



Revista da Escola de Enfermagem da USP

ISSN: 0080-6234

reeusp@usp.br

Universidade de São Paulo

Brasil

Mota Monteiro, Michele; Paiva Figueiredo, Virgínia; Antero Sousa Machado, Maria de Fátima
Formação do vínculo na implantação do Programa Saúde da Família numa Unidade Básica de Saúde
Revista da Escola de Enfermagem da USP, vol. 43, núm. 2, junio, 2009, pp. 358-364
Universidade de São Paulo
São Paulo, Brasil

Available in: <http://www.redalyc.org/articulo.oa?id=361033298015>

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Bonding to implement the family health program at a basic health unit

FORMAÇÃO DO VÍNCULO NA IMPLANTAÇÃO DO PROGRAMA SAÚDE DA FAMÍLIA NUMA UNIDADE BÁSICA DE SAÚDE

FORMACIÓN DEL VÍNCULO EN LA IMPLANTACIÓN DEL PROGRAMA SALUD DE LA FAMILIA EN UNA UNIDAD BÁSICA DE SALUD

Michele Mota Monteiro¹, Virgínia Paiva Figueiredo², Maria de Fátima Antero Sousa Machado³

ABSTRACT

The objective of this study was to learn about strategies to develop binding between patients and Family Health Program (FHP) professionals at a basic health unit in the city of Fortaleza-CE. This descriptive and qualitative study was performed in August and September 2007 in Fortaleza, Ceará, Brazil. Study informants were the 12 professionals working in the family health program teams. Data was collected through interviews and organized in the form of subject discourse categories, based on the Collective Subject Discourse technique, and analyzed according to the literature. The study complied with inherent ethical issues regarding research involving human beings. The professionals understand bond as relationship, complicity and trust. They believe that service organization, commitment and respect are indispensable to consolidate this process, which can be established with groups, user embracement and home visits. Emphasis is given to the importance of developing bonding in the Family Health Program as a strategy to improve health care.

KEY WORDS

Family Health Program.
Patient care team.
Health services.
User embracement

RESUMO

Este estudo objetivou conhecer as estratégias de formação do vínculo entre usuários e profissionais do Programa de Saúde da Família (PSF) de uma unidade básica em Fortaleza-CE. Estudo descritivo de natureza qualitativa, realizado nos meses de agosto e setembro de 2007 em Fortaleza-Ceará-Brasil. Os informantes do estudo foram os 12 profissionais das equipes de saúde da família. Os dados foram coletados por meio de entrevista e organizados na forma de categorização das falas dos sujeitos, com base na técnica do Discurso do Sujeito Coletivo e analisados com a literatura. Foram respeitadas as questões éticas inerentes a estudos com seres humanos. Os profissionais compreendem vínculo como relacionamento, cumplicidade e confiança. Acreditam que organização do serviço, compromisso e respeito são indispensáveis para a consolidação deste processo, que pode ser formado com grupos, acolhimento e visita domiciliar. Ressalta-se a importância da formação do vínculo no Programa Saúde da Família como estratégia para uma melhor assistência à saúde.

DESCRIPTORES

Programa Saúde da Família.
Equipe de assistência ao paciente.
Serviços de saúde.
Acolhimento.

RESUMEN

Este estudio tuvo como objetivo conocer las estrategias de formación del vínculo entre usuarios y profesionales del Programa Salud de La Familia (PSF) de una unidad básica en Fortaleza-CE. Estudio descriptivo, de naturaleza cualitativa, realizado en los meses de agosto y septiembre de 2007 en Fortaleza-Ceará-Brasil. Los informantes del estudio fueron los 12 profesionales de los equipos de salud de la familia. Los datos fueron recolectados por medio de una entrevista y los discursos de los sujetos fueron organizados en categorías, con base en la técnica del Discurso del Sujeto Colectivo y analizados con la literatura. Fueron respetadas las cuestiones éticas inherentes a los estudios con seres humanos. Los profesionales comprenden al vínculo como siendo una relación, una complicitad y en la que debe existir confianza. Piensan que la organización del servicio, el compromiso y el respeto son indispensables para la consolidación de este proceso, que puede ser formado con grupos, acogimiento y visita domiciliar. Se destaca la importancia de la formación del vínculo en el Programa Salud de la Familia, como estrategia para obtener una mejor asistencia a la salud.

DESCRIPTORES

Programa de Salud Familiar.
Grupo de atención al paciente.
Servicios de salud.
Acogimiento.

¹ Nursing undergraduate at Universidade de Fortaleza. Fortaleza, CE, Brazil. ² Nursing undergraduante at Universidade de Fortaleza. Fortaleza, CE, Brazil. ³ Nurse, PhD in Nursing. Professor of the nursing course at Universidade de Fortaleza and at Universidade Regional do Cariri. Nurse of the Ceará School of Public Health. Coordinator of the Research Group: GRUPESC at Universidade Regional do Cariri. Member of the Núcleo de Pesquisa Saúde da Criança - NUPESC. Ceará, Brazil. fatimaantero@uol.com.br

INTRODUCTION

In 1978, the International Conference on Primary Health Care gathered in Alma-Ata urged all governments and the international community to promote health-related actions for all peoples of the world. The Conference was dedicated to formulating strategies that allowed countries to individually and collectively reach an acceptable sanitary level by the year 2000, a social development action based on a spirit of justice⁽¹⁾. In several countries, including Brazil, it is unfortunately clear that this level of acceptable sanitation was not reached until the current time.

In the 1980's, Brazil developed a series of programs in an attempt to restructure the healthcare system, using the world scenario as an inspiring model, during which time several discussions took place on this change of paradigm concerning healthcare. One of the results of these discussions was the creation of a movement called Sanitary Reform, which promoted measures that led to the unification of assistive and preventive components under a single command, and organized in a decentralized basis⁽²⁾.

The Reform's doctrinaire dimension was progressively solidified, climaxing at the 8th National Health Conference in 1986. Counting on massive participation of representatives from the organized society, a new proposal to the healthcare system was achieved and consolidated, becoming a bit later, at the advent of the 1988 Constitution, the Single Health System (SHS), which incorporated all basic principles of universality, equity, and integrality, besides regionalizing and hierarchizing both the network and social participation⁽²⁾. Such principles were later applied to operating the Family Health Program (FHP).

Countless advances were reported in the SHS regarding the establishment of its objectives; however, there are still several relevant challenges to be overcome, such as the often inadequate welcoming process, the low degree of appreciation of healthcare work, the lack of bonding between users and healthcare teams, and the fragmentation of actions in the process of patient care⁽³⁾.

In 1994, as a new development strategy of SHS and as the central axis for coverage extension promotion, the Family Health Program was created⁽⁴⁾. The FHP launch represents a realization of the most far-reaching, all-embracing healthcare program in the history of the country; it was implemented in order to organize the system's resources, so that appropriate responses could be given to the needs of population⁽⁵⁾.

The Family Health Program is one of the Ministry of Health's priority strategies to organize basic healthcare attention, and its major challenge is to promote the reorganization of health practices and actions in a smooth, uninter-

rupted way, bringing them closer to families, so that the quality of life of Brazilian people is improved. The program incorporates and reaffirms SHS's basic principles – universalization, decentralization, integrality, and community participation – by means of users' database insertion and bonding⁽⁶⁾.

Professional family healthcare teams (doctors, nurses, nursing assistants, healthcare community agents, dentists, and dental clinic assistants) provide assistance either at healthcare units or in the home. The team and the target population generate co-responsibility bonds, making it easier to identify, assist, and follow up eventual health problems of community individuals and families⁽⁶⁾.

The State of Ceará, the birthplace of the FHP, was the target of a rapid expansion of teams, and in 2006 the network of healthcare community agents (HCA) already covered almost 100% of population, as 99.5% of the demographic quota had been covered by family healthcare teams (FHT) and by oral healthcare teams (OHT), according to the Department of Basic Attention (DBA). In Fortaleza, 256 FHTs were created, covering 37.19% of the population, as well as 212 OHTs, thus covering 61.59% of the total of 2,374,944 inhabitants⁽⁷⁾. The above-mentioned data demonstrate that the State of Ceará is highly covered by the FHS, and Fortaleza has been searching for investments in order to widen the coverage scope of populations that need a more effective SHS. Using a territorial plan, consisting of radiographs of urban spaces aimed at identifying a population's characteristics and needs, the municipality of Fortaleza concluded that the coverage of 100% of the population would demand the work of 460 FHP teams comprised of doctors, nurses, nursing assistants, and dentists, besides 2,700 healthcare community agents.

Hence, given the need for widening FHP coverage, the Fortaleza City Hall organized for the first time a public competition so that the necessary 460 FHP teams could be hired. A public process selected the agents and legally hired them to work under a municipal autarchy. Immediately after the competition in February 2006, the number of teams jumped from 102 to 200. Professionals have been gradually called in, according to the structural status of the basic healthcare centers⁽⁸⁾.

There is clear evidence, therefore, of the progress in the FHP and its emphasis on coverage expansion. This aspect is extremely relevant to the consolidation of the proposed assistance model. Yet, other aspects should also be valued, such as the HCA and user bonding within the program.

Bonding formation takes place when system users and healthcare workers draw closer, with both parties bringing their intentions, interpretations, needs, reasons, and feelings; however, this exchange occurs in an unbalanced environment with distinct abilities and expectations, since the user, on the one hand, is in search of assistance, usually

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displaying a fragile physical and emotional status; is a supposedly skilled professional that assists and cares for the source of the user's fragility⁽⁶⁾. We are in full agreement with a study⁽⁹⁾ who reinforces the notion that a bond involves affection, support, and respect, encouraging autonomy and citizenship that leads to a negotiation that promotes identification of needs and searches for the production of ties, therefore stimulating users to achieve autonomy in their own healthcare status⁽¹⁰⁾.

Grounded on another study⁽¹⁰⁾, the creation of bonds with users broadens the effectiveness of healthcare actions, and favors users' participation throughout the service-rendering process. This gap between users and healthcare providers must be filled in such a way that it promotes autonomous subjects, both professionals and patients, for there is no bond without the recognition of the user and his condition as a subject who acts, judges, and desires⁽¹⁰⁾.

Based on these reflections, the present study established as its investigative axis the bonds between users and professionals of the Family Healthcare Program. The interest in this issue was born from our experience as nursing students during the Curricular Phase at a basic healthcare center located in the municipality of Fortaleza - CE, in which we had the opportunity to attend the implementation of the Family Healthcare Program, and observe the insertion of team professionals, focused on the formation of their bonds with the population they served.

We consider this to be a timely moment to highlight the discussions on the theme - actually the backgrounds of this study, so that it can trigger the reflections of healthcare professionals, and also those of the healthcare management, in order to improve the value of bonding together with the population.

OBJECTIVE

To acknowledge the path of bonding between users and professionals of the Family Healthcare Teams in a basic healthcare center in Fortaleza, CE.

METHOD

This is a descriptive, qualitative-based study performed in the months of August and September of 2007 in a Basic Family Healthcare Center of the Regional Executive Secretariat VI located in the municipality of Fortaleza, Ceará, Brazil. The study's scenario-center is featured as a unit-school, following a partnership project between the Fortaleza City Hall and the University of Fortaleza – UNIFOR.

The healthcare professionals who rendered the referred service, and who agreed to take part in the study, were the informants. We applied a semi-structured interview as the research instrument, which made possible the

achievement of data related to the characterization of the professionals, as well as to the aspects related to their knowledge on the bonding; each interview lasted, on average, 20 minutes.

Twelve professionals who were present at the basic healthcare unit (UBASF) were interviewed, and agreed to participate in the experiment. This number represented the total amount of professionals enrolled in the teams. Interviewed professionals were doctors, nurses, dentists, and dental clinic assistants. HCAs (health care aides) and nursing assistants were not part of the unit in the investigated reality yet – at the data collection period – as recommended by the Ministry of Health; for this reason, they were not inserted into the study.

Data were organized under the Collective Subject Discourse technique, a strategic methodology that aims at shedding more light on any given social representation and the set of representations that ratifies an imaginary input. This discourse allows for a better visualization of social representation as it appears, not under a more vivid form of language, but in the way individuals think. Hence, the proceedings for the analysis involved: the selection of key expressions of each particular discourse; identification of the core idea of each one of these key expressions, which is the synthesis of the content of the expressions; and the gathering of key expressions regarding similar or complimentary core ideas in one synthesis-discourse, or in other words, the collective subject discourse⁽¹¹⁾. The analysis of the discourses was taken into practice by means of revised literature aimed at theoretically and empirically grounding the investigation.

During the implementation of the study, ethical issues that govern research with human beings were respected, in accordance with CNS-MS Brazil Resolution number 196/96. Thus, the project was submitted to the Ethics Committee in Research of the University of Fortaleza, and was approved by the protocol number 132/2007, 19 June 2007.

RESULT PRESENTATION AND DISCUSSION

The results are presented within the boundaries of the Collective Subject Discourse technique, according to previous information in this text. Results were provided by interviews with professionals belonging to family healthcare teams. For the sake of the organization of the study, we first present the characterization of the researched professionals, and next the informers' discourses regarding the formation of bonds.

Characterization of the professionals

Study participants were professionals who worked in family healthcare teams in a basic healthcare center, totaling 12 professionals. Of these, five were doctors, three were nurses, two were dentists, and two were dental clinic assistants.

In regards to gender, there were 10 females and two males. Their ages varied between 25 and 42 years old. Of the total amount of interviewees, three were taking medical residency in this field, four were specialized in family healthcare, and one holds the titles of specialist and master in collective healthcare. Graduation periods varied from seven months to 12 years among doctors, from three to 13 years among nurses, and from 12 to 18 years among dentists. When we approached the length of time at FHP, it varied from seven months to ten years. The length of working time at the healthcare center varied from seven months to one year.

Healthcare training processes for professionals of the Family Healthcare Program are deemed as very important, because:

The professional profile of graduated healthcare workers have been insufficiently adequate to prepare them for field work, in the perspective of healthcare holistic attention and the practices that trigger promotion, protection, prevention, precocious attention, cure, and rehabilitation actions. These concerns are reflected in the reports of the National Human Resources Conferences held in 1986 and 1993, as well as in the Basic Operational Human Resources Norm for the SHS (NOB/RH/SUS); these documents express the position of a representative set of segments and social actors around the theme⁽¹²⁾.

In Brazil, the implementation of specialized courses in healthcare fields as a strategy to strengthen public policies is a practice that is usually employed by the Ministry of Health. As such, Family Healthcare Specialization and Multi-professional Residency courses have been conceived in order to provide theoretical-practical support to professionals who are already inserted into healthcare teams, and especially to offer newcomers from Medicine and Nursing courses an education that focuses on the FHP needs. Another expected purpose was the encouragement, within universities and State schools of public health, and the insertion of this theme into *lato-sensu* (university extension) post-graduation programs⁽¹²⁾.

The path of the Family Healthcare Program records positive and significant transformations regarding the reorganization of basic attention standards, as it seeks to focus its institutional objectives and goals on all-embracing actions of attention and care towards families⁽¹³⁾.

In order to make this possible, the team of professionals was identified as a relevant element to achieve such objectives; thus, mechanisms to formulate and to stimulate the implementation of activities aimed at forming, training, and paying team members were created⁽¹³⁾.

We undoubtedly see the importance of training professionals towards high quality work in the Family Healthcare Program; concurrently, as part of the SHS principles, it is also relevant to value the bonds that unite the professional and the user for the enhanced humanization of healthcare practices.

Collective Subject Discourse

The formation of bonds between the HCA and users guarantees ties of confidence and co-responsibility in their congruent work. The following discourse depicts the perspective of professionals towards what bonding is.

Bonding to me is the relationship the professional has with the user, the community and the service, grounded in co-authorship, confidence, and kinship, which favor humanized and resolute assistance (CSD 1 – Core Idea 1 – bonding is the relationship, co-authorship, confidence, and affinity between professionals and service users).

The professionals' discourse denotes a perception directed to the understanding of bonding as a relationship between the professional and the user, a relationship between people and, in general, it is considered as a relationship that the professional develops with the community, opening opportunities for the user to trust him.

A bond, according to what has already been broadly discussed in this study thus far, is characterized as a significant element in the work developed by FHP professionals.

The formation of the bond between the family healthcare team and the user represents a cardinal tool to the Family Healthcare Program. This process guarantees ties of confidence and co-responsibility in the conjoint work of professionals and users⁽⁶⁾.

The notion of bonding makes us reflect on responsibility and commitment. Hence, the idea is in full accordance with one of the concepts of integrality. To create a bond implies having such close and clear relationships that we are sensitized towards the suffering of others, feeling responsibility for the patient's life and death, and thus making possible a personal, non-bureaucratic intervention⁽¹¹⁾.

According to such a definition, it is valid to state that the FHP's operational guidelines point to a new kind of care, and direct us towards accountability and commitment in bonding practices; it is also important to say that this desire is shared by the Civil Society⁽¹¹⁾.

In addition to the above, we highlight the fact that professionals in this academic area have knowledge of essential elements in the formation of bonds, which is extremely helpful towards our objective of establishing this relationship in the service. We believe that a deeper level of comprehension on the part of professionals of what bonding can bring forth in the service environment is a consolidation of the SHS integrality principle.

The strategies used by professionals to generate bonding processes with users are highlighted in the following discourse:

I use several strategies to form and keep bonds with users since the initial formation of healthcare education groups; meeting users in order to address doubts, explaining what the Family Healthcare Program is, welcoming users from

the very first moment they access the healthcare unit to the moment I assist them, and also visiting them at home (CSD 2 – Core Idea 2 – group formation, meetings, welcome, home visit, addressing doubts, educating about what the FHP is, taking note of complaints, and optimizing assistance).

Professionals make use of strategies such as the formation of Healthcare Education groups, meetings with members of the population they are serving, making users aware of what the FHP is, and using the welcome principle, which is the moment the professional and the user draw closer.

The welcoming process is a technological arrangement that aims at providing users with access; it is the moment when all patients are heard, all simpler problems are solved or referenced, and whatever else is necessary. The welcoming moment consists of an open forum for demands, and provides an accountability process concerning all healthcare problems in a given region. When people truly feel they are welcome, they will look for receptive and resolute services, beyond their geographical areas⁽¹⁰⁾.

Groups, as a strategy in the educational process, constitute an important tool for bonding. A group is an educational strategy that tends to facilitate participation, communication of experiences and doubts, and favors decision-making practices toward subjects' self-care⁽¹⁴⁾.

Listening to and taking heed of users' complaints lead them to feel important; this enhances the confidence in the professional, and consequently facilitates the bond formation. A high quality of assistance also encourages users to realize that their citizenship rights are being guaranteed and respected.

Problems such as the lack of professionals on the teams were referred to by the study participants as factors that hinder the bond formation, as FHP is an ongoing project in the healthcare unit. Neither the healthcare community agents approved in the competition, nor the nursing assistants and nurses who were beginning their work both in the community and in the healthcare center, had arrived yet.

The HCA must work outside the healthcare center, forming the connection between the community and the healthcare services⁽¹⁵⁾. This link occurs mainly at the time of home visits, when HCAs have the opportunity to acknowledge the problems that make the population suffer, as they are either perceived or expressed by people; hence, he can communicate his perception to the team, and go back to the community with defined procedures, along with the other team professionals⁽¹⁶⁾. In this way, he becomes an articulator of the team work, precisely because he lives in his own working area and has a deep knowledge of the community where he lives, thus having more open access to people's homes; therefore, this professional is quite important to the team and in the formation of the professional-user bond.

As per the elements that denote the formation of bonds, the discourse of the professionals shows that the investi-

gated service already points to the configuration of the bonding.

Folks in my boundaries know me, people are free to visit, I know some people by their names, I know their families, how many kids they have, and who they are married to. I think that they already have a certain degree of confidence in me, because sometimes they look for me just to chat. I feel they trust that we can solve their problems (CSD 3 – Core Idea – professionals and users know each other).

Bond formation in the investigated healthcare unit is evidenced when professionals disclose that they are already known of in the population, despite the short period of insertion of the FHP in the area. On the other hand, professionals already know the population by name, identifying the person and the family people belong to. This causes the population to be at ease and trust the professional, smoothing the way to solving their health problems.

The bond formation is a proposal of the Ministry of Health to the FHP; it elects the establishment of bonding and the creation of commitment and co-responsibility ties between health professionals and users as a core strategy. In order to implement it, professionals must gain the population's trust grounded on the recognition of their participatory actions; from then on, users will have professionals to refer to, and may even make confessions after understanding their work.⁽¹⁷⁾

It's worth highlighting here the need for the development of a conjoint work in which all professionals are engaged at every moment of the assistance process; acting in accordance with their specific level of competence, they will be able to cope with the complexity of healthcare problems and the needs of individuals and the collectivity⁽¹⁸⁾.

A study carried out in a municipality in the State of Ceará investigated bonding within the FHP. The study concluded that the idea is still fragile as a result of the Program's own reframing process. One of the identified elements of such fragility is the professional shifting process inside the teams, or even in the municipalities, where users reported they were not able to identify the professionals⁽⁹⁾.

According to reports from the professionals participating in the study, we realized that they feel attached to users, much the same way that users look to them to have their problems solved, such as asking for home visits to sick or disabled family members with locomotion difficulties, for instance. At patient's screening time, as reported by participants, users are able to identify professionals and the team they are inserted into.

In the following discourse, professionals set forth indispensable bonding elements:

For bonding to take place, I think it is very necessary to organize Family Healthcare Teams and the rendered services, as well as ensuring the qualification of professionals that work at the Family Healthcare Program, who seek a closer relation with users, in such a way that they feel wel-

come, thus generating confidence, respect, empathy, so that the community is willing to participate (CSD 4 – Core Idea 4 – service organization, commitment, confidence, respect, empathy, and community participation).

The indispensable elements of bond formation processes pointed out by professionals were team organization and professional qualification. In this way, users draw closer to the services and feel welcome, respected, and willing to take part in community actions.

Respect and commitment of the professional towards the community, as well as the creation of public competitions that contribute to the permanence of the FHT in the area, thus preventing professionals from shifting processes, are also elements indicated by participants in the study as quite significant to the bond formation.

Population feel better cared for, once the teams bring a broader vision based on community knowledge, stimulating its autonomy and participation in treatment processes, building respectful relationships, valuing differences, and creating population co-responsibility towards their well-being. Users commit to proposed activities and allow for bonding to be set once they are satisfied with healthcare services, thus improving quality of life and promoting the program's dissemination throughout the country⁽¹⁷⁾.

Bonding processes are but consequences of a closer relationship between the population and healthcare teams, an interaction that facilitates popular adherence to healthcare services.

FINAL CONSIDERATIONS

Results presented here show that the bonding process is an ongoing practice in the studied healthcare unit. According to the discourses of professionals, we can conclude that they understand what it is and its importance toward improving healthcare assistance actions.

It is quite clear that the bond formation takes place at a slow, progressive speed, yet many users already know the

professionals in their area, and thus know who they will search for at the moment a problem arises. There is still a lack of relevant elements so that the link between the professional team and users occurs in a faster, more consistent way, such as, for instance, the presence of the healthcare community agents. The study made clear that professionals totally understand the importance of bonding to the team work, and how significant it is to have it in their work environment.

Participants indicated that confidence, commitment, respect, empathy, and service organization are key elements in the bond formation process, as these characteristics open the way to a broader understanding of the community they render work to, improving the population's quality of life.

Professionals came up with several strategies in order to create bonding, since the FHP is progressively being implemented in the unit and teams are still in the initial steps of organization; professionals that compose the teams, therefore, should make their best effort to get acquainted with users.

We understand that the professionals' social responsibility toward any given population is essential to the success of the FHP. The lack of stability of professionals in the teams or in the cities consequently yields instability in the work idealized by the FHP; but most of all, in the involvement of the FHT with users in their search for bond formation, aiming at encouraging their autonomy toward improving their own healthcare status. Bondings between professionals and users are the only possible way to create population-focused actions.

We therefore believe that bonding is fundamental in healthcare service, as it provides users with the opportunity to play the role of a citizen, granting him stronger autonomy regarding his own healthcare, allowing him to have his right to expression, question, and choice respected, and allowing professionals to get familiar with users, so that they collaborate with them for the maintenance of health and reduction of health problems.

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