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# The concept and practice of comprehensiveness in Primary Health Care: nurses' perception\*

CONCEITO E PRÁTICA DA INTEGRALIDADE NA ATENÇÃO BÁSICA: A PERCEPÇÃO DAS ENFERMEIRAS

CONCEPTO Y PRÁCTICA DE LA INTEGRALIDAD EN LA ATENCIÓN BÁSICA: LA PERCEPCIÓN DE LAS ENFERMERAS.

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## ABSTRACT

The objective of this study is to debate on the nurses' discourse on the concept of health comprehensiveness and how to implement it in primary health care practice. Considering that comprehensiveness is one of the pillars of the Brazilian public health system (SUS) and taking nursing work force as a considerable commission of people to work for the construction of the SUS, the authors considered important to identify the conceptual bases and practices that guide nurses' work towards in the construction of health comprehensive-ness. In this qualitative, exploratory study interviews were performed with 10 nurses working in primary health care centers in three cities in the interior state of São Paulo. Data collection was performed through semi-structured interviews and analyzed according to the collective subject discourse technique. Results showed that the nurses' conceptions on comprehensiveness are directly relates with providing care, and that these professionals put comprehensiveness into practice through their everyday work.

## DESCRIPTORS

Primary Health Care  
Comprehensive Health Care  
Community health nursing  
Public health nursing

## RESUMO

O objetivo deste estudo é debater o discurso das enfermeiras sobre o conceito da integralidade em saúde e como operacionalizar na prática a integralidade na Atenção Básica. Considerando a integralidade como um dos pilares do SUS e tomando a força de trabalho em enfermagem como um contingente considerável de pessoas para operar na construção do SUS, considerou-se importante identificar as bases conceituais e práticas que direcionam o trabalho das enfermeiras para a construção da integralidade na saúde. Neste estudo qualitativo exploratório, foram entrevistadas 10 enfermeiras que atuam na atenção básica em três municípios do interior do estado de São Paulo. Os dados foram coletados através de entrevistas semiestruturadas e analisados segundo a técnica do discurso do sujeito coletivo. Os resultados mostraram que as concepções que as enfermeiras possuem sobre integralidade estão diretamente relacionadas à prestação de assistência e que estas profissionais colocam a integralidade em prática ao executar seu processo de trabalho cotidiano.

## DESCRIPTORES

Atenção Primária à Saúde  
Assistência Integral à Saúde  
Enfermagem em saúde comunitária  
Enfermagem em saúde pública

## RESUMEN

Se objetivó discutir el discurso de enfermeras sobre el concepto de integralidad en salud y cómo operacionalizar en la práctica la integralidad en Atención Básica. Constituyéndose la integralidad como uno de los pilares del SUS y tomando la fuerza laboral de enfermería como un contingente razonable de personas para operar en la construcción del SUS, se consideró importante identificar las bases conceptuales y prácticas que orientan el trabajo de enfermeras para la constitución de la integralidad en salud. Estudio cualitativo, exploratorio. Fueron entrevistadas 10 enfermeras actantes en Atención Básica en tres municipios del estado de São Paulo. Se recolectaron datos a través de entrevistas semiestructuradas, analizadas según técnica del Discurso del Sujeto Colectivo. Los resultados mostraron que las concepciones de las enfermeras acerca de la integralidad están directamente relacionadas a la prestación de atención y que estas profesionales colocan a la integralidad en práctica al ejecutar su laboral cotidiano.

## DESCRIPTORES

Atención Primaria de Salud  
Atención Integral de Salud  
Enfermería en salud comunitaria  
Enfermería en salud publica

\*Extracted from the study "Semântica e Operacionalização dos princípios éticos do SUS: um enfoque bioético", University of São Paulo, School of Nursing, 2005. <sup>1</sup>Professor, University of São Paulo, School of Nursing, São Paulo, SP, Brazil. lislaine@usp.br <sup>2</sup>Professor, University of São Paulo, School of Nursing, São Paulo, SP, Brazil. elma@usp.br <sup>3</sup>RN, MS, University of São Paulo, School of Nursing, São Paulo, SP, Brazil. gabrielafranja@hotmail.com <sup>4</sup>RN, Doctoral Student, " , University of São Paulo, School of Nursing, São Paulo, SP, Brazil reginaermel@usp.br

## INTRODUCTION

The struggle to provide integral care according to the principles of the Single Health System (SUS) implies rethinking important aspects in the organization of the work process, planning and development of new knowledge and health practice<sup>(1)</sup>.

A radical change in the health care model involves not only giving priority to primary health care but also removing the role of the hospital and specialties from the focus of attention and focusing mainly on the user-citizen as a integral being, abandoning fragmented care that transforms people into organs, systems or just pieces of sick individuals. Interactive practices should be available as care alternatives. The humanization of care, which involves everything from being respectful in receiving patients and delivering care to providing a clean and comfortable environment in health services, should guide all the health interventions based on the concept of integrality<sup>(2)</sup>.

In rational terms, care models have not been very efficient in meeting their objectives, which has reinforced the idea that practices could be more efficacious when powerful tools are part of the construction of SUS, considering the goal of putting into practice integrality as a right and service<sup>(3)</sup>.

Integrality is defined as a principle of the SUS, which considers the biological, cultural, and social dimensions of users, guides policies and health actions capable of meeting the population's demands and needs in terms of access to the services network. It is constructed in the praxis of health teams *with* and *within* health services<sup>(4)</sup>.

Integrality in primary health care is implemented in the work routine through interactions that occur between users and professionals including nursing workers<sup>(4)</sup>. Hence, considering integrality as one of the pillars of the SUS and viewing the workforce in nursing as an important contingent of people to participate in the construction of the SUS, we considered identifying the conceptual bases and practices that direct the work of nurses toward the construction of integrality in health to be important.

## LITERATURE REVIEW

The term *integrality* is included in discourses of international agencies linked to primary health care and health promotion. This concept has more recently been found in the proposals of programs by the Brazilian Ministry of Health and in critiques and propositions concerning health care by some Brazilian scholars. This broad use of the concept of integrality perhaps explains, even if partially, the scarcity of studies addressing the theme<sup>(5)</sup>.

The term integrality has been currently used to designate one of the SUS principles. Before it was established as such by the Brazilian Constitution, integrality was one of the objectives of the Brazilian Sanitary Movement. On the other hand, in spite of the progress achieved by SUS since its creation, integrality is still a principle that has yet to be fully implemented in the routine of many Brazilians<sup>(6)</sup>.

After all, what is integrality? We could say in a first attempt that it is one of the basic guidelines of SUS. In fact, the constitution's text does not use the term "integrality". It refers to "integral care, with priority given to preventive activities, not hindering care services". However, the term integrality has been commonly used to designate precisely this guideline<sup>(7)</sup>.

One study<sup>(8)</sup> sought to define integrality using the old dictionary *Aurélio*<sup>(a)</sup> but could not find its definition in it. However, its semantic core is very clear and precise: be whole, entire, complete and there are many different understandings in the field of health concerning integrality, which essentially depend on how different technical political projects in the field are intended to integrate, that is, *to make whole, complete, integrate*.

One initial meaning of integrality is related to a movement that became known as integral medicine. Its origins date back to discussions on medical education in the United States. For integral medicine, integrality would have to do with an attitude of physicians that would be desirable, which would be characterized by a refusal to reduce a patient to the biological system that supposedly produces suffering and hence the complaints of such a patient<sup>(7)</sup>.

There are different professionals in health services trying to practice integrality. One example would be an encounter of a physician with a patient affected by an ailment. The physician takes the opportunity to consider risk factors for other diseases not implicated in the concrete suffering of that patient, and/or investigates the presence of diseases that have not manifested yet. Another example would be when a community health agent who is on his/her way to home visits is faced with a resident who wants to talk about a problem afflicting him/her<sup>(7)</sup>. Or further, when a nurse, during a nursing consultation with children, seeks to identify the social and affective conditions of the family to provide care and stimulate these children. When such situations occur, the professional is trying concomitantly to link and work with both prevention and care delivery.

The principle of integrality corresponds to a critique of the dissociation between public health practices (pre-

<sup>(a)</sup> T.N. Commonly used Brazilian dictionary.

ventive) and care delivery practices. Linking public health practices and care practices means to blur the distinctions, so far crystalized, between public health services and care services. Integrality is understood as a continuum and connected set of individual and collective preventive and curative actions and services at the system's different levels of complexity<sup>(6)</sup>.

Integrality emerges as a principle of the continuous organization of the work process in the health services, which is characterized by an also continuous search to broaden the possibilities of grasping the health needs of a population. Such broadening cannot be expected if a dialog is not established among the different subjects considering their different ways of perceiving the needs of health services<sup>(3)</sup>.

Few studies addressing integrality and the understanding of integrality from the perspective of nurses were found in the literature. There was only one study carried out with nurses working with primary care in a city in the state of Matogrosso do Sul, Brazil<sup>(9)</sup>. The study aimed to identify the social representations of nurses concerning integral care delivery in women's health. This study concludes that nurses have a fragmented view of care provided to women. Such a view is still based on physical complaints, does not define integrality, and repeats the discourse of holistic care without actually understanding what it really means. The authors assert that nurses work in an individualized way and that the service is not organized to achieve integrality in care delivery.

Integrality as every *objective image* is polysemic, that is, has many meanings. It brings within it a large number of possibilities of future realities, to be created<sup>(7)</sup>. Thus, we shall not define integrality, rather we shall identify the meanings health workers in general, and more specifically nurses, attribute to the concept and practice of this principle so important to the SUS.

Hence, this study identifies the conceptions and how integrality in health is put into practice from the perspective of nurses working in primary care.

## METHOD

This paper was extracted from the project *Semantics and the implementation of SUS ethical principles: a bio-ethical approach* financially supported by CNPq (process nº402429/2005-2).

This study has a qualitative approach because the investigated phenomenon is within the universe of meanings, motivations, aspirations, beliefs, values and attitudes and is inherent to qualitative research seeking to understand this deeper space of relationships, of processes and phenomena, which can hardly be reduced to the operation of variables typical of quantitative approaches<sup>(10)</sup>.

The study's setting included three different cities in the state of São Paulo with more than 150,000 inhabitants each: Santos, Marília, and São Carlos. These cities, in addition to being in distinct regions in the state, also have variations in their Social Responsibility Index, which indicates their different levels of development. We believe these cities would provide the variability and range required for a qualitative sample, whose representativeness is not numerical, but a variability that would comprise the totality of the investigated issue in its multiple dimensions.

The study's participants were 10 nurses working in the primary health care system of these cities both in Primary Health Care units (PHC) and Family Health Strategy units (FHS), since these two strategies already existed in these cities, composing the primary health care network. The health units to be included in the study were chosen considering the criterion of variability. The primary network in Marília was composed of 28 FHS and 13 PHCU units; in São Carlos there were 11 FHS and 11 PHC units. Santos had 21 PHC units in four regions of the city (Continental, dos Morros, Northwest and historic downtown), whose activities were mixed with those of the FHS units. These units were then considered FHS units and only those organized according to PHC units were considered as such.

Two units from each city network and for each type of health unit were included: the newest and the oldest, considering when their activities were initiated in the city. At least one complete team was interviewed in the FHS units and all the health workers were interviewed in PHC units not organized according to FHS guidelines. Hence, the oldest and newest nurses, considering when they initiated their activities in the city, were selected to participate in this study. To determine the units to be included, an essential source of information was the knowledge the researchers had concerning the history of the health network of each of the cities, since there was no written documentation easily accessible, concerning the trajectory of the implementation of the Health Departments' services.

In accordance to the guidelines of Resolution 196/96 National Council of Health, the project was submitted to the Ethics Research Committee at the University of São Paulo at Ribeirão Preto, College of Nursing. After obtaining initial approval, the project was submitted to each of the three cities. Only after approval was received from the local committees, the City Health Department and the health units, were the chosen nurses contacted to sign free and informed consent forms that included an explanation concerning the project. The participants were ensured the freedom to withdraw from the study without any harm or embarrassment. Nurses were individually addressed in private during working hours so that they would feel free to refuse participating in the study or to provide their testimony without any constraint in the case of their consent.

The data collection instrument was a script containing three guiding questions. This script was pretested twice before a final version was achieved. The guiding questions addressed conceptions of nurses concerning integral

health care and their perceptions concerning how integral care was implemented in their daily routine. After three pretests, the questions were defined as: *Would you please tell me about integral health care?*; *How do you see integral health care in your practice?* and *What does integrality mean for you?*

All the reports were digitally recorded and later transcribed. Data collected were organized through Collective Subject Discourse (CSD)<sup>(11)</sup>, to identify the attributed meanings and implementation and the semantics of the term *integrality*.

CSD is a technique used to organize reports in qualitative research that permits one to recover the inventory of representations concerning a given theme in a given universe. The raw material to be worked by CSD is thinking, which is orally expressed by a group of individuals concerning a given subject. Reports are submitted to content analysis that is initiated with the deconstruction of such testimonies into the core or central ideas presented in each testimony and in all of them together, which is then followed by a synthesis aiming for a discursive reconstitution of the social representation<sup>(11-12)</sup>.

Hence, after transcribing the interviews, the reports of the interviewed individuals were organized with the use of a methodological approach that constitutes the central CSD proposal: key expression, central idea, and discourse of the collective subject.

*Key expression* is the literal transcription of continuous or discontinuous excerpts of the reports that allow recovering the core of the discursive content. This part of the analysis is crucial because it compares the selected key expressions with the entire discourse and with the central ideas that permit readers to judge the relevance of the researcher's interpretation of testimonies, which confers a character of *empirical discursive proof* onto the key expressions concerning the veracity of the content analysis<sup>(11-12)</sup>.

*Central Idea (CI)* is a name or linguistic expression that translates the core of the discursive content expressed by the participants. It reveals and describes the meaning and the theme of each of the analyzed reports, constituting a synthesis of a report or of a group of homogenous reports<sup>(10-11)</sup>.

The Collection Subject Discourse (CSD) gathers the key expressions that manifest the same central idea into a discourse-synthesis. In the Social Representation presented through the CSD, the individuals in the collective that generates the representation *are no longer individuals, but are transmuted, dissolved and incorporated in one or various collective discourses that express them and the representation per se*<sup>(11)</sup>.

Once the CSD was constructed, the interviewees' testimonies were analyzed from the perspective of content thematic analysis<sup>(13)</sup>. The purpose was to isolate units in

the context that could illustrate the CSD, which at this point configured themes as recording units. Content analysis is a set of communication analysis techniques using systematic and objective procedures of message content descriptions, quantitative or qualitative indicators, allowing the inference of knowledge related to the conditions of production and/or reception of such messages<sup>(13)</sup>.

In general, qualitative research allows one to incorporate the issue of meaning and intentionality of acts into social relationships and structures, enabling researchers to unveil little known social processes concerning a given group. Hence, it enables the construction of new approaches, the review and creation of new concepts and categories<sup>(10)</sup>. It is clear that successive approaches to the same object contribute to deepen the understanding of meanings and this is especially true when addressing complex subjects such as integrality. That is why this single approach, even though mixing methodologies to analyze testimonies, is still limited in the construction of a broad conception of what integrality in health means from the perspective of nurses in primary health care. However, it is sufficient to make clear the polysemic nature of this term, when it shows that there is not a single understanding of what integrality means for the interviewees; it contributes to the understanding of common difficulties faced in delimiting specific indicators to evaluate the implementation of this SUS principle.

## RESULTS AND DISCUSSION

The analysis of the reports of nurses concerning the conception of integrality enabled us to construct one CSD with three different CI, which are presented as follow:

### ***CSD 1A – Integrality means... The individual as a whole (bio-psycho-social)***

Integrality means seeing the individual as a whole, as a biological, psychological, social and sometimes spiritual being, also. Integrality means to keep in mind that the individual is a complete being, an integral being, trying to take care of the patient as a whole, not only that sick part. Beyond the complaint, integral care means to look at the disease and also the social and psychological parts. We are able to do it by talking and caring for patients in every way: the individual needs not only a bandage, but also a conversation, some attention. Integrality is health care as a whole, so the person can live with the disease with dignity and be happy.

### ***CSD 1B – Integrality means... To identify one's health needs and problems***

Integrality means caring for all the needs for which individuals seek solutions at the unit. It is in the community, it is to care for all the people; as they get to the unit, you care for the individual meeting all his/her demands. Integrality means to pay attention to each need the patient has.



### **CSD 1C - Integrality means... linking curative and care actions**

Integrality means seeing the actions directed to the citizen and his family as a whole: both the preventive and curative parts. It is not only collecting material for the Pap smear, but also identifying whether she (the woman) has hypertension, diabetes, what is her diet, life, exercise like, whether she has any knowledge of nutrition. Integrality, depending on the community, is water supply or providing care at schools. Integral care means to first prevent diseases, not only cure them, and also to keep in mind that you need to provide guidance to help prevent diseases.

The analysis of reports above shows that the conceptions of nurses concerning integrality are directly related to care delivery. Even though the nurses recognize in the reports that integrality is an element of the FHS, they do not make the correlations between integral care and integrality as principles of SUS clear. They mostly express them as a guiding principle of a certain clinical practice. In the CSD of nurses, the conception of integrality is treated as a critique of the dissociation between public health practices (preventive) and care practices (curative) care practices, though such a critique is not sufficiently strong to propose a care practice as an important focus of integrality. Nurses indicate in their reports that connecting health promotion, prevention and healing practices imply blurring distinctions, so far crystallized, between preventive and care practices. In the conceptions of nurses, integrality is seen as a set of individual and collective, preventive and curative, actions at the different levels of complexity in the system but which always has a single point of departure: the individual needs of health care services users<sup>(14)</sup>.

Nurses present a view in their reports that is focused on integral care and not as a principle of organization of care networks from the primary health service. That is, aspects related to the micro cosmos of the unit and care delivered to users predominates in the perception of nurses concerning integrality. A more macro perception concerning the organization of health care and the relation of their work within the unit with the remaining levels in the system is not clear.

In relation to the ways nurses identify how the principle of integrality is implemented into practice in the primary care routine of work in the CSD, they presented three different CIs. The semantic categories that proposed these CIs were very alike those obtained in the identification of the concept of integrality described earlier. It shows that nurses use the theoretical matrix they possess concerning integrality to put it into the sphere of primary care practice.

### **CSD 2A – I implement integrality through care that considers the individual as a whole**

When working in the FHS unit we see care delivered to individuals in a broader context, looking at the disease and

the individual as a whole: a complete being with general needs. This way of seeing things is facilitated because we work with families, practically inside the person's house, we know their context of life. The Family Health Program helps us to see the individual as a whole, an integral being, who needs care facilities and also need to be a priority. The perception of the individual as a whole is something we need to encourage within the FHS unit though it is very difficult to put it into practice given the large demand.

### **CSD 2B – I include integrality in practice through the identification of health needs and problems and offering a solution**

Integrality, in practice, I welcome the patient, care for him, identify the disease while paying attention to each need presented by the patient. It means trying to meet the needs the individual has in the community where he lives. (This) is one of the very important tools for the FHS. From the moment the user comes to the health unit, we listen to the user, seek to transform reception into an approximation of the family to the health unit. It is not an easy practice, we have a certain difficulty because of the physical area and demand. When there is a need to refer this patient, we refer the patient to specialized secondary care.

### **CSD 2C – I put integrality into practice through the connection between curative and care actions**

Integral care within health programs (child, adult, elderly), in health in general or in adult health and women's health is to prevent, promote, recover and reestablish health. It is curative care according to the population's spontaneous demands and preventive when evaluating collected data or planning. It is primary care; health prevention; care before the disease sets in, visiting the patient, identifying the disease. It means developing educational care, guidance, specific programs, women's health, for children and the elderly, trying to promote health.

The nurses' testimonies show that they put integrality into practice in their routine work process. Analyzing the reports showed that the work process *per se* is composed of health actions that seek integrality in care. A study<sup>(15)</sup> that resulted in the Vocabulary Inventory<sup>(b)</sup> to guide nursing practice in Brazil makes it clear that the focus of nursing practice and intervention actions that originate from it clearly present integral care as an element inherent to the nurses' actions and work process. When we analyze the object and purpose of nursing care, as well as the means and instruments used in the work process of nurses in the primary health care sphere, we verify that such an object and purpose is enlarged, that is, the phenomena upon which nursing focuses are not merely biological or pathological phenomena; these are also social and interactional phenomena.

<sup>(b)</sup> T.N. The Vocabulary Inventory originated in the CIPESC project and was developed by the Brazilian Association of Nursing (ABEN).

Another issue present in the way nurses see integrality put into operation is the organization of work within the primary health care sphere through the FHS. The nurses consider this strategy to be a way of organizing health care that enables the development of integral care delivery. Studies carried out in the sphere of the FHS show that this way of organizing health work in fact enables an integral and integrating approach from an enlarged perspective of health promotion<sup>(14)</sup>.

## CONCLUSION

Integrality has been seen as a part of an *objective image* that moves us and tries to indicate the direction toward which we want to transform reality. We can consider that the *objective image* originates in a critical mode of thinking that does not reduce reality to what *exists*, when one becomes outraged at characteristics of what exists, and seeks to overcome them, its statement summarizes this movement.

It is apparent that integrality should be the result of cooperation in each health service, whether it is a health unit, a FHS unit, a specialized outpatient clinic or a hospital, and should be considered in the unique space of each service and action of each health worker<sup>(16)</sup>. Hence, when nursing science attempts to construct indicators to evaluate the integrity of care delivered within the SUS, the cooperation and connection established between epidemiological knowledge and social sciences should be incorporated into studies within a participatory and inclusive dialog held with the health system's social actors. That is, integrality is the object addressed in comprehensive approaches and participatory methodologies of research.

In relation to professional practice, the study showed the importance of different health workers rethinking their work processes and tools in order to verify whether

these processes approximate or deviate from integral health care. The elements used to systematize nursing care presented by CIPESC are powerful theoretical-practical references when implementing it in nursing practice and are important in supporting the discussion of integrality in other professional practices in health<sup>(15)</sup>.

The challenge currently posed to nursing is to think of care integrality as conceived in the network, that connects integrality focused in the interior of each work process, with an enlarged integrality either implemented in a health services network or not. The importance of taking integrality as an object that reflect (new) practices of the health team and its management is based on the understanding that the construction of integrality does not occur in a single place, whether because the many technologies in health that improve and prolong life are distributed in a large range of services, or because improving living conditions is an inter-sector task.

Therefore, integrality brings an invitation to policymakers who devise policies aimed to confront and eradicate diseases so these policies are not reduced to health policies with the single objective of reducing the magnitude of certain diseases. They should also consider increasing access and ensuring coverage of health actions and care based on the adoption of measures to enlarge and organize health services networks so that they are connected and cooperate with each other<sup>(6)</sup>.

The reorganization of primary health within the FHS has allowed the organization of more welcoming primary health care units, with better quality and increased problem-solving capacity, with integral, preventive and curative nursing actions based on the population's needs and demands. It is necessary to internally activate the problem-solving capacity of these health units and encourage cooperation with the remaining components of the local health system through ensuring referrals and counter-referrals.

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