais de Educação Física no campo é marcado por agentes, objetos, meios, produtos e resultados que caracterizam o trabalho na Atenção Primária, composto por ações de núcleo e outras abrangentes, além das especificidades da área. Perpassa por atividades individuais, coletivas, a partir da realidade e necessidades específicas da população do campo, contribuindo com a atenção à saúde, facilitando a coordenação e continuidade do cuidado dessa população.

Palavras-chave: *Atenção primária à saúde; População rural; Educação física; Fluxo de trabalho; Educação permanente.*

Introduction

The history of Brazilian Public Health is marked by several processes of grassroot struggles and the movement for the Brazilian Health Reform, a historic landmark, was the result of these intense popular mobilizations in the process of redemocratization of Brazil and the construction of public policies that boosted the demands and achievements for social security, with the Unified Health System (*Sistema Único de Saúde*, SUS in Portuguese) as an achievement guaranteed in the Federal Constitution of 1988 and regulated by laws 8.080 and 8.142[1,2].

The SUS proposes the execution and planning of actions and services that bring the promotion, protection and recovery of health as potential and has Primary Health Care (PHC) as its priority gateway for

users, acting as organizer and coordinator of the health network, having a set of health actions in the collective and individual scope, based on health promotion and protection, disease prevention, diagnosis, treatment, rehabilitation, harm reduction and health maintenance for the development of a comprehensive care[2].

Faced with several advances in access to health, some of the conquered rights present some challenges, one of which is the access to health by the Populations of the Rural Areas and Forests, referred to in this article as communities and peoples with a way of life, production and social reproduction predominantly related to land, such as quilombola communities, indigenous peoples, settled or camped rural workers, among other populations[3,4].

Historically in Brazil, the territories where these populations are found were marked by a process of marginalization and denials produced by the model of capitalist society with the modernization of agriculture through large concentrations of land, the expansion of agribusiness with monoculture, the use of pesticides and conflicts over land that cause an abyss of poverty, inequality and death of the rural and forest populations, in addition to the absence of public policies, contributing to the inequities of their health conditions[3].

The absence of public policies in the rural areas has intensified the process of organizational need of the social movements of the rural and forest populations in the search for the right to claims in which the fight for land is also a fight for access to health, having as a result in 2005 the elaboration of the National Policy of Integral Health of the Populations of the Field and the Forest (PNSIPCF) which aims to "improve the health level of rural, forest and water populations, through actions and initiatives that recognize gender specificities, generation, race/color, ethnicity and sexual orientation, aiming at the access to health services; the reduction of health risks arising from work processes and agricultural technological innovations; and the improvement of health and quality of life indicators"[4].

Therefore, it is important to highlight that in the rural area, social dynamics present themselves in different ways from the urban population, with a greater absence of social facilities and the presence of barriers to the access to social public policies, health, education, leisure and culture, negatively influencing health, style and quality of life of these populations when their determinants and social conditions present in this rural context are conveyed, differentiating them from the relationships present in cities[3].

In this way, having PHC as a gateway to access to health for these populations, there is a need to guide discussions about the performance of health professionals, and in this context, the discussion about the performance of the Physical Education (PE) professional and the promotion of health in a comprehensive way in rural contexts, where the insertion of the PE professional in the context of PHC takes place mainly through the Expanded Nucleus of Family Health and Primary Care (*Núcleos Ampliados de Saúde da Família e Atenção Básica*, NASF-AB in Portuguese), according to the National Primary Care Policy[5].

In addition to the NASF-AB being an important gateway for the PE professional to work in PHC, providing the Family Health teams with clinical, sanitary and pedagogical support, other policies and programs have strengthened the entry of this professional into the SUS, using as examples the Health Academy Program, the National Health Promotion Policy, the Multiprofessional Residencies in Health, among others[5].

The performance of the PE professionals of the Multiprofessional Residency Program in Family Health with an emphasis on the rural population and the search for understanding and improvement of work processes in primary care in rural territories, made it possible to describe and reflect on what these processes are and how to overcome barriers to access to health, given the complex dynamics that the rural context and rural and forest populations bring.

Thus, this article aims to describe the work process of PE professionals residing in PHC in rural territories based on their experiences.

Methods

This is an experience report systematized from the experiences of resident PE professionals operating in PHC. The performance of these professionals from the Multiprofessional Residency Program in Family Health with an emphasis on the Rural Population for this research took place in tutoring sessions and field actions in the rural territories of Garanhuns and Caruaru, two cities in the agreste of the state of Pernambuco, with quilombola populations and settlers from land reform territories, from January to August 2021.

Through the Nucleus Tutoring, organizational structure of the Multiprofessional Residency Program in Family Health with emphasis on the Rural Population, which is constituted as a systematization of the

teaching-learning process of the University Time by the method of Pedagogy of Alternation, being carried out fortnightly, the construction of materials to understand the process of work in health in the field and its application in the day-to-day activities of the Community Time was systematized and divided into some stages.

The first stage brought the description through slide shows and the construction of a picture of what had already been done in the territories by the resident PE professionals and how the workflow took place in the Family Health Units which were supported in their acting.

The next step was to introduce readings of scientific articles on the theme of work process in PHC and the Basic Care Notebook of the Family Health Support Center number 39 for the systematization of the components and tools used in the work process in PHC.

In the third stage, the cycle of theoretical-reflective debates began with the use of materials from the scientific literature and dialogue circles with PE professionals from management, which were invited to raise the debate about what are the elements of the process of work in PHC.

To compose the theoretical scope of the work process of the PE professional in PHC in rural territories, scientific articles that addressed the topic were sought and indexed in databases such as Scielo and the Virtual Health Library, from 2015 to 2021, using the following keywords as descriptors: Workflow, Physical Education and Training, PHC, Rural Population, SUS.

The following step consisted in the construction of a framework made by the resident PE professionals with the elements of the work process in the context of PHC including the Actions in the Field of Collective Health and Specific Actions of the Nucleus of Family Health to understand and know how to differentiate both forms of actions.

The present study sought to protect ethical aspects through anonymity, as well as which activities are restricted to one or another Family Health Unit (FHU) and community, ensuring the use of information only for academic purposes, respecting the recommendations of the National Research Ethics Committee.

Results

Table 1 presents the description of the workflow in the health units and what actions were developed in the territories by us, PE professionals of the Multiprofessional Residency Program in Family Health with emphasis on the rural population. As an outcome of this health care process, we perform continuous care, bringing the user as a co-responsible actor in the construction of care, as well as the prescription of physical exercises, referrals and networking for comprehensive care and the execution and evaluation of the care plan.

After the development of this framework reporting the workflow and our interventions as PE professionals residing in the countryside, the theoretical-reflective training cycle begins with the use of materials from scientific literature and dialogue circles with external PE professionals from the Multiprofessional Residency Program in Family Health with emphasis on the rural population.

The first round table of debate brought together PE professionals from the teams of the Expanded NASF-AB in the city of Jaboatão, Pernambuco, who explained their experiences as professionals working in PHC as a NASF-AB and from an analysis of the elements of the work process, they brought the experiences of the

Table 1 – Workflow at NASF-AB health units in the Multiprofessional Residency Program in Family Health with an emphasis on the rural population

Origin of demands	How does this demand arrive?	Conduct adopted	Outcome for health care
Family Health Team (Community Health Agents doctor and nurse)	Home-based services; Territory Demands; Referrals; Matrix-based strategies.	Initial Listening; Reception; Construction of the Care Plan; Health care guidelines; Physical assessment; Indication for Groups.	Continuing service; User co-responsibility; Exercise prescription; referrals; Network articulation; Execution of the care plan.
Multiprofessional Residency in Family Health with emphasis on the Rural Population	Shared service; Shared visits; Nucleus Meetings.		
Through Integrative and Complementary Health Practices	Listening; Territory demand.	Care guidelines; Care/control forms.	Continuing service.
Therapeutic Groups	Listening; Circles of conversation.	Care guidelines;	Continuing service.
Health education	User demand; Waiting rooms.	Action planning; Qualified listening.	Execution and evaluation of the action plan.

NASF-AB = *Núcleos Ampliados de Saúde da Família e Atenção Básica* in Portuguese

construction of flows, actions developed and their elements, which tools were used and how to implement this in the practice of Physical Education in Nucleus specific actions – while PE professional with specific assignments – and actions in the field of Public Health.

The second round table of debate brought the participation of a PE professional and technologist in Sciences and Technologies of the Health Department, who held the debate on the work process, health promotion and physical activity in the context of PHC.

The theoretical-reflective training cycle with the use of materials from the scientific literature and dialogue circles with external PE professionals from the Multiprofessional Residency Program in Family Health with an emphasis on the rural population brought subsidies for the construction and improvement of the planning of our actions as resident PE professionals and the understanding of the elements of the work processes in PHC and the differentiation of the actions of Specific Nucleus and actions of the Field of Collective Health.

Table 2 presents the systematization and understanding of the elements of the work process in PHC

Table 2 – Elements of the work process of the Physical Education professional in Primary Health Care such as agents, means, objects, product, result and purpose

Nucleus activity	Agents	Objects	Means	Products	Results	Purposes
Recyclable toys	Physical Education professional of the Multiprofessional Residency in Family Health with emphasis on the Rural Population.	Children from the Quilombola community of Caluête.	PET bottles, old broom handle, paper, colored pencils, string, glue.	Toy made from recyclable materials.	Construction of a hobby horse.	Show the importance of nature preservation with the recycling of materials that would go to waste. Preservation of popular games. Stimulate children's creativity and observe their motor repertoire.
Popular games	Physical Education professional of the Multiprofessional Residency in Family Health with emphasis on the Rural Population.	Children from the Quilombola community of Caluête.	Soccer field of the Quilombola community of Caluête.	Remember and preserve popular games.	Scavenger hunt and popular games circuits.	Rescue the games passed from generation to generation with the aim of preserving its history and that of the community, in addition to providing a repertoire of body practice and leisure for children with various stimulations.
Cultural groups	Physical Education professional of the Multiprofessional Residency in Family Health with emphasis on the Rural Population. Quilombola communities. Service for coexistence and strengthening of bonds.	Quilombola communities. Caluête, Timbó and Estrela.	Articulation in an intersectoral network and quilombola communities.	Rescue groups for cultural body expressions such as dances, games, games made in their territories.	Formation of groups and carrying out activities to rescue the expressions of body culture.	Rescue the culture of body expression in the territories as a political reaffirmation of being quilombola.
Fitness assessment	Physical Education professional of the Multiprofessional Residency in Family Health with emphasis on the Rural Population and nutritionist.	Quilombola population.	Adipometer; Anthropometric tape; Scale; Laptop.	Body assessment	Percentage of fat mass and lean muscle mass; body mass; stature; movement pattern.	Identify some issues that may have an attention to the promotion of physical activity for weight loss, improvement of quality of life.
Hypertension and diabetes group	Physical Education professional of the Multiprofessional Residency in Family Health with emphasis on the Rural Population and multiprofessional team, NASF-AB Professionals and Family Health Team Professionals.	Registered users in quilombola territories.	Basic Health Units and quilombola associations.	Weekly health education meetings with community members.	Discuss health care, more specifically hypertension and diabetes.	Improvement in the quality of life of users, reduction of injuries and health promotion.
Female group	Physical Education professional of the Multiprofessional Residency in Family Health with emphasis on the Rural Population and multiprofessional team, NASF-AB.	Women from the registered territories.	Familiar Health Unit.	Weekly meetings, physical exercise and dialogue about health.	Adherence of users in health promotion actions to improve women's quality of life.	Discuss about health care; Encouragement to a more physically active life.

NASF-AB = *Núcleos Ampliados de Saúde da Família e Atenção Básica* in Portuguese

regarding the actions of the PE professional nucleus that us, resident PE professionals, obtained after the conclusion of the aforementioned steps, bringing the relevance of the healthcare professional in having ownership of these elements for the construction and planning of health actions in PHC.

Table 3 brings the actions related to the work process in the field of collective health in PHC, listing the multiprofessional actions of us PE professionals resident with the Family Health teams and NASF-AB that tutored us and with our Multiprofessional Team of the Multiprofessional Residency Program in Family Health with emphasis on the rural population.

Discussion

Table 1 shows the flowchart indicating the means by

Table 3 – Elements of the work process in the field of collective health in primary care with agents, means, objects, product, result and purpose

Activity in the field of public health	Agents	Objects	Means	Products	Results	Purpopses
Culture Circles	Health professionals from NASF-AB team; Family Health team and Multiprofessional Residency in Family Health with emphasis on the Rural Population.	Quilombola communities.	FHU space.	Comprehensive health care.	Discussions on health policies aimed at some demands.	Improvement in the quality of life within the principles of SUS as a right to access public health.
Meetings with the municipalities' NASF-AB	Health Department.	Health professionals from the NASF-AB team and team of the Multiprofessional Residency in Family Health with emphasis on the Rural Population.	Health Network spaces for meetings.	Clinical and continuing education meetings.	Discuss some complex cases in the territory.	Discuss and seek solutions to resolve the demands of the territory.
Yes to health, no to COVID-19.	Quilombola Association and Multiprofessional Family Health Residency team with emphasis on the Rural Population.	Quilombola communities.	Linking with networking and social movements.	Masks, water and cleaning products.	Distribution of masks, water in cisterns and cleaning products.	Prevent contagion and give access to water to intensify hygienic-sanitary measures.
Vaccination	Health Department, Quilombola leaders and team of the Multiprofessional Residency in Family Health with an emphasis on the Rural Population.	Quilombola communitites.	CONAQ and quilombola social movements.	Vaccine against COVID-19.	Vaccinate the quilombola population.	Immunization against COVID-19 and preservation of lives.
Team meeting of the Multiprofessional Residency in Family Health with emphasis on the Rural Population	Team of the Multiprofessional Residency in Family Health with emphasis on the Rural Population.	Team of the Multiprofessional Residency in Family Health with emphasis on the rural population.	Basic Health Unit; University of Pernambuco.	Improvement of the work process.	Action planning.	Organize and discuss the work process, build an agenda.
Clinical meeting	Team of the Multiprofessional Residency in Family Health with emphasis on the Rural Population; NASF-AB and FHU professionals.	FHU and NASF-AB/ Multiprofessional Residency in Family Health with emphasis on the Rural Population.	Basic Health Unit; Health Department; University of Pernambuco.	Singular Therapeutic Projects.	Referrals and possibility of care.	Discuss cases of users monitored by NASF/ Multiprofessional Residency Program in Family Health with an emphasis on the rural population and Familiar Health Unit.

Continue…

Continuation of **Table 3 –** Elements of the work process in the field of collective health in primary care with agents, means, objects, product, result and purpose

Activity in the field of public health	Agents	Objects	Means	Products	Results	Purpopses
Health education	Team of the Multiprofessional Residency in Family Health with emphasis on the Rural Population;	Families and Users of the territories.	Bonds with the community/Basic Health Unit Space; Quilombola associations.	Guidance on health and quality of life in view of the demands present in the territories.	Improvement in quality of life.	That users adopt healthier lifestyle habits.
Home-based services	Team of the Multiprofessional Residency in Family Health with emphasis on the Rural Population;	Families and Territory Users; Diabetics; Obese; Hypertensive; patients bedridden at home.	Reception Evaluation Guidance Referral to the Multiprofessional team.	Development of a singular therapeutic project together with families and users.	Improvement in quality of life.	Accomotade the user in an integral way with a multiprofessional vision.
Community awareness for Vaccination against COVID-19	Team of the Multiprofessional Residency in Family Health with an emphasis on the Rural Population and the team.	Users of Quilombola Communities who were resistant to taking the vaccine.	Active search Educational reports, awareness through digital media.	Community immunization.	Population protected from COVID-19.	Community immunization.
Sociogroup	Physical Education professionals +Nutritionist +Psychologist of the Multiprofessional Residency team in Family Health with emphasis on the Rural Population.	Users.	Collective/individual listening and groups.	Weekly meetings, dialogue and physical exercise.	User participation and adherence.	Talk about health, exercise and promote a more physically active life.
Social Technologies to Combat COVID-19	Multiprofessional Residency team in Family Health with emphasis on the Rural Population and Quilombola Community.	Quilombola communities.	popular health education groups about COVID-19, popular care and community defense alternatives to contain the contagion.	Development of Social Technologies of hand washers in the fight against COVID-19.	Installation and use of Social Technologies at points of greater circulation in the communities.	Prevent contagion and intensify hygienic-sanitary measures.

NASF-AB = *Núcleos Ampliados de Saúde da Família e Atenção Básica* in Portuguese; FHU = Family Health Unit; SUS = *Sistema Único de Saúde* in Portuguese, CONAQ = *Coordenação Nacional de Articulação das Comunidades Negras Rurais Quilombolas* in Portuguese.

which the demands reach us, PE professionals of the Multiprofessional Residency Program in Family Health with emphasis on the rural population inserted in the FHU, where we reveal the work processes of the unit, articulate actions and make it possible to identify the "critical nodes" of the unit's operation, in order to seek solutions and better approaches, also configuring it as an important tool to analyze the development of activities[6].

The Family Health instruments used by us, PE professionals of the Multiprofessional Residency Program in Family Health with emphasis on the rural population, as one of the ways to develop comprehensive health care such as home visits, matrix-based strategies, care and shared services and visits, meetings, Grassroots Nucleus Meetings, qualified listening, dialogue circles and the waiting room are strategies present in the Basic Care Notebook of the Family Health Support Center number 39 and were used to identify the main problems and aggravations in the territory, raising a reflection on the causes of the problems listed and the selection of critical nodes, in addition to deliberating key problems to be faced, with the elaboration of intervention strategies to overcome these problems as well as making agreements with the individuals involved in the actions to be implemented[7].

The team of multiprofessional residents of the Multiprofessional Residency Program in Family Health with an emphasis on the rural population, have been playing the role of articulators between the Family Health teams in rural communities and other services

of the health network and intersectoral bodies, favoring the flow of health care, facilitating the coordination and continuity of care in which the NASF-AB team, preceptor of the residents, had structural limits to matrix the demands and understand the specificities of the National Policy for the Comprehensive Health of Rural and Forest Populations in these areas of activity.

This difficulty also slips into access to health for rural and forest populations, where the PNSIPCF reaffirms the universality of health as one of the principles of the SUS through health actions that are inclusive, consolidating the guarantee of access to integral health for these populations, seeking solutions to problems and aggravations related to health and to the work process in rural areas[8].

However, the barriers still existent run through the lack of specific information about the health of these populations, inconsistency in the SUS information systems, the distance and isolation of many communities in the territories registered in the health units, with the latent lack of access to health services and limitations in the training of professionals who work in these territories[8].

Thus, the matrix-based support becomes essential in the workflows at the FHU both in the assistance dimension, with direct care to individuals, as well as in the technical-pedagogical dimension, providing support for the teams, aiming at increasing the possibilities of intervention, bringing with it a new look and comprehension that is established during case discussions, shared care, home visits and understanding of the PNSIPCF[6].

Among the practices used by FHU professionals in rural areas for community care are the Integrative and Complementary Practices in Health (*Práticas Integrativas e Complementares em Saúde*, PICS in portuguese). The use of PICS in PHC resulted in the promotion of comprehensive care to the user as well as an alternative to the biomedical model. The use of PICS in our actions made it possible to build a bond between the professional and the community, allowing non-pharmacological alternatives for the treatment of Chronic Non-Communicable Diseases, rehabilitation in cases of muscle pain, reduction of stress and anxiety, among others[9].

Regarding Table 2, which presents the actions of the PE professional work process at the FHU, one should, among other issues, seek to institute full comprehensiveness of physical and mental care for SUS users. This professional needs creativity and a high degree of autonomy to plan, improvise, have initiative and be able to perform an effective work within the PHC with health promotion actions at individual and collective levels[10].

The physical exercise groups have emerged through the need of the community members of the territory and for the creation of a space for dialogue about health, rescue of their cultures and comprehensive care. As a result, the activities carried out in the groups were aimed at rescuing popular games, dancing, walking, circuit training, mobility and stability exercises, in addition to conversations about healthy eating and food sovereignty, mental health, sedentary behavior, culture, territory and its potential. These spaces provided the creation of bonds and showed the need of the PE professional working together with the FHU [5].

The interventions carried out by us, PE professionals of the Multiprofessional Residency Program in Family Health with emphasis on the rural population in the FHU, showed that the Family Health instruments are used as a means for solving the demands, such as the initial and qualified listening with the user, the receiving of demands and the construction of a care plan**,** guidelines regarding health care, indication for therapeutic groups and planning of actions.

As seen in Table 3, the performance of our team of multiprofessional residents inserted in the FHU permeates the core of action, so that there is comprehensive care to the singularities and collectivities were considered and respected. Therefore, there was a need to use PHC work process tools such as qualified listening, team meetings, case discussions, elaboration of Singular Therapeutic Projects, intersectoral articulations, among other actions[11].

In the midst of the COVID-19 pandemic, our team of multiprofessional residents of the Multiprofessional Residency Program in Family Health with an emphasis on the rural population acted in the guidance and prevention of infection by the virus through health education, operationalization of user registration data, logistics of vaccination points, as well as participation in vaccination against COVID-19 in quilombola communities[12].

The health education actions led by us residents were thought of as a strategy for creating bonds with the community and as a starting point for raising awareness to the importance of vaccination. Health education should be an essential part of health promotion, disease prevention, as well as contributing to the early and effective treatment of diseases, reducing suffering and disability[12].

In the day-to-day work of the FHU teams, it was

possible to observe several times that the process is limited to reaching numerical goals and pre-determined procedures, without due reflection on the quality of the service provided. However, professionals included in the NASF-AB should break this pattern and collaborate for the implementation of qualified actions, increasing the teams' capacity to solve problems and discussing with the teams and service users the determinants of the health-disease process and the possibilities coping with the conditions that lead to illness and death[5].

All actions carried out by our team of multiprofessional residents of the Multiprofessional Residency Program in Family Health with an emphasis on the rural population are within a territory covered by the family health teams, which is also under our responsibility, and in it, actions are structured by shared actions for an interdisciplinary intervention, with exchange of knowledge and mutual responsibilities[5].

It is important to highlight and reflect on the new configuration of the National Primary Care Policy reformulated in 2017, as it presents a new definition of different standards of services offered by PHC, segmentation of access to care with possibilities of recomposing the teams, the disconnection of teams from the territories, the disqualification of the work of Community Health Agents and the reorganization of the work process in PHC, presenting a great risk of lack of assistance for a significant part of the population and loss in the quality of FHU services, especially for those who need assistance the most[13].

Furthermore, given that studies on the subject in the context of rural populations are scarce, the results obtained with this study may help future research and the work process of other PE professionals inserted in the FHU in rural communities, as well as, to collaborate in the understanding of the professionals inserted in the FHU about the performance of the PE professional in the context of the SUS.

Conflict of interest

The authors declare no conflict of interest.

Author Contributions

Lima F contributed to the initial design of the study, data collection and analysis, writing and critical review of the text. Almeida MDSS contributed to the bibliographic research and critical review of the text. Silva NCN, Melo TPG, Silva RM, Santos DL, Francisco LMM and Rodrigues Junior WS contributed to the critical review of the text. Lages I contributed to the initial design of the study and critical review of the text. Lemos EC contributed to the initial design of the study, writing and critical review of the text. The final version of the manuscript has been approved by all named authors.

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