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PROFESSIONAL PRACTICE OF NURSES IN PRIMARY HEALTH CARE: CHALLENGES AND OPPORTUNITIES FOR AUTONOMY

PRÁTICA PROFISSIONAL DE ENFERMEIROS NA ATENÇÃO PRIMÁRIA À SAÚDE: DESAFIOS E POTENCIALIDADES PARA A AUTONOMIA

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RESUMO

Objetivo: Descrever as ações desempenhadas por enfermeiros e compreender suas percepções acerca da autonomia na atenção primária à saúde (APS). **Método:** Estudo qualitativo, exploratório, de casos múltiplos, com sete enfermeiros de Unidades Básicas de Saúde com e sem Estratégia Saúde da Família, em Goiânia. As entrevistas on-line, realizadas entre janeiro e junho de 2021, foram transcritas e analisadas por quatro pesquisadores mediante análise de conteúdo. **Resultados:** Mapearam-se 55 ações desenvolvidas pelos enfermeiros, agrupadas em três eixos: assistência individual ao usuário, atividades coletivas e ações de gestão. Duas categorias analíticas expressaram a autonomia profissional: "Condições de trabalho dos enfermeiros na APS" e "Prática profissional dos enfermeiros na APS". **Conclusão:** A autonomia do enfermeiro é moldada pela organização do processo de trabalho e pela disponibilidade de recursos humanos, materiais, físicos e informacionais. Escopo de prática, nitidez de papéis e limites institucionais condicionam a concretização da prática profissional.

Descritores: Autonomia Profissional; Enfermeiros de Saúde da Família; Atenção Primária à Saúde; Atenção à Saúde; Estratégia Saúde da Família.

ABSTRACT

Objective: To describe the actions performed by nurses and understand their perceptions of autonomy in primary health care (PHC). **Method:** A qualitative, exploratory, multiple-case study was conducted with seven nurses from Basic Health Units, both with and without the Family Health Strategy, in Goiânia, Brazil. Online interviews were conducted between January and June 2021, transcribed, and analyzed by four researchers using content analysis. **Results:** A total of 55 actions performed by nurses were mapped and grouped into three categories: individual care, collective activities, and management actions. Two analytical categories reflected professional autonomy: "Working Conditions of Nurses in PHC" and "Professional Practice of Nurses in PHC." **Conclusion:** Nurses' autonomy is shaped by the organization of work processes and the availability of human, material, physical, and informational resources. The scope of practice, clarity of roles, and institutional boundaries determine the realization of professional practice.

Descriptors: Professional Autonomy; Family Health Nurses; Primary Health Care; Health Care; Family Health Strategy.

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What is already known:

- Nursing plays a central role in PHC, with essential functions in health promotion, disease prevention, and longitudinal care.
- Nurses' autonomy is influenced by federal, state, and municipal legislation and protocols, affecting both clinical and managerial practice.
- Despite regulatory support, limitations and heterogeneity persist in implementing autonomous practices across different local contexts.

What this article adds:

- Clear institutional protocols and precise role definitions strengthen nurses' autonomy in PHC.
- Inadequate infrastructure, scarcity of resources, and limited organizational support are barriers to autonomous practice.
- Analyzing factors that influence autonomy provides insights for management decisions aimed at improving nurses' working conditions.

INTRODUCTION

Nursing holds a strategic position in primary health care (PHC) and within the Health Care Network (HCN), focusing on health promotion, disease prevention, and comprehensive population care[1]. In Brazil, PHC within the Unified Health System (SUS) is structured around multiprofessional work, where nurses play a central role in ensuring access and continuity of care[2]. In several countries, the scope of these responsibilities is linked to the degree of professional autonomy, which depends on institutional support, proper training, and a collaborative culture[3-5].

Autonomy is defined as the ability to make independent decisions without external coercion[6]. In the professional context, it implies the freedom to innovate, solve problems, and organize work according to one's own criteria[7]. In nursing, it translates into self-governed practice, supported by clinical and managerial decisions aligned with the ethical and legal boundaries of the profession[3].

Despite Brazilian regulation (Law No. 7.498/86) and specific guidelines for PHC practice[2], the degree of nurses' autonomy varies across services, even within the same level of care. This heterogeneity can create barriers to workflow and compromise problem-solving capacity. Although the National Primary Care Policy (PNAB) includes responsibilities such as nursing consultations, clinical and educational activities, procedures, ordering tests, prescribing medications, and making referrals[2], greater standardization is still needed to ensure safety, access, and quality. The lack of uniformity in the scope of practice imposes limitations, particularly regarding the ordering of imaging exams and the prescription of certain medications[8].

Nurses' practice in PHC is guided by legally supported clinical protocols that structure and direct care. However, professionals' perceptions vary between recognizing autonomy within these protocols and perceiving that such instruments also impose restrictions — even when there is room for decisions based on clinical judgment and focused on problem-solving[9].

Because of the organizational diversity of PHC in Brazil, analyzing nursing practice through the lens of autonomy is essential to understand daily challenges and improve practices. In Goiânia, a city operating within a decentralized system supported by a specific nursing protocol for PHC[10], this discussion is particularly relevant. Therefore, this study aimed to describe the actions performed by nurses and understand their perceptions of autonomy in PHC.

METHOD

Study design

Qualitative study using a multiple-case design, appropriate for capturing reality from different perspectives of nurses working in PHC services[11]. Because of the existence of a state nursing protocol for PHC in Goiás[10] — grounded in best practices and current regulations — we assumed the presence of professional autonomy, albeit with limitations. Reporting follows the Consolidated Criteria for Reporting Qualitative Research[12].

Setting and sample

The study was conducted in Goiânia (population 1,437,366)[13]. The local PHC network comprises 21 traditional health centers and 53 Family Health Strategy (FHS) units, distributed across seven health districts under direct municipal management[14]. According to the National Registry of Health Facilities (CNES), 306 nurses work in municipal PHC, assigned to health centers and Family Health teams (FHt).

The sample included nurses based in units that necessarily had physicians and other nurses on the team, both in health centers and in FHS units. Selection used simple random sampling from the CNES nominal list of nurses, with cluster sampling to ensure at least one participant per health district and to include both service types. The sample size was defined a priori and, during data collection, complementarity and repetition of information were observed[15]. The final sample comprised seven nurses: three from health centers and four from FHS units.

Procedures

The study was performed in 2021 in three stages: i) definition and planning; ii) preparation and data collection; and iii) analysis and conclusion[11].

In planning, we specified the guiding hypothesis regarding nurses' autonomy in PHC, defined the cases, and established the data-collection protocol. We developed a semi-structured interview guide covering actions and procedures performed, groups served, and perceptions of the impact of the COVID-19 pandemic, given the collection context. The instrument was produced by a network of researchers experienced in the topic.

For data collection, the interviews constituted the study cases. Initial contact was made with managers via CNES phone numbers, who indicated potential nurse participants. Beyond invitation, disclosure of objectives, and scheduling, no additional recruitment strategies were used. Interviews were conducted online (Google Meet), lasted 10–20 minutes, and were led by two master's-level nurses (GOS and FSO) with PHC experience. The team received specific training and support materials. Twelve professionals were invited; seven accepted and five were unavailable. Interviews were held during business hours. Participants were

asked to be in a private setting without third parties to ensure confidentiality and to keep their cameras on. Recordings were transcribed in Microsoft Word and returned to participants for review; all agreed with the content. Transcripts were then analyzed case by case by a panel of four researchers, who produced reports with initial codes representing perceptions.

We applied Bardin's thematic content analysis[16] in three movements: i) pre-analysis; ii) exploration of the material; and iii) treatment and interpretation. In pre-analysis, we conducted exhaustive reading to identify meaning units related to professional practice and autonomy. During exploration and treatment, these units were organized into thematic categories that expressed essential aspects of the phenomenon. Interpretation discussed the findings in light of the framework that supported the emergent themes[17]. Discrepancies were debated by the team until consensus. For this stage, three meetings were held to discuss the key points from each interview.

Ethical considerations

The study was approved by the Research Ethics Committee of the Faculty of Health Sciences, Universidade de Brasília (CAAE no. 20814619.2.0000.0030). Participation was voluntary and contingent on reading and signing an informed consent form, in accordance with Resolution No. 466/2012 and other applicable regulations. Anonymity was ensured through alphanumeric codes, identifying each participant by the letter "N" followed by an Arabic numeral corresponding to the interview order.

RESULTS

Profile of nurses and actions performed in PHC

Seven nurses participated in the study (six women and one man), with a mean age of 51.14 years. Five graduated from private institutions and two from public institutions. The mean length of PHC experience was 16.6 ± 6.2 years. Household income ranged from BRL 7,000 to BRL 20,000. Participants were distributed across different municipal health units, with no more than one interviewee per service.

Analysis of the interviews identified 55 actions performed by nurses, grouped into three domains: i) individual user care; ii) group activities; and iii) management actions. Chart 1 summarizes these actions and shows how they were distributed across participants.

Professional practice and nurses' autonomy in PHC

The content analysis of the interviews revealed four thematic axes that influence nurses' autonomy in day-to-day care. These axes were grouped into two categories that synthesize practice in PHC: i) nurses' working conditions and ii) nurses' professional practice (Figure 1). Illustrative excerpts for each category and their respective axes are presented in Chart 2.

The two categories emerging from the analysis reveal interdependent dimensions of professional autonomy. The first highlights how the organization of the work process and the availability of human, material, physical, and informational resources condition nurses' practice, often limiting practical autonomy even when there is legal support.

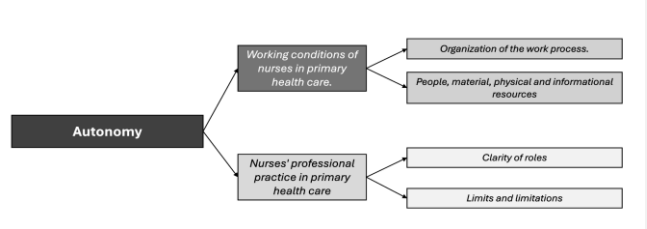

Figure 1 – Categories and thematic axes representing nurses' autonomy in primary health care. Goiânia, Goiás, Brazil, 2021

> *I schedule the consultation, make the request through the Ministry of Health […] I already define where the patient will take the exam, in the clinics accredited by the Ministry of Health […] and the patient already leaves with the test scheduled. […] On Tuesday mornings, I collect six Pap smears, and that's when we focus on women's health. If I find any abnormalities during the collection, I also schedule a clinical evaluation […] and, if necessary, I refer the patient to a gynecologist for further evaluation. There's also the possibility of referring the patient to a dermatologist when needed.* (N2, Family Health Strategy)

At the same time, professional practice varies according to the type of unit, reconfiguring the work process based on team composition, especially when specialists are present.

> *We don't provide prenatal care — unlike in the Strategy. I begin prenatal care when I identify a woman with a delayed period, I request tests, the result comes back positive, and I start with the 'Mom Test,' but I don't request routine tests. At the Health Center, pregnant women must schedule through the 0800 [*call center for citizens not registered in the Family Health Program*], so I don't have the autonomy to schedule the second prenatal visit for that patient because there are specialists there. In the Family Health Strategy, the nurse and the doctor alternate prenatal visits.* (N7, Health Center)

> *[...] For the FHS staff, they have a broader range of protocols and receive training, which gives them some autonomy [*for prescribing medications*]. In the traditional network, we are much more limited. In the FHS, you can have greater autonomy.* (N4, Health Center)

> *Primary Care nurses are generalists, right? We see patients of all ages — from babies to older adults — covering pregnant women, women's health, men's health, adolescence, and geriatrics. The Family Health Strategy encompasses all of that.* (N3, Family Health Strategy)

This framework aligns with the wide range of actions summarized in Chart 1, encompassing various lines of care across the life course.

Chart 1 – Actions described by nurses in the context of primary health care. Goiânia, Goiás, Brazil, 2021

Actions performed	N1	N2	N3	N4	N5	N6	N7
1. Activities related to individualized user care							
Triage/reception			X	X	X		X
Nursing consultation	X	X	X	X	X	X	X
Referral and counter-referral	X	X					
Immunization	X		X		X		X
Rapid tests for sexually transmitted infections	X		X	X	X	X	X
Rapid COVID-19 testing (during the pandemic)			X		X	X	
Reception of patients with suspected COVID-19			X		X	X	
Case notifications	X					X	X
Care related to rabies control							X
Care pathways							
Care for people with hypertension	X	X	X	X	X	X	X
Care for people with diabetes	X	X	X	X	X	X	X
Care for people with tuberculosis	X	X		X	X	X	X
Care for people with leprosy	X	X		X	X	X	X
Mental health care		X				X	
People across the life course							
Reproductive planning	X			X		X	X
Rapid pregnancy test/request for beta-hCG							X
Prenatal follow-up	X		X	X	X	X	X
Maternal screening tests 1 and 2	X			X			
Prescription of ferrous sulfate and vitamin A	X						X
Postpartum follow-up					X		
Newborn heel-prick test	X						X
Child growth and development consultation			X		X	X	X
Breastfeeding counseling	X						X
Ordering and tracking mammograms		X	X		X	X	X
Breast self-examination counseling			X				
Pap smear (cervical cytology)	X		X		X	X	X
Adolescent health consultation			X		X		
Older adult health consultation		X	X		X	X	
Alzheimer's classification scale					X		
Men's health consultation			X				
School Health Program		X	X		X		
Test requests							
Requests for biochemical tests		X	X			X	X
Urinalysis (EAS) request			X				
Urine culture request			X				
Stool culture request			X				
Other actions							
Management of skin lesions with dressing prescriptions	X		X		X	X	X
Suture removal							X
Circulating nurse in minor surgery				X			
Integrative Health Practices					X		
Follow-up of people in vulnerable situations and risk groups			X				X
Home visits		X	X		X		
Prescribing medications recommended by the Ministry of Health	X	X	X				
2. Group activities							
Health education groups	X	X	X	X	X	X	X
Health education group for older adults					X		
Health education group for pregnant women					X		X
Health education group on obesity			X		X		
Health education group on smoking cessation			X	X	X		
Physical activity and leisure groups					X		
Pink October (breast-cancer awareness) campaign actions					X		
Lectures/talks	X		X		X		
3. Management/administrative actions							
Personnel and materials management	X	X	X	X	X	X	X
Supervision of the Central Sterile Supply Department			X				
Supervision of community health agents		X					

Chart 2 – Categories and thematic axes representing nurses' autonomy in PHC. Goiânia, Goiás, Brazil, 2021

Category	Thematic axis	Nurses' perceptions
Nurses' working conditions in PHC	Organization of the work process in PHC	*I think, well… a lot still needs to happen. I say that some protocols are outdated, old. I think each nurse in each place does it in a different way. Some don't do it because they don't know how, some don't cooperate because they don't want to know, some say 'oh, I'm not getting anything for this.'* (N5, Family Health Strategy) *So when they get a possible [*leprosy*] case, they do exactly that, colleague: they put a question mark and mark MB [multibacillary leprosy] so we'll know. I said: no, there is an investigation form for this; you will take it to your physician — he has to fill it out, because diagnosis is his role* (N4, Health Center) *[...]So, we don't do prenatal care; we support the professionals who do prenatal care.* (N7, Health Center) *We support managers on health issues and work organization. Each month as the work is presented, we organize ourselves and carry it out. I provide child growth and development care, care for pregnant women, women's health, and care for patients with hypertension and diabetes. So we perform all those assessments, all those nursing consultations, right?!* (N2, Family Health Strategy) *[…] Children not so much, since the Basic Health Unit has a pediatrician, a general practitioner, and a gynecologist — children usually stay with the pediatrician. […] When the gynecologist was missing, they wanted us to handle prenatal care. In a few days, when the dentist can't see patients, I think they'll call us. So, the GP — today I told the pediatrician, 'Wow, in a few days I'll be doing childcare in your place…' The nurse becomes the do-it-all when certain professionals are absent; the nurse is called to do whatever is needed.* (N7, Health Center)
	People, material, physical, and information resources	*We're short on human resources, right? We have only two nursing technicians in the morning, and there's the issue of filling in the spreadsheets — for example, the Tuberculosis spreadsheet, I don't know if you're familiar with it… the Leprosy spreadsheet, the SISCOLO [Cervical Cancer Information System] spreadsheet, and then you have to enter data into SISCOLO too. So I help them with that as well, because I think the nurse can help with everything. And while doing that I talk to mothers about their children's development before the physician sees them.* (N1, Health Center) *The difficulties — if we stop to think — are structural and related to adequacy. We don't have the conditions to work, you know? Sometimes there's a lack of supplies, a lack of physical conditions. […] At first there was a lack of material.* (N2, Family Health Strategy) *[…] Even with all the difficulties we face today with this pandemic, with terrible working conditions — the unit where I work, the ceiling is literally falling on our heads; the physical structure is extremely precarious, awful; the ceiling is moldy, the roof is actually falling. So even with all those difficulties we manage to get things done, right? There's a lack of supplies, a lack of material resources, a lack of staff — for example, I've been without a nursing technician for about 6 months. All of that makes the process harder, right? But we love what we do; we're nursing, so we're always working.* (N3, Family Health Strategy) *Our biggest difficulty is human resources. Look, there's a shortage of nursing technicians and they want the nurse to do it. […] So for me, it has always been — and will always be — a human resources issue.* (N7, Health Center)
Nurses' professional practice in PHC	Scope of practice	*We see patients in the leprosy and tuberculosis programs; we do rapid tests when they come up; prenatal consultations; 'Mom Tests' 1 and 2; family planning […] the diabetes and hypertension program. I worked for a few years with the smoking cessation program — basically whatever came up in the unit. Sometimes I even served as circulating nurse in minor vasectomy surgeries; when there's no professional, we step in. […] We can get mammography, mammography yes. On SISCAN [Cancer Information System] we can also get the Pap smear; the person can have the sample collected, because in the Strategy there are colleagues who do it, right?! […] We can order beta [*hCG*], we can order a CBC […] for family planning, smoking cessation, […] for Hiperdia [*hypertension/diabetes groups*], and there was a group for pregnant women.* (N4, Health Center) *I've worked in the Strategy for 20 years and I provide care for people with hypertension, diabetes, tuberculosis, and leprosy; I do prenatal, postpartum, and pregnancy care; we make home visits; I provide child growth and development care; I do risk classification and nursing process; I also do acupuncture and auriculotherapy at the clinic, uh… what else? In addition to caring for older adults… I use that Alzheimer's classification scale; I take part in vaccination campaigns; I also work in schools, doing School Health and work in daycare centers. So we see children from 0 to 5 years old, and then we have the School Health [Program], where we serve other ages; in School Health we do prevention of eye diseases, toothbrushing, we teach oral hygiene to the class, we give talks about drugs and STIs…* (N5, Family Health Strategy) *[…] I supervise nursing services, and what we offer to the population in Primary Care is the immunization service, triage with suture removal, blood pressure checks, and blood glucose checks. We do the first and second 'Mom Tests,' the heel-prick test, dressings, and suture removal. […] Anti-rabies care […] We handle the epidemiology component: reports, active case finding; we're there as 'bacillus killers' for leprosy and tuberculosis. We can do early case finding for TB and leprosy and, if the clinical picture is decisive, we can start treatment as well. We see patients for the first 'Mom Test' and, if positive for syphilis, the nurse already starts early treatment […] nurses handle suspected pregnancy; we order the rapid test or request a beta-hCG […] we provide vitamin A […] we have nursing consultations [for people with hypertension and diabetes], and the Hiperdia group.* (N7, Health Center)

(continued)

Category	Thematic axis	Nurses' perceptions
Nurses' professional practice in PHC	Role clarity	*I follow the Ministry of Health ordinance; I prescribe [*medications for sexually transmitted infections*]. As long as the medication is available at basic health units. When a medication isn't available, then I take it to the physician and ask for an evaluation, because regular pharmacies don't accept our prescriptions. So we run into that barrier — I only prescribe what is available in the system, that I know the network carries.* (N3, Family Health Strategy) *[…] Like, when someone arrived [*at the health center*], we tried to provide the best possible resolution; if it wasn't within our remit, we made the referral and explained everything.* (N4, Health Center) *In the past, when I worked with other professionals, I would fill out the form and they would stamp it. Today I prefer to bring in the patient, attach the data, and say, 'go for a consultation now and ask for the ultrasound.' I'm no longer doing that thing of filling out and stamping everything; I refer them and say, 'ask for it there.'* (N5, Family Health Strategy) *Because here [*at the unit*] we usually pause together — me and the physician — and if there's any case, there are other nurse colleagues we usually discuss it with. We don't work alone. So if I have a patient in crisis, my colleague also knows about my patient; she has full autonomy to see them even if I'm not here, because she knows everything that's going on, just as I know what's happening with her patients.* (N6, Family Health Strategy)
	Boundaries and limitations	*I believe it could be improved — for example, in prenatal care. We do the first visit, order tests and so on, but then we run into the ultrasound. I think ultrasound — we've even discussed this with the health department — should be ordered at the first visit, but nurses can't order ultrasound, whereas screening mammography is enabled in the system for nurses to request. So sometimes things get blocked. You have to track down a physician to order the ultrasound for the patient you're seeing. There are things that could be improved, you know? I think it could be better. […] Now, biochemical tests are fine; the system doesn't block them — CBC, glucose — I can order all of those.* (N3, Family Health Strategy) *Ultrasound, no — only physicians [*can request imaging*]. We can get mammography, mammography yes. On SISCAN we can also request the Pap test, the person can have the sample collected. We don't prescribe; only physicians [*can prescribe ultrasound*]. There are some laboratory tests we can order. We can order beta [hCG], we can order a CBC. […] A semen analysis — some of those are authorized for us.* (N4, Health Center) *Unfortunately we need [*another professional's evaluation or prescription to complete care that I initiated*], because our prescription is valid within the municipality, and the municipality doesn't dispense that medication. The patient can't obtain metronidazole, so it turns into a back-and-forth to get the antihypertensive medication as well; we end up having to turn to the physician every time.* (N6, Family Health Strategy) *No, nurses don't order any imaging exams. We request some lab tests, mammography, and preventive screening. We can also request the PP) and sputum smear microscopy, but not imaging tests. […] Those are diagnostic, and we are not allowed to make diagnoses.* (N7, Health Center)

> *Here we provide care — well, we used to — for growth and development, women's health with Pap tests, I'm also involved in family planning, care for pregnant women, prenatal, care for older adults. So it's comprehensive care, from birth onward…* (N6, Family Health Strategy)

There is also a shared perception that the lack of personnel, supplies, and infrastructure undermines performance and exacerbates the precariousness of services.

> *The same difficulties everyone faces: lack of physical structure, sometimes lack of supplies. For example, we couldn't perform minor surgeries because we ran out of sutures — can you imagine that?! […] Last week, we even ran out of alcohol; we had to borrow it from the cleaning staff, who are outsourced, you know?! […] We were using their alcohol, just so you have an idea.* (N4, Health Center)

> *We don't have access to a proper office; four nurses share one. It used to be two offices for four nurses, but since the pandemic, it's just one, and there's no physical structure at all — it's all improvised. We don't have transport for patients. Sometimes a patient arrives unwell, and we have no way to transport them. A patient came in short of breath, and I couldn't find the oximeter; another nurse had stored it somewhere, but she wasn't here. I had to ask the nursing technician if she had one. So we run into these issues all the time — lack of equipment. What was sent to me was already defective, and they've never sent a replacement. All of that hinders the workflow.* (N6, Family Health Strategy)

The second category shows that although the scope of practice is broad and supported by policies and protocols, unclear role definitions and institutional restrictions impose limits—particularly regarding test ordering and medication prescription. According to professionals, nonexistent or outdated Health Care Network (RAS) pathways make it difficult for users to navigate the system.

Reports converge on limitations in test ordering and patient referral, demonstrating a lack of autonomy in specific areas. Some nurses mention being able to order biochemical tests and mammograms but express frustration at being unable to request ultrasounds, even when clinically indicated. This restriction — attributed to network limitations — forces them to depend on physicians to continue patient care, even though they are qualified to manage these situations more

effectively.

> *[...] The only imaging test I'm authorized to order is [*mammography*]. What's really problematic is the lack of a designated referral center so that I can send patients who need an endocrinologist or cardiologist, for example. Today, when we refer a patient, they enter a long waiting list.* (N2, Family Health Strategy)

> *[...] For me, it's discouraging; the protocols remain rigid. For instance, if the doctor is absent, people say, 'How will the nurse handle it? How will they refer the patient?' Today nurses have extensive knowledge — we study hard and prepare well — but I see that the protocols are the same as 20 years ago. Nothing has changed; it's still the same situation. In that regard, I think the system is very outdated.* (N5, Family Health Strategy)

In light of the nursing autonomy framework — defined as the ability to decide and act based on clinical judgment within ethical and legal boundaries — clinical protocols play an ambivalent role: they provide technical-scientific support and safety but restrict autonomy when not implemented, poorly understood by teams, or excessively normative. Thus, nurses' autonomy in PHC depends not only on the existence of protocols but on their concrete applicability and the clarity of roles within multidisciplinary teams.

DISCUSSION

This study identified, among the activities performed by nurses in PHC, individual user care, group activities, and management actions as well as two categories representing professional autonomy — working conditions and professional practice — that cut across everyday health-care delivery.

Since in Brazil PHC units with and without FHt coexist[18], participants' statements indicate that scope of practice and the degree of autonomy vary across services, especially when medical specialists are present. This arrangement affects how work processes are organized and how resources are allocated, with perceptible effects on users' experience.

This context can also hinder public understanding of PHC, as observed in a study comparing users' perceptions in traditional units and units with the FHS[19], including public understanding of nurses' roles and autonomy at these points of care.

Several constructs emerged as autonomy enhancers: knowledge of the service network, clarity about the nurse's role in PHC and within the multiprofessional team, and well-defined clinical pathways and protocols. When these elements are not internalized by professionals, scope of practice varies and the user experience is affected, whether in terms of problem-solving capacity or care continuity.

Understanding RAS points of care, public policies, and service offerings within the SUS enables nurses to steer care along the lines of care available in PHC, fostering continuity and comprehensiveness of services[20]. The accounts suggest that, as nurses develop this knowledge, they expand their capacity for intervention and resource mobilization, strengthening their role as change agents and contributing to care quality[21-22].

Internationally — particularly in countries such as Canada and the United States — studies show that PHC nurses conduct over 90% of consultations autonomously, with progressive gains in autonomy over the first months of practice[23-24]. Such autonomy does not stem solely from academic training; it is linked to competence developed on the job, clinical decision-making, and collaborative interactions, with potential positive effects on quality of work life[25-27].

Similarly, our results indicate that role clarity for nurses — both individually and within the multiprofessional team — supports autonomy and can improve interprofessional communication and collaboration, with positive impacts on care quality in the SUS[28-29]. In a study with FHt professionals in a city of the state of São Paulo, autonomy was perceived when ideas were valued and decision-making and trust were encouraged by management and team members[28] — an outcome consistent with the perceptions reported here.

Practice supported by evidence-based protocols tends to confer safety to autonomous decision-making and improve care quality[30]. Nurses recognize these instruments as guides for care; while they do not encompass the entirety of practice, they provide technical-scientific and ethical backing for actions and procedures within the professional scope[31]. These findings converge with our results, despite mentions of outdated protocols and a lack of protocol familiarity among other professionals. In our setting, PHC is supported by a state nursing protocol[10] that organizes practice within the network.

Conversely, barriers to autonomy emerged related to the removal of nursing functions and to shortages of human, material, physical, and informational resources. These factors comprise working conditions that constrain practice and reduce job satisfaction[32].

In recent years, Brazil has faced financial constraints, precarious infrastructure, medication shortages, and reductions in multiprofessional teams, undermining care quality and the effectiveness of preventive and health-promotion actions within the SUS[33] — conditions associated, in part, with changes in PHC financing[34-35]. Participants' accounts illustrate how this scenario directly affects nurses' autonomy by limiting execution of competencies, imposing barriers to implementing interventions, and hindering team coordination, with consequent losses in problem-solving capacity.

The SUS adopts a decentralized, integrated, intersectoral model of multiprofessional care aimed at overcoming care fragmentation[36]. Within this framework — and considering nurses' pivotal role in sustaining PHC and the system as a whole — it is crucial to strengthen nurses' actions. Greater investment is needed in PHC infrastructure, continuing health education, and the organization of workflows and work processes — preferably from a horizontal perspective — as well as in consolidating PHC as the coordinator of care[37].

In light of the two emergent categories, participants' perceptions reinforce that professional practice and working conditions must be improved to increase service problem-solving capacity and efficiency. Such improvements intersect with aspects of nurses' autonomy already outlined in the PNAB but depend on regulations at other levels and on the concrete organization of work processes within units.

Consistent with the National Survey on Nurses' Practice in PHC[38] — which points to work overload, lack of updated protocols, and limitations in test ordering and medica-

tion prescribing — our local analysis shows how these barriers materialize in the daily work of professionals in the Metropolitan Region of Goiânia. Moreover, while the national study identifies diffuse perceptions regarding scope-of-practice limits, our findings underscore the urgency of management strategies and public policies that ensure better working conditions, role clarity, and the strengthening of clinical autonomy as a structuring axis of PHC practice.

The study has some limitations, namely: a predefined sampling approach (mitigated by data saturation), recruitment difficulties — due to workload overload during the COVID-19 pandemic — and the impossibility of statistical inference, as it is a case study restricted to the participants and the conditions of the data collection period. Future research could further explore the understanding of autonomy based on the categories identified here (using qualitative approaches) and, additionally, employ quantitative methods that allow inferential analysis of nurses' practice autonomy in PHC.

CONCLUSION

The study identified both barriers and enabling factors that shape nurses' autonomy in PHC, organized into two analytical categories: i) working conditions, influenced by how the work process is organized and by the availability of human, material, physical, and informational resources; and ii) professional practice, particularly regarding scope of practice, role clarity, and the limits imposed by institutional regulations and protocols.

As a contribution, the study deepens the discussion on work organization and professional scope, offering insights for managers at local and central levels. The findings highlight the need for investments in infrastructure, updates to evidence-based protocols, and greater recognition of clinical decision-making to strengthen autonomy in PHC. Such measures can guide public policies that expand nurses' leadership, promoting more resolutive and higher-quality practices, with a positive impact on care coordination and the effectiveness of health actions within the SUS.

CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

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Project design: Silva GO, Oliveira FS, Aredes NDA.
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Data analysis: Carmo BA, Rocha JS, Silva GO, Aredes NDA.
Data interpretation: Carmo BA, Rocha JS, Silva GO, Oliveira FS, Santos PT, Aredes NDA.
All authors are responsible for the writing and critical review of the intellectual content, the final published version, and all ethical, legal, and scientific aspects related to the accuracy and integrity of the study.