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Application of the SWOT Matrix: work management technology in primary health care

Aplicação da matriz SWOT: tecnologia para a gestão do trabalho na atenção primária à saúde

Aplicación de la matriz SWOT: tecnología para la gestión del trabajo en la atención primaria de la salud

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ABSTRACT

Objective: To analyze, organize and plan the work of a Primary Health Care team by applying the SWOT Matrix. **Method:** This is an action-research, qualitative study carried out in a Health Unit, the production and information record of which comprised 15 participants, representing the fields of teaching, care, management and social control. There were five conversation sessions and the SWOT Matrix tool was used as organization technology. Thematic analysis was used to assess the data. All the ethical measures were taken. **Results:** The application of the SWOT Matrix allowed mapping potentialities, namely: bond and longitudinality, associated with the professionals' time of service, qualified infrastructure, good relationship between team members and users. Rethinking the health production scenario made it possible to identify weaknesses, such as bureaucratization, charging for production, inefficient action planning, political interference, and users' lack of self-care. **Conclusion**: The insertion of the technology was successful, especially because it was conceived based on the perception of local strengths and weaknesses.

Descriptors: Nursing; Primary Health Care; Management Quality Circles; Planning; Technological Development.

RESUMO

Objetivo: Analisar, organizar e planejar o trabalho da equipe da Atenção Primária à Saúde, mediante a aplicação da Matriz SWOT. **Método:** Estudo qualitativo do tipo pesquisa-ação, realizada em uma Unidade de Saúde, cuja produção e registro das informações envolveram representantes do ensino, atenção, gestão e controle social, totalizando 15 participantes. Foram cinco rodas de conversa e utilizou-se a Matriz SWOT como tecnologia para a organização do trabalho. Os dados foram tratados mediante análise temática. **Resultados:** A aplicação da Matriz SWOT permitiu mapear potencialidades: vínculo e longitudinalidade, associados ao tempo de serviço dos profissionais, infraestrutura de qualidade, bom relacionamento entre equipe e com usuários. O repensar acerca do cenário da produção de saúde permitiu identificar fragilidades: burocratização, cobrança por produção, ineficiente planejamento das ações, interferências políticas e falta de autocuidado dos usuários. **Conclusão:** A inserção da tecnologia foi exitosa, especialmente por ser idealizada, a partir da percepção das potencialidades e fragilidades locais.

Descritores: Enfermagem; Atenção Primária à Saúde; Participação nas Decisões; Planejamento; Desenvolvimento Tecnológico.

RESUMEN

Objetivo: Analizar, organizar y planificar el trabajo del equipo de Atención Primaria de la Salud, aplicando la Matriz SWOT. **Método**: Investigación-acción realizada en una Unidad de Salud, cuya producción y registro de información involucró a representantes de educación, atención, gestión y control social, totalizando 15 participantes. Hubo cinco rondas de conversaciones y se utilizó la Matriz SWOT como tecnología para la organización del trabajo. Los datos se procesaron mediante análisis temático. **Resultados**: La aplicación de la Matriz SWOT permitió mapear potencialidades: vínculo y longitudinalidad, asociadas al tiempo de servicio de los profesionales, infraestructura de calidad, buena relación entre el equipo y con los usuarios. El replanteamiento del escenario de producción en salud permitió identificar debilidades: burocratización, cobro por producción, planificación ineficiente de acciones, injerencia política y falta de autocuidado por parte de los usuarios. **Conclusión**: La inserción de la tecnología fue exitosa, especialmente porque se concibió a partir de la percepción de fortalezas y debilidades locales.

Descriptores: Enfermería; Atención Primaria de la Salud; Participación en las Decisiones; Planificación; Desarrollo Tecnológico.

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INTRODUCTION

In the health area, the term technology takes on a range of meanings and covers everything from the construction of products and materials to the development of scientific knowledge, in the search to modify perceived weaknesses in work spaces[1]. It is a concept originating from an association of Greek words, which are connected with the reason for knowing how to do[2]. In the health services and when used in a timely manner, technologies support decision-making processes and qualify care, transcending the assistance focus; thus, communication between the teams and with the users, for example, also operates as a technological device[3].

In Primary Health Care (PHC) services, the manager of the Basic Health Units (BHUs), as well as the professionals from the Family Health Teams (FHTs) or Primary Care Teams (PCTs), uses various tools, which operate as technologies. The daily life of the work in health is often permeated by weaknesses that are commonly repeated in different scenarios, with excess of activities with overload, as well as bureaucratic demands and requirements, reasons generating dissatisfaction at work by health professionals, which can be related to low adherence to the use of technologies[4].

Amidst so many challenges, it is perceived that the incorporation and use of technologies, as organization and planning tools, can be a facilitator for the qualification of the work practices. In line with this, one of the main attributes of PHC is to establish itself as a first-contact service, seeking to solve the priority problems within the territory. Therefore, the inclusion of new social actors and community involvement in moments of discussion, planning and evaluation of the health services is fundamental[5].

To achieve success in work institutions, it is not enough to have the best location and good equipment, it is necessary to combine technologies with planning. Planning is nothing more than carrying out a diagnosis of past and present actions, associated with alternatives to achieve future objectives. From this perspective, the theoretical model known as “SWOT Analysis or Matrix” assists in the creation of a general panorama of the work environment and, therefore, allows for the elaboration of an action plan. The acronym comes from the following terms: Strengths, Weaknesses, Opportunities and Threats, in Brazil also recognized as "*Análise FOFA*", in which the organization's strengths/weaknesses, opportunities/threats in the environment are related[6].

From the idea of health technology, as a set of knowledge and hypotheses that stimulate individuals in the process of thinking and acting, making them protagonists of the actions[1], with this study, the need to sensitize the health team about the introduction of the use of technology to the organization and planning of the team's work emerged, based on the following questions: What are the team's strengths, weaknesses, opportunities and threats, in your work process? How can the SWOT Matrix contribute to work management in a PHC team? The objective of this study was to analyze, organize and plan the work of the Primary Health Care team, by applying the SWOT Matrix.

METHODOLOGY

A qualitative action-research study, developed in a BHU, which has a PCT, located in a municipality in the westernmost area of the state of Santa Catarina (SC), the researcher's workplace. The participatory method mobilized the transformative action of a reality, in which all the actors are involved and are protagonists, including the researcher, in this type of study, being a positive factor to better understand the action context, in addition to fostering the relationship between theory and practice (praxis) and investigating everyday problems[7].

The study participants were representatives from the care (work), management, teaching (University) and social control segments, involved in the production of health in the scope of PHC. The invitation was made at meetings of the team and of the Municipal Health Council (*Conselho Municipal de Saúde*, CMS), after presentation of the research. Of all the subjects present at these meetings and therefore invited, 15 accepted to take part in the study: nine PCT professionals (physician, nurse, and seven nursing technicians), representing the care segment; the manager of the Municipal Health Secretariat (*Secretaria Municipal de Saúde*, SMS) and the director of Primary Care, representing the management; three members of institutions representing health users – CMS – representing social control; and the researcher/mediator, representing the teaching segment, for being, together with the Higher Education Institution, the research proponent. As this is an action-research, it is believed that the

direct involvement of the researcher, as a mediator and member of that health team, did not interfere with the study development, without implications with the proposal and, on the contrary, it was important to meet the method prerogatives[7]. All the participants signed the Free and Informed Consent Form (FICF).

Action-research must be elaborated with the participation of all the individuals or groups involved in the specific problem or situation that is being investigated[7]. In this sense, the involvement of the representative segments of care, management, teaching and social control is also fundamental in processes aimed at pedagogical actions towards the transformation/change of a certain reality in health[8]. Thus, a starting point and a destination were created, allowing the path to be designed by everyone involved in the process, through the exchanges that took place in the conversation circles. The circles consist in the creation of dialogical spaces, in which the subjects express themselves, can listen to themselves and others and, thus, the construction of autonomy is stimulated, through problematization, in which dialog produces a movement of co-responsibility with the work processes[8].

To such end, the following action-research phases were adopted: 1) Exploratory phase: it defines the theme and elaborates a diagnosis that gathers information and identifies possible problems to be worked on; 2) Problematization: identification of the problems that can be modified; 3) Integrating Seminars, which sensitize and encourage the group to reflect and make decisions; 4) Disclosure of the Results, which foresaw, in addition to return to the group, to publicize the results[7].

To develop the study and produce the diverse information, five meetings were held, in the form of conversation circles. This movement took place between May and October 2019, in the BHU meeting room, lasting one hour and with a mean of 12 participants per meeting. This study will present and analyze the data produced in the second meeting, in which the SWOT Matrix was applied. This tool is frequently used in order to assist people and companies in identifying their strengths and weaknesses, and therefore plan their project-actions[6]. The movement is characterized as a pedagogical practice, as it implies collective reflection on the problems and potential of people and of the institution, with a search for change possibilities[6,8].

During the conversation circle, for the phase of problematizing the points highlighted by the participants, the themes generated in the previous round were resumed to continue the discussion. A specific way of reflection was proposed to the participants, through the construction of a SWOT Matrix, on brown paper, in which strengths and weaknesses were recorded, such as internal factors (controllable by people) and opportunities and threats, as external to the institution (uncontrollable).

Figure 1 - Illustration of the SWOT Matrix

	Positive factors	Negative factors
External factors	S – *Strengths*	W – *Weaknesses*
Internal factors	O – *Opportunities*	T – *Threats*

Source: Adapted by the authors (2020).

The information generated in the conversation circles was recorded and transcribed. It was later subjected to thematic analysis[9]. The reference used for the analysis was the theoretical-philosophical framework guiding the SUS. A pre-analysis of the material produced was performed, starting with the floating reading of the transcripts of the statements, in order to constitute the information corpus. Subsequently, the exploratory phase was initiated, which resulted in the first coding to reach the cores of understanding/meaning of the text. Finally, the text was clipped into registration units, which gave rise to categories. The following categories will be presented in this manuscript: “Scenario diagnosis from the application of the SWOT Matrix” through the following dimensions: strengths, opportunities, weaknesses and threats and “Assessing the work and the change possibilities, through the use of the SWOT Matrix”.

The research observed the ethical precepts required by Resolution No. 466/12 of the National Health Council (*Conselho Nacional de Saúde*, CNS) for research studies conducted with human beings. It was submitted to and approved by the local Committee of Ethics in Research involving human

beings and by the health manager of the participating municipality. Approval was under opinion number 3,140,187/2019 and CAAE 03338918.4.0000.0118. To preserve the participants' anonymity, they were identified by the the letter "P" (Participants) and by the letter representing their respective segment: A – *Atenção* (Care), E – *Ensino* (Teaching), G – *Gestão* (Management), and CS – *Controle Social* (Social Control), followed by the order number.

RESULTS AND DISCUSSION

Participants' profiles

Figure 2 presents an overview of the study participants' characterization/profiles, the different segments involved, time of experience and other relevant characteristics in action-research that imply the pedagogical movement[8].

Figure 2 - Characterization of the participants: segment represented, number in each segment, gender, age and time working in the Unit.

Segments represented by the participants				
	Social Control	Management in Health	Care	Teaching
Gender	Three female	1(one) female 1(one) male	Seven female Two male	Female
Age	(40-49) 1(one) person (50-59) 1(one) person (60-69) 1(one) person	(40-49) 1(one) person (50-59) 1(one) person	(30-39) four people (40-49) two people (50-59) three people	(30-39 years old)
Time working in the health area	Does not apply	(>1 year) 1(one) person (5-10 years) 1(one) person	(Four years) 1(one) person (Five-10 years) six people (>10 years) two people	(<10 years)
Number of participants per segment	Three users	1(one) municipal manager 1(one) PHC coordinator	1(one) physician 1(one) nurse, seven nursing technicians	1(one) MS student

Source: The authors (2020).

The action scenario reflects the profile of the health sector, in which female participation is prevalent; the author who assessed the profile of physicians and nurses who work in the Zona da Mata region in the State of Minas Gerais found that 83.8% of the nurses are female, while 53.3% are female in the medical professional category[16].

The profile of the representatives of the care segment reveals a minimum working time condition above three years, a mean of sufficient time, when considering the prescription of the National Policy for Primary Care (*Política Nacional de Atenção Básica*, PNAB)[10] on the recognition of the territory and bonding with the users and the community. As the BHU is the gateway to the health services, valuing interpersonal relationships and fostering bonds are important means to achieve the attributes of PHC[11].

Also on the working time of the professionals, it is worth noting that this factor is fundamental since, among the essential attributes that guide health actions, care longitudinality and integrality are important and are directly linked to the service time of the professionals, considering that it refers to the continuous monitoring of the patient, over time, and directly interferes with quality of care[12].

As for the professionals who represented the management, one of them had already worked as a health manager at another point in his career and has been active again for three years, with an estimated time of 6-10 years in this function, although without training in health. The other representative of this segment has higher education in the health area, has been the director for less than a year and is undergoing her first experience in this role. Both management representatives were hired via a political/commissioned nomination position. In this sense, the literature makes a critical analysis of the fact that management positions, in a large part of the Brazilian reality, are constituted as a function of political trust and/or indication[13].

The participants representing social control took part for the first time in a survey with different segments involved, although they had already been involved in other movements with social representation, such as CMS, Municipal Conferences, and public hearings. In other studies, it is evidenced that the incipient representation of

social control, in decision-making instances in the health area, can interfere negatively, given its relationship in recognizing the particular demands of the communities. Although participation is a right guaranteed by law in Brazil, through an action called social control, exercised especially in management councils, it is still not effectively practiced[14-15].

Scenario diagnosis from the application of the SWOT Matrix

The conversation circle was the space in which the participants reported their impressions about that health-producing scenario, mapping the problems and potentialities observed, which can interfere in their daily work and in the quality of the services offered. The participants expressed their impressions about the work process, with a productive dialog, despite the differences, and therefore constructive. The group's heterogeneity enriches dialog and enables the exercise of democracy, even if there is divergence of opinions. Critical perceptions turn the subjects involved into protagonists of the process, enhancing the result of the movement, through the different segments represented there[8,14]. It is considered that there are few research studies that contribute the benefit of qualification in the service, which can be identified in the exercise of the analysis of the work process itself, especially when mediated by planning tools and/or evaluation of the context in which the health teams work.

Based on the reality of the work of the health team at the BHU and their impressions, the most relevant aspects in each subdivision of the constructed Matrix will be presented below.

Strengths

The first group to make their explanation was the representative of the "strengths" category, who explained to the other circle participants his reflection on the team's internal potentialities, related to this category. He highlighted the union between teammates and good communication between professionals and users as positive aspects:

"The unity of the team, I think we are organized and united to develop our activities" (P14/A).

"Clear and unified communication, communication between the patients and the team as well, let's say 'everyone speaks the same language'" (P14/A).

"[...] I feel very comfortable, well informed, if I need information" (P2/CS).

"In this day-to-day rush, people no longer have time to talk, this is missed by a lot of people" (P5/CS).

"Dialog, because sometimes, just with a brief conversation with a person, you no longer [...] need to be in a meeting, just a conversation" (P8/A).

Union and good communication between people who work in the same place is the result of a continuous interpersonal interaction that favors the construction of a bond, through a relationship of trust and empathy between those involved. This behavior is a good ally of care and can be understood as an organizational practice in the workplace[11].

The testimonies show that the team's good rapport favors bonding in the relationships, with an emphasis on the proximity of the care providers to each other and between them and the service users. They show concern and involvement in the broad aspects that are directly or indirectly related to health.

"I think that even the bond with the user, this issue of Doctor X, the concern is because he is close, he has a bond, he cares effectively" (P6/E).

"This, when we visit new families for registration, you are faced with a shocking reality [...] So, sometimes, it's a mother who doesn't have a husband anymore, who has to take care of the child, who can't work, can't study; this creates other problems, because it's a child who won't have a good education maybe, or can't have a good family structure and then she'll know how she will be as a teenager or not" (P9/A).

In this sense, it is worth noting the work carried out by the community health agents (CHAs), who constitute an important link between the community and other team members, considering that they know the life reality and health of their users. In a work permeated by welcoming and bonding, the CHA visits favor the identification of problems, jointly seeking possible solutions, being considered as mediators of the relationships[17].

"[...] we donate, we always want to do the best we can [...]" (P1/A).

"Very comfortable talking about the issues, we [users] realize this in you [professionals] [...] the health agents are committed [...] to what we don't have access to, to what don't know, we are very close to the health agent" (P2/CS).

The participants' testimonies follow the valuation of the collaborative and interprofessional practices, which have been identified as potentiating the resoluteness of teamwork, care integrality and, according to some excerpts, the strengthening of bonds, thus being a force indirectly mapped in the study[18].

Regarding the service time, it is observed that the turnover of professionals can negatively interfere in the longitudinality of the care actions and becomes an unfavorable factor in the organizational configuration[19]. In this sense, the working time of the team professionals participating in the study, in the same place, can be a positive aspect, regarding the construction of the bond between colleagues and with their users, contributing to the smooth running of the health actions and services.

"I think that an important thing about health agents is their working time here, years that you work here, and you see people coming and going and you are always the same" (P7/G).

The statements presented above corroborate the literature, as the bond assumes multiple functions in the health services, from organization, co-responsibility in providing care, building relationships of attention, listening, affection and trust; towards comprehensive care, in addition to focusing on the health and disease process, as a facilitator in the therapeutic relationships[10].

Communication, previously discussed, returns to the debate, associated with the use of information technologies, such as telephones, the Internet and other applications, such as WhatsApp. The group highlighted good communication and planning as important elements:

"[...] you need to communicate with the patient, because there was a change in some exam, you now have a very easy connection, you have a health agent, you have the technology" (P3/G).

"Me too, any doubt I have I call [P12/A] and send them a WhatsApp" (P5/CS).

"[...] team planning is also a force to improve care, improve a lot [...]" (P14/A).

"The use of technology we synthesized, today technology is working in our favor [...]" (P3/G).

With technological evolution, traditional methods of communication are replaced by different technologies, as a possibility to establish dialog between FHT members and other PHC professionals or with users[20].

Planning can be understood as a technology that is constructed and applied, in order to attain certain objective; when present, it is associated with improvements in the management of the health services. It can be configured as a tool, whose most important product is the path taken, collectively, with the involvement of people directly interested in the reality that one wishes to transform. The quality of planning can be directly associated with the involvement of multiple individuals, respecting people's rights[21]. Planning in public health has a long trajectory, based, above all, on communicative action, collectively seeking to build and assume commitments that lead to the expected purposes, guaranteeing autonomy in the interventions in a way that can relate assessment and planning[22].

The testimonies show planning as one of the strengths in the team's ideology, although with a need for improvement, especially regarding the use of protocols, which reveals certain concern:

"[...] we need, within our planning and organization that is still flawed today, to create this routine. We need to have this moment to think about this, to reflect and build this material together [...]" (P6/E).

"But, then, we can focus more on this, right, let's do it between us, the team, everyone sit down and speak the same language, put this into practice!" (P1/A).

"[...] in a work practice, where we are putting out fires every day, working with free demand, which is not the main objective of the BHU, how are we going to organize and plan our services so that we have these moments for this, these spaces?" (P6/E).

"The protocols that streamline and qualify [...] the protocols give us opportunities to develop things in the unit" (P14/A).

"[...] the protocols are already developed, people who, sometimes, in the flow of assisting, assisting, assisting, we leave this perspective, that's why this stop moment is so important [...]" (P15/A).

In this perspective, the protocols, remembered by the professionals as ancillary tools in planning, are configured as relevant instruments that assist in the organization of thought and of the care process, their importance being equal to human, physical and material resources, being indispensable for the development of the work in health[23].

The findings confirm that health planning as a tool that strengthens the teams' work; however, technological devices that can mediate its execution, as well as continuing education activities on the subject, are forces that need to be inserted more strongly in this context.

Opportunities

Regarding the "opportunities" dimension, the participants recognize the following: the way in which the BHUs territory is distributed; spaces for popular participation in health decisions, such as municipal conferences; the universalization of services; investments in physical structure, supplies and medications; the use of protocols and, finally, the possibility of training courses/permanent education.

"So, redistribution [planning carried out recently by the SMS for better organization with the redistribution of the population in each BHU] was, is and will be an opportunity for support, from the municipal government, the Secretariat, the teams, the Municipal Health Council, the Municipal Conference" (P14/A).

"The expanded and equipped Units, which have everything, provide comfort for patients, care" (P14/A).

"It can even go into the issue of resources [...] to invest in structure, which I think we have a good physical structure, compared to many municipalities" (P6/E).

"[...] today we have a very broad line of medications and the major concern is within that line that everyone knows exists, which is the list of medications, it has to be there always, it can't be missing [...]" (P3/G).

The defined territory and the organization of services in the BHU are perceived as an opportunity to improve health actions, based on the local needs and particularities with the support of the CMS, which regulates and optimizes popular participation in the decisions. The ideal of territorialization goes beyond bureaucratic and geographical issues; it follows the need to understand space, life and the needs that are presented there[24].

In the participants'(P14/A, P6/E and P3/G) testimonies, it is possible to perceive the positive recognition about the physical structure and materials of the BHU, which guarantees the minimum necessary for professionals to do what is their competence. This local reality is a privilege, considering that a recent study showed that a large part of the BHUs does not have minimum structural conditions, hindering medical, nursing and dental appointment, as well as dispensing of medications and vaccines[12].

One of the highlighted elements, although with less emphasis (only one participant) among the opportunities, is related to the Permanent Education in Health (PHE) movements, made possible, even at a distance, such as through Telehealth:

"[...] the opportunities would also be the issue of the free courses, we have through Telehealth and have several linked websites that professionals who are registered as professionals linked to the National Register of Health Establishments [Cadastro Nacional de Estabelecimentos de Saúde, CNES] [...] is also an opportunity for improvement" (P6/E).

PHE is associated with positive changes in the care to users and in the daily work of the professionals working in a BHU. The users' participation as co-responsible for their own health-disease process is highlighted. When this movement becomes possible, the work provides learning, with joint construction of knowledge[8].

The BHU presents itself as a meeting place between the different social actors involved in the production of health: professionals, users, managers and the community, configuring itself as a generating space for pedagogical movements, in which collective construction of knowledge can occur through team meetings and case studies, as a way to exercise democratic and participatory co-management[25]. Other spaces, such as the CLS, CMS and Health Conferences, also encourage and guarantee popular participation in health decisions[5]. In this sense, the participants point to some strength elements:

"[...] the universal is everyone, it no longer exists: "Oh because I was a friend of the secretary or the politician asked, will you get some help to pay for an exam abroad, right?" What is universal,

what is for one is for everyone, access is effectively equal" (P3/G).

"Meeting can be considered a [PHE] strategy" (P6/E).

"[...] the Conferences are of three spheres, we had the Municipal Conferences, last week the State Conference and now in August the National Conference, so this is the right moment for the proposals that the municipalities had to be discussed at the state level, selected and classified which are priority [...] it is the right moment for popular opinion to reach the governmental sphere" (P3/G).

The involvement between the care and social control segments can be transformative in building relationships and promoting health. In Brazil, this right of the users to participate in health decisions is guaranteed by law; the aim is that, with these spaces, different social actors are involved in dialogs, decision-making and also in the sharing of responsibilities[14].

Thus, the spaces for social participation and qualification in the service are confirmed as a locus of opportunities, to qualify the work of the PHC teams, in which dialog and rescue of the health actions focus are potentially strengthened, thus contributing to a better direction of the work process, observing both managerial and care needs.

Weaknesses

The second group was asked to reflect on the possible weaknesses and threats that can interfere in the health team's work. The weaknesses refer to internal factors, those that the group can change. The group presented some that are directly related to work demand, such as: mental exhaustion; failures in the structure and lack of material resources for assistance; excessive demands on productivity and users' failures with self-care.

"[...] the issue of the professionals' mental and physical exhaustion, remembering the Burnout Syndrome. But, what is this daily exhaustion, the demands that come, the issue of lack of motivation, suddenly the quality of the service itself decreases a little, precisely because of this difficulty for the professional to work" (P15/A).

"[...] sometimes, a weakness is the demand for numbers, we put it as a weakness, because these are issues that can be improved, it depends a lot on us professionals as well as colleagues helping each other [...]" (P15/A).

A study that addresses the dissatisfaction of health professionals at work shows the lack of material resources and inefficient physical structure, as well as the user's posture, management failures, and relates the increased workload to the workers' wear out and illness[4]. Another perception of the participants was related to lack of self-care in the population:

[...] lack of self-care, mainly of the population, which, at times, lack of family planning, lack of care with their diet, sedentary lifestyle, so this generates many diseases for which the population comes to the clinic for an answer that, sometimes is not here, and cultural issues, which we gave as an example, alcoholism, which is very cultural, we have several problems triggered because of this, but we still need to work on this (P15/A).

A number of studies by a group of researchers have signaled an increase in the workloads of the FHTs in Brazil, as a result of elements that, unfortunately, have typified the teams' work process, including those related to the working conditions, especially the structures of the Units and the lack of supplies in quantity and quality, the high work demand required and the various managerial problems and the users' health conditions, which result in wear out, dissatisfaction and even illness in the professionals[26-27].

Threats

In the "threats" dimension, important notes emerged, such as: micro- and macro-political interference, bureaucratization of the health services and seasonal diseases.

"[...] threats then would be those factors that we wouldn't be able to control, we commented on the political changes in the three spheres, it is noticeable because each government changes the focus a little, we already have a work routine and it ends up, sometimes, having to change [...] this, not only municipal, but state and federal [...]" (P9/A).

Policy interference, whether at the municipal, state or federal instances, is part of the daily work of the health professionals and can also be a decisive factor in the implementation of public policies, adherence to programs, contracts and purchases; in short, it can define and redefine the scenario, according to skills and powers and, in this

way, improve or not the working and health conditions of the population, according to the knowledge and goodwill of the managers involved[4].

"The legislation, bureaucracy [...] you have to open a notice, I don't know what it is, it takes how long, five, six months. For the person who wants care, they want it today, they don't want it in six months, so everything that is our daily life [...]" (P9/A).

"The seasonal diseases, we have the example that we are not free from an epidemic here, as we had in neighboring cities, it could be dengue, it could be the flu, there were some measles cases in Rio Grande do Sul, so they are diseases that are sometimes difficult to control [...]" (P9/A).

The growing bureaucracy is a worrying factor in PHC, which requires more and more dedication and can result in lack of time for the development of activities directly aimed at care. With this legal obligation, the development of promotion and prevention actions can be hampered, significantly compromising quality of care and other attributes of this care level[11].

Threats deal with external factors, which will not always have a solution or will be foreseen by us, as the participant (P9/A) reports about seasonal diseases and the possibility of epidemics. Normally, these issues are related to different factors, such as environmental, cultural, economic and political factors, as well as those pertaining to the quality of the health services. In line with this, epidemiological surveillance has made important advances in Brazil in recent years and continues with this challenge, after all, new diseases often arise[28].

In this sense, the statements above represent the concern of the health service workers about the difficulties they perceive, related to the excess demand and the growing bureaucratization of the services (use of computerized systems, modification of this system and the way to fill it out by the professionals, which requires more time) and uncertainties related to management and public administration positions. Together, the threats are also part of the uncertainties in the teams' work process, which hinder work and bring insecurities for the teams.

Assessing the work and the change possibilities, through the use of the SWOT Matrix

The use of the SWOT Matrix, as an inciting praxis tool, seems to have provided an enriching experience for the participants. From the dialogs held during the conversation circles, situations and testimonies emerged, in addition to the idealized proposal, expressed as potentialities for the management of the PHC work: the users' admiration towards the professionals, the recognition of the adequate care provided, the leading role of the community agent in the enrolled community and the good relationship among the multidisciplinary team members:

"[...] it's admirable, I think it's out there, there are several positive things, I feel very happy to live here in a neighborhood with all this capacity for assistance that we have in relation to health. I'm happy for that, I know there's always a lot that we can improve and evolve, but we have to see this" (P2/CS).

"The health agents are committed. Effectiveness in their work [...]" (P2/CS).

"I think it's the good relationship of your team, I think it would be a potentiality, that it's a team which gets along well, that has affection for each other, that respects each other, I think it's one of the strengths here in this team" (P7/G).

Collaboration between the health team is related to collective work to improve health care. Thus, interprofessionality concerns the negotiation of decision-making processes and the construction of common objectives, directed to the users' needs. In the care and management of the health services and of Brazilian public health, collaborative practices are consistent with meeting health needs, in the context of the Unified Health System (*Sistema Único de Saúde*, SUS), with resoluteness and quality. Interprofessional work (in addition to teamwork) allows us to operate with areas/professions which meet and constitute unique knowledge. By moving across these specific areas, in a collaborative manner, it is possible to qualify the health practices[25].

The representatives of the social control segment, in the development of the circles, expressed their point of view about the health service offered by the BHU and also about the professionals' behavior, perceived by them, which involve health actions:

"[...] you arrive here and you're always seen [...] sometimes you don't get the appointment for that day, but you don't wait, we feel important when you arrive, there is a human being there and

this is transmitted [to the user] when you arrive" (P2/CS).

"I think this is the best point, because many people sometimes come from their homes, all that's left is to die, right, come here and if you are poorly assisted, the situation worsens, and if you are well assisted [...] go home calmly, happy in life, so, the service I think is essential" (P5/CS).

"I'm sure it's step by step, the work you're doing is extremely important, the anguish I felt in the doctor's testimony, but if he didn't talk, he could just take it and prescribe it, not worrying that the exercise, he could say: 'This is it for here and now', as there are many [...]" (P2/CS).

The aforementioned reports show the users' recognition about welcoming and qualified listening, carried out by the health team, which largely meets the health needs of people who seek the service, evaluating priorities and seeking resolute care. With such a perspective, the bond between team professionals and users allows for the construction of trust, capable of stimulating self-care and favoring understanding of the disease and the development of therapeutic strategies. As well as welcoming, bonding is another technology associated with care humanization, which does not exist without users being recognized as subjects, expanding the effectiveness of actions and favoring participation during care[11].

The group also pointed out a diagnosis of their perceptions about the weaknesses common to the team of professionals and to the users. In relation to the professionals, associated with insufficient planning and organization regarding time is lack of articulation with management. In time, it referred to specific vulnerabilities of people who inhabit that territory, such as lack of family planning, sedentary lifestyle, little opportunity for group dialog:

"[...] visit day is visit day, not prescription day or procedure day, the staff have to leave the Units. Oh, there's no time, it really accumulates, there's a lot, there's a lot of patients, how are we going to do it?" (P7/G).

"Suddenly you'll have to pick it up and go there, to the Secretariat and get the car, you'll have to go to social assistance, you'll have to go somewhere else, you'll have to go to the guardianship council, you'll have to go to school, then everything passes through you [professionals]" (P7/G).

"[...] lack of family planning among the families, which I think is a huge problem, which generates other problems [...] sedentary lifestyle, this is a triggered problem, no one does anything, no one does physical activity, I say so every day [...]" (P9/A).

"In this day-to-day rush, people don't have time to talk, that's missed by a lot of people" (P5/CS).

The testimonies point out specific weaknesses of that population and place, which were highlighted after the local diagnosis, built during the conversation circles. In this sense, in addition to signaling the weaknesses and strengths, the dialog evolved into some proposals, with a view to solving operational issues:

"[...] bringing education and health closer together, the two secretariats, suddenly it's not even up to you [the team] that much, but taking it forward, at a higher level for this to happen [...]" (P2/CS).

"It's to bring points like this: today we're going to discuss Maria's family, so-and-so, that happened, she became a widow, she has four children, you're going to discuss her as a case study, and from that moment you'll then draw the objectives, as you're doing" (P7/G).

"Information is very important, people have to be informed of what is happening, and with that too, it will help people to see better the work of the health center, which is not just coming here to consult, to get medication [...]" (P5/CS).

"But then we can focus more on that, right, let's do it between us, the team, sit down and let everyone speak the same language and put this into practice" (P1/CS).

Some relevant suggestions are highlighted, such as intensifying preventive actions in education, health and intersectoral actions, with articulation with the Education Secretariat, for example. Discussion of cases among the team was also highlighted as a possibility for managing teamwork. Finally, the participants again share that good communication is essential for this interprofessional work management[8,14,25].

The research itinerary made important moves possible, which later originated the following: implementation of technologies to facilitate the planning and organization of the work developed by the BHU team; creation of the first toy library, inside a BHU in the city, thinking about

qualifying welcoming; construction of an Education in Health script for schoolchildren, with the purpose of expanding the scope of educational and preventive health actions; improvement of the professionals' schedules, in order to guarantee spaces for home visits, expanded clinic and meetings.

FINAL CONSIDERATIONS

In order to be as assertive as possible in the construction of a situational diagnosis of the work environment, the SWOT Intervention Matrix was applied as a guiding tool. By “placing in the circle” four segments – management, care, teaching and social control – in an interaction process based on action and on reality, it was possible to make changes, mobilize paths, summon leading roles and detect the movement of individuals, in a scenario of knowledge and technological inventions. This is because a dialogical space that seeks permanent education and work transformation requires horizontality and, therefore, dispenses with representation and participation, as basic constituents, in this democratic process.

The experience of using the SWOT Matrix was important to understand the context of the team's work, identify strengths/weaknesses, opportunities/threats, establish an information base and outline coping strategies for the problems, together with the planning of future actions, through collective discussions about the services provided in that health-producing space. The conversation circles and the application of the tool were propellers of the expansion of the bond between those involved and gave rise to other technologies, which have already been implemented and are still in use, such as: a toy library in the BHU and an articulated roadmap for education in health for schoolchildren.

With the development of the SWOT Matrix, the participants recognized potentialities, such as: good relationship and communication among the team members and between the team and the users, bond and care longitudinality, quality infrastructure and popular participation, among others. They identified the weaknesses that can interfere with the health practices, such as the growing bureaucratization of the services, micro- and macro-political interference, charge for production, mental exhaustion; and some related to the enrolled population, such as lack of self-care and unsatisfactory family planning, among others.

As study limitations, there is the scarce participation and representation of some segments, such as social control, represented by the CMS members. On the other hand, Nursing remains markedly involved in the management and education in health processes. The lack of periodicity in actions of this nature is highlighted, in order to promote a process of permanent improvement of the team. In this sense, it is opportune for managers, health professionals and the community to rethink the management of work in Family Health, through planning with the use of technologies such as the SWOT Matrix.

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