Journal of Nursing
Revista de Enfermagem
UFPE On Line
ISSN: 1981-8963

ORIGINAL ARTICLE

THE MEANING AND THE PRACTICE OF HOSTING FOR THE WORKERS OF THE FAMILY HEALTH STRATEGY

O SIGNIFICADO E A PRÁTICA DO ACOLHIMENTO PARA OS TRABALHADORES DA ESTRATÉGIA SAÚDE DA FAMÍLIA

EL SIGNIFICADO Y LA PRÁCTICA DEL ACOGIMIENTO PARA LOS TRABAJADORES DE LA ESTRATEGIA SALUD DE LA FAMILIA

Janaina Aparecida Tintori[1], Fernanda Rodrigues Helmo[2], Ana Carolina de Assis Simões[3], Leiner Resende Rodrigues[4], Lucieli Dias Pedreschi Chaves[5], Bethania Ferreira Goulart[6]

ABSTRACT

Objective: to analyze the perception of the workers of the Family Health Strategy (FHS) in relation to the hosting and its development. ***Method:*** this is a descriptive study, with qualitative approach, with 17 workers of the Family Health Strategy. The data production was conducted by means of semi-structured interviews, were recorded and fully transcribed. The analysis was based on Thematic Analysis, after the project has been approved by the Research Ethics Committee, with the Opinion nº 1277. ***Results:*** perception of hosting, Difficulties in the practice of hosting and Perception of the technical-health care model. There is the culture indicating that the hosting is a step in the working process; the perception of hosting under the perspective of humanization is incipient. ***Conclusion:*** some workers have described the hosting under the perspective of humanization; they linked it to an additional task to be performed; that the worker has the role of identifying the problem and solving it. ***Descriptors:*** Care Humanization; Family Health; Hosting.

RESUMO

Objetivo: analisar a percepção dos trabalhadores da Estratégia Saúde da Família (ESF) em relação ao acolhimento e seu desenvolvimento. ***Método:*** estudo descritivo, de abordagem qualitativa, com 17 trabalhadores da Estratégia Saúde da Família. A produção de dados foi realizada por meio de entrevistas semiestruturadas, as quais foram gravadas e transcritas na íntegra. A análise foi fundamentada na Análise Temática, após o projeto ter sido aprovado pelo Comitê de Ética em Pesquisa, com o Parecer nº 1277. ***Resultados:*** Percepção do acolhimento, Dificuldades na prática do acolhimento e Percepção do modelo técnico-assistencial. Há a cultura de que o acolhimento é uma etapa do processo de trabalho; a percepção do acolhimento na perspectiva da humanização é incipiente. ***Conclusão:*** alguns trabalhadores descreveram o acolhimento na perspectiva da humanização; o articularam com uma tarefa a mais a ser realizada; que compete ao trabalhador a tarefa de identificar o problema e resolvê-lo. ***Descritores:*** Humanização da Assistência; Saúde da Família; Acolhimento.

RESUMEN

Objetivo: analizar la percepción de la Estrategia Salud de la Familia en relación al acogimiento y su desarrollo. ***Método:*** estudio descriptivo, con abordaje cualitativo, con 17 trabajadores de la Estrategia de Salud de la Familia. La producción de datos se llevó a cabo a través de entrevistas semiestructuradas, las cuales fueron grabadas y transcritas. El análisis se basó en el análisis temático, después del proyecto ha sido aprobado por el Comité de Ética de Investigación, a través del Opinión N ° 1277. ***Resultados:*** Percepción del acogimiento, las dificultades en la práctica del acogimiento y la percepción del modelo técnico-asistencial. Hay una cultura que el acogimiento es un paso en el proceso de trabajo, la percepción del acogimiento desde la perspectiva de la humanización es incipiente. ***Conclusión:*** algunos trabajadores han descrito el acogimiento en la perspectiva de humanización, articularon con una más tarea a realizar, que compete la tarea de identificar el problema y resolverlo. ***Descriptores:*** Humanización de la Asistencia, Salud de la Familia, Acogimiento.

[1]Nurse, Post-Graduation Student in Obstetrics, Faculty of Medical Sciences from the Santa Casa of São Paulo, University of São Paulo/USP. São Paulo (SP), Brazil. E-mail: jana_tintori@yahoo.com.br; [2]urse, Post-Graduation Student in Health Sciences, Federal University of Triângulo Mineiro/UFTM. Uberaba (MG), Brazil. E-mail: fernanda.helmo@yahoo.com.br; [3]Dental Surgeon, Master in Health Care, Federal University of Triângulo Mineiro/UFTM. Uberaba (MG), Brazil. E-mail: aninhassim@yahoo.com.br; [4]Nurse, University Teacher and PHD in Psychiatric Nursing, Graduation Course in Nursing, Federal University of Triângulo Mineiro/UFTM. Uberaba (MG), Brazil. E-mail: leinerrr@bol.com.br; [5]Nurse, University Teacher and PHD in Nursing, Departament of General and Specialized Nursing, Ribeirão Preto School of Nursing, University of São Paulo/USP. Ribeirão Preto (SP), Brazil. E-mail: dpchaves@eerp.usp.br; [6]Nurse, University Teacher, Graduation Course in Nursing, Federal University of Triângulo Mineiro/UFTM. PHD Student in Nursing, Inter-unit Program, Ribeirão Preto School of Nursing, University of São Paulo/USP. Ribeirão Preto (SP), Brazil. E-mail: bethaniagoulart@yahoo.com.br

INTRODUCTION

Under the perspective of humanization, the act of hosting is welcoming people, receiving and acting with proximity, which represents an attitude of inclusion. The hosting might contribute to the construction of bond and commitment of users and health workers,[1] and it is instrumental in the organization and structuring of the primary health care (PHC) as a gateway to the Brazilian Unified Health System (known as SUS) and for the integration of other levels of care.[2]

Humanization entails the appreciation of different individuals participating in the working process, including users, workers and managers. The National Humanization Policy (NHP) has the autonomy and appreciation of the subject, the creation of solidary bonds and collective participation in the management process as guiding principles. The PHC should take responsibility for encouraging promote health practices, by assessing the health and social needs; for the commitment to effectively host the user, by optimizing care actions; and for the elaboration of the individual and collective projects aimed at improving the quality of health and care.[3]

The hosting presupposes the recognition of the other in its needs, the invention of strategies for conducting a more dignified and fair care, the implementation of the general principles of the NHP, the social inclusion and the solvability, by having dialogical relationships as support. [1,4] It might provoke reflections and changes with respect to the organization of health services and of how the skills are used or not to qualify the actions in the sector; in other words, the degree of access and governance of teams in the face of the developed practices, thereby prioritizing the care humanization.[5-7]

The construction of bond favors the effectiveness of health actions and user participation in the elaboration and implementation of the therapeutic project. This enables the development of autonomous individuals, whether they are professionals or users, since the bond does not exist if the user is not recognized in the condition of subject of rights, who talks, thinks and desires.[7-9]

In everyday life, the hosting is often limited to the spatial dimension of health facilities, with concern for the comfort, as well as with beauty of furniture and equipment. In general, it is reduced to a treatment of friendliness at the reception of the unit by a properly trained employee for holding such function. It is performed as a screening of users, which is conducted by means of a specific professional, with pre-defined start and end time, in a certain place, where individuals will be selected to undergo the medical consultation or will be referred to another service, for example.

Given this context and the way in which the health work is configured, one establishes dehumanizing practices, posters informing the limited number of consultations in order to restrict access, with distribution of tickets to ensure the attendance on a first-come first-served basis, little listening to the needs brought by users, fragility of teamwork and prevalence of the biomedical model of health care.[5,10]

The work organized in this manner reveals the hegemonic, technical-scientific and positivist model, which reproduces the traditional way of health care, characterized by high turnover of workers within the teams, centralization of work upon the figure of the physician, [7,11] social division of work and fragmentation of health care.[7,11-12]

The model that underlies and guides the health work hampers the construction of the bond between the team and the community, values quantitative results and hard technologies and might converge to the low solvability of services.[13] In this context, there is the possibility of having conflicting relationships between workers and users, thereby triggering reactions of indifference, neglect, passivity and accommodation, [8, 10,14] which directly affects the quality of the provided care.

As a product of human relationships, the hosting goes beyond the care and consideration for others. It advocates the appreciation of subjectivity and the listening to the needs of individuals, by learning and recognizing the human being in a large and complex dimension.[7,15] It cannot be restricted to one more stage of care, but rather serve as a tool for changing health practices established with the purpose of strengthening the doctrines and principles of the SUS, [2] in order to empower subjects and make them protagonists in their lives and in the choices that they make.

The opinion of workers in relation to the hosting implies in the way of working in the health care field. The act of unveiling this understanding might represent a possibility of transforming the practice and subsidizing spaces for dialogue, in light of the theoretical benchmark of NHP. Faced with this statement, we believe that, when analyzing a given reality, one can identify weak points and strengthen them. The comprehension of the

practice of hosting in the light of the technical-health care model, proposed by the SUS, might be a strong triggering factor for transforming the everyday life, with a view to enhancing care actions from the perspective of humanization and implementation of a comprehensive, equitable and fair care model.

This study aims at analyzing the perception of the workers of the Family Health Strategy (FHS) in relation to the hosting and its development, in the Sanitary District I, in Uberaba/MG/Brazil.

METHOD

This is a descriptive study with qualitative approach, developed in Uberaba/MG/Brazil.

Uberaba is a municipality located in the macro-region Triângulo do Sul, in the State of Minas Gerais/MG. It is subdivided into three sanitary districts (Sanitary District I, II and III), with a view to achieving the best location of sub-regions and distribution of government programs. Concerning the FHS, the municipality has 47 FHS units, 40 in urban areas and seven in rural areas.[16]

The Sanitary District I is the reference sector for clinical education and training of academic students from the Federal University of Triângulo Mineiro and encompasses a large number of teams, thereby being a good representation of the care model established in the municipality at stake. In light of the foregoing, we chose this district to compose the scenario of our study.

The above mentioned district has 19 FHS teams and a total of 289 health workers, with 19 physicians, 19 nurses, 22 nursing assistants, 19 dental surgeons, 19 dental office assistants and 191 community health workers.[17] All the mentioned teams include such professional categories. By considering that the hosting is an approach to be implemented by all health workers and, in the municipality at stake, they all received the same training targeted to the thematic, we chose to randomly select a health worker from each team, from any of the professional categories, to participate in the research. We used a list with all the names of health workers of the FHS, and the draw was made by a member of the team.

The study participants were 17 health workers from the FHS at the Sanitary District I, who met the inclusion criteria: being a worker from the FHS and agreeing to participate in the interview after reading the Free and Informed Consent Form (FICF). One physician, nine nurses, two nursing technicians, three dental office assistants, one community health worker and one administrative assistant were the participants. In order to stop collection, we made use of the saturation criterion towards the thematic axes.[18]

The data were produced by means of semi-structured interviews, with the following guiding questions: “Tell me what you understand by hosting”; “Tell me how the hosting is developed here in the service”; “Tell me if there are difficulties in the implementation of the proposal of hosting here in the service”; “Tell me about hosting and technical-health care model”.

The data production took place from August to December 2010, in the workplace of the participants, and the meeting was previously scheduled. The interviews were conducted by two researchers involved in the study.

The interviews were recorded and fully transcribed and, subsequently, the data analysis was performed. The health workers were identified as E1, E2, E3 and so on until E17. The FICF was signed by the individuals before the beginning of the study.

The data were subjected to the Thematic Analysis,[19] by following the stages below: decomposition into registration units, identifying the essence of the idea exposed by the participant; division of registration units in groups that composed the thematic units; description of the contents of each thematic unit. Lastly, we proceeded to the interpretation of what was revealed by the participant in the light of the theoretical benchmark about hosting proposed by the Brazilian Ministry of Health.[1]

The ethical standards of the Resolution 466/2012[20] were respected and the project was approved by the Research Ethics Committee with human beings from the Federal University of Triângulo Mineiro, with the Opinion nº 1277.

RESULTS AND DISCUSSION

From the completion of interviews and the results obtained after Thematic Analysis, 82 registration units were abstracted and divided into three thematic units: *Perception of hosting, Difficulties in the practice of hosting and Perception of the technical-health care model*.

The theme *Perception of hosting* shows different views of interviewees with respect to the issue. On one hand, some interviewees express a *humanized view of hosting*, through which they support the idea that users should be hosted, respected and attended in their needs in a friendly and comprehensive way.

This perception might be verified by means of the speeches of workers:

> *It means hosting the user in the unit according to his complaints and at any time he comes to the unit [...]. (E4)*
>
> *Hosting is the coziness[...] is[...] then the hosting works like this, people come here with many problems and we have to try to solve the situation of everyone who arrives. (E7)*
>
> *Hosting is welcoming the patient and knowing why he sought the health unit and trying to help him in the best possible way, trying to solve all the possibilities. (E16)*
>
> *We begin to host him from the moment he arrives. (E17)*

According to the speeches, we have found that some health workers realize the hosting under the perspective of humanization and highlight that the user needs to be fully attended in its needs. This denotes the appreciation of life and of the ethical action that seeks a broader care, with a focus that transcends the disease and also considers the subjectivity and needs of the individual.[21]

Accordingly, it is worth remembering that, for the worker to implement the completeness of care, it is necessary that he considers the individual as a participant subject and this requires appreciation of subjectivity. The act of welcoming the knowledge and experience of the individual, through a therapeutic listening, is a basic assumption for a dignified and qualitative care.[22]

Workers need to comprehend that it is not enough having technical knowledge and being ethical, because one should link the technical competence to the bonds of solidarity, respect, tenderness and concern for others; also promoting affective relationships with their team colleagues, thereby making the work environment harmonious and pleasurable. The changes in the physical environment are necessary, but changes in professional practices when it comes to humanization are essential.[23]

While on the one hand, the interviewees express a humanized view of hosting, on the other hand, some realize it through another perspective, which is represented by the *fragmented view of health care*. Such view reveals the strength of the biomedical model to guide health actions, by highlighting a care divided into specialties, which provokes damages in the comprehension of the individual as a whole, emphasis on the scheduling of consultations and the understanding that the hosting is held by means of lectures. Some statements confirm these observations:

> *We usually hold this training in groups, we have a lot of success if we hold them in groups (...), and the hosting, for the time being, it is only through lectures [...]. (E1)*
>
> *We try to solve the problem of the person, to the extent that we can, you know! If she wants a consultation with a particular complaint, we try to solve it. If there is no consultation, we try to send to another place. If the person comes to take a medication, then you have to make a registration, you must have a document, then we try to solve as far as possible [...]. (E5)*
>
> *We will check what it is, if the person will need a consultation, if it requires a blood pressure measurement, it requires a vaccine, or is only a little bit of information that has nothing to do, that is to say... with health issues. (E5)*
>
> *People come here and we welcome them and check what is; what consultation, what specialization is, in order to send them to the sector. (E7)*

In the light of the exposed speeches, we have observed that the care is reactive based on the complaints of users. When the interviewee states that the hosting is only held by means of lectures, he wonders what health professionals understand as hosting, since the speeches show a viewpoint in which the hosting is a step, a part of the health work, accomplished through specific actions.

It is worth highlighting that hosting is a technology that needs to integrate the "toolbox" into any and every type of attendance. Nevertheless, the fragmented perception of attendance might be aggravated by the working conditions and the individual style of each professional, which strengthens the biomedical model and emphasizes the unpreparedness to deal with the subjectivity of the user.[24]

It is suspected that this care model, which leads to the perception and implementation of a type of hosting that fragments the actions, is strengthened not only by the worker, but by the training that he receives and by the lack of qualification related to service actions.

The Humanization Program involves not only technical aspects, but relational ones, encourages health workers to attend in a welcoming manner, thereby overcoming the biomedical model producer of procedures. Whatever the occupation, the pursuit of this balance must be constant, by respecting the individual as a whole, knowing that he is inserted into a structured social and cultural context that involves skills, state of mind and autonomy.[8,25]

Another theme that emerged from the interviews was Difficulties in the practice of hosting, which expresses the obstacles revealed by the interviewees for the accomplishment of the hosting. They have emphasized that limited number of professionals, problems with the professional qualification, limitation of physical structure, high demand and the time-related factor are the hindering elements for the conduction of hosting. This might be seen in the following speeches:

> *It says that hosting, even the guard can conduct the hosting, but not all people are ready for this procedure. [...] We (nursing staff) always host, but, for the remaining things, I think it should have training and has difficulty. (E5)*
>
> *The person is walking half an hour, but the problem is not resolved here and, sometimes, the information she wants cannot be found here within the unit, so I think it's difficult[...] In this sense, I think there is lack of training on the part of all. (E5)*
>
> *In fact, we do not perform the hosting, because I think the demand is pretty great, and there is no professional for holding this more individualized care. (E15)*

Regarding the limited number of professionals and the low level of qualification, it is evident that some professionals, due to not performing a friendly care, justify themselves through the disorganization of the health unit and the habit of blaming the other, which might generate the deceptive feeling of never being co-responsible for the problem.[15]

Some interviewees indicated the limitation of physical structure as a hindering factor for the practice of hosting. This is evidenced in the statements below:

> *We do not have a screening, what we have is a waiting room [...] we have a professional who gives a lecture every day [...] only a group of lecture. (E1)*
>
> *The physical structure, physical structure is the major difficulty. (E6)*
>
> *The difficulty is the lack of space.* (E12)

According to some authors, the issue of physical space is an important condition for the completion of hosting. The hosting is not performed in a satisfactory manner when the physical environment is arranged in a disorganized form, which entails a poor quality of the provision of health care. The physical structure and the organization of the unit influence in the way in which the user is received and how he interprets this attendance, given that some FHS units do not have adequate infrastructure to accommodate the user in a humanized way.[5]

The bond of trust professional/user might be facilitated if the environment is welcoming, harmonious, with private spaces, with warranty of discretion, thereby resulting in a better attendance and enabling the humanized and ethical care.[26]

In turn, we highlight that the fact of having an adequate physical structure does not ensure a humanized and friendly attendance, because the adequate physical space is a necessary condition, but not enough for the completion of a qualitative care. We understand that privacy must be ensured in any and every attendance, but the welcoming attitude is not conducted by the physical space, but by the health worker.

Other difficulties shown by the interviewees are related to the great demand as something that hinders the practice of hosting, by blaming the non-welcoming attendance by the large number of users to be served.

> *Our spontaneous demand is pretty large, because changing the type of thought of the population is still very difficult. (E1)*
>
> *The demand is so large that it prevents the hosting, so we make schedules [consultations]. (E15)*

Far beyond a theoretical difference, the hosting, as a practice, remains attached to a technical activity and to the posture of accommodating far from the ideal in the real plan of actions.[25] The demand cannot be held responsible for a dehumanized care; hence, workers must be aware of a dignified and friendly treatment to all users, regardless of amount, and, from this reality, create bonds of trust. Perhaps a change would be the act of thinking about health work in a more proactive way, with planning of actions in different sectors, since the organization and the appreciation of knowledge of different health professionals in the construction of this working process allows the development and the implementation of coping strategies for the needs of users.[7-8, 14, 27]

One interviewee identifies that the time is a hindering factor for the practice of hosting, as he believes that "performing hosting" requires more time.

> *I do not feel much difficulty; the problem is that the hosting requires more time, so the biggest problem is that.* (E17)

Such speech reflects a model established in everyday life that advocates the quick attendance, by seeking to identify complaints to be solved. Not always the needs of users can be expressed in a few words, and neither

solved with a prescription. They might require more time for listening and understanding the suffering that the user experiences. It is believed that some health workers realize the hosting as another service to be developed, another step of the working process. Perhaps they have not perceived that the hosting must be inherent to any type of attendance, i.e., the care needs to be impregnated of hosting in its essence.

In the municipality at stake, the hosting takes place as a specific moment to identify needs, complaints, besides conducting the proper direction of the user, i.e., one identifies the complaint and makes the referral to the professional responsible for that type of care. This reduces the proposal of hosting to a step of the therapeutic project, detached from the wholeness.

The user must be respected in its right to be assisted in a comprehensive and humanized way, in addition to having its needs attended in a respectful manner, in his entirety, regardless of the difficulties of the service. Perhaps the workers have not yet realized the fact that conducting hosting is indispensable for care actions, since, when placing itself as a reference in this process, it will be possible to promote the empowerment of the user in the face of the health care.[28]

Another theme was *Perception of the technical-health care model*. The interviewees reported that the model that guides their actions is based on health promotion, disease prevention and recovery.

> *We work with health promotion and prevention, health promotion and recovery too [...] promote health through community training. (E1)*
>
> *We focus on family health, it is prevention and promotion. (E4)*
>
> *Here, due to being a primary service level, we work addressing the issue of prevention. (E14)*
>
> *Model of primary care, primary, here we give preference to the prevention method, prevent in order to avoid undesirable things. (E17)*

We have found that the health work is often guided in disease prevention, since health promotion represents a wider dimension based on comprehensiveness, social participation, even encompassing healthy public policies and community empowerment.[7-8,29-30]

When asked about the technical-health care model, which was one of the guiding questions of the interview, some interviewees could not talk about it, because they did not have knowledge of the matter. This is evidenced in the following speeches:

> *I cannot answer this rightly. [referring to the technical-health care model] (E2)*
>
> *Honestly, I have never heard about it. [referring to the technical-health-care model] (E3)*
>
> *As for this technical model, I thought it is very complex, I do not understand such a matter. (E6)*

The hosting presupposes a humanized stance from the health worker and a comprehensive, equitable and fair care. But, in order to implement such practice, it is essential to review the model established in everyday life, because the hosting requires a health care model that seeks more than an assertive gaze over tangible issues that are solvable by means of prescriptions. One should go further and contribute to the reconstruction of a model that allows reinventing the health care model focusing on the development of autonomy and self-care of individuals.

In light of the foregoing, it is believed that the workers do not make reflections about how the work has been conducted. The scenario of services should act as a space that could promote discussions, reflections and negotiations about the health care actions.

FINAL REMARKS

This study allowed us to deduce that there is an established idea that the hosting represents one more step in the working process. Some workers have described it under the perspective of humanization, but many more have linked it to an additional task to be performed, by understanding that the worker has the role of identifying the problem and solving it. The solvability in health services is essential, but, in the reports, the question of solving the problem has been focused on the biomedical model, based on the complaint-conduct and on normative acts. Given the above, we realize that the health services are unique and complex realities, which are full of contradictions and different ways of conducting actions.

The workers highlighted the idea that the hosting required a greater number of workers, more time from workers and demanded adequate physical structure. We have found that the culture that recommends that the hosting should take place at a specific time, in specific rooms and by a worker able to perform it, demonstrates that many of them were unaware of the perspective of humanization.

The conception that people have about the hosting was consistent with the fragmented model that is established in the everyday life, in which the hosting was identified as one more step in the working process. We raised the possibility that there was no perception of hosting as a mild technology to be used throughout the care process.

The daily practice has not yet absorbed the hosting as an attitude of listening, approximation and respect. In order to work in the health scope, it is essential to understand the pathways that should be travelled and what results can be achieved. The workers need to know, discuss and debate about new possibilities at work. The reactive model of care focused on complaint-conduct and prescriptive solutions has not contributed to the development of self-care and autonomy of individuals who are users of services and protagonists in their lives.

We believe that such considerations might be used in practice to guide discussions in the processes of education related to service actions, starting from actual and tangible questions in order to allow the group of workers to rethink its actions. We suggest the completion of service-related workshops with the aim of expanding the gaze on the work object, reconstruct concepts and review conceptions. We do not intend to deplete the thematic and we believe that further studies must be conducted with the purpose of elucidating the weak points and strengthen them.

ACKOWLEDGEMENTS

To the Coordination for the Improvement of Higher Education Personnel (CAPES), through the Tutorial Education Program (PET).

FUNDING

This study has funding from MEC/CAPES, through the Tutorial Education Program (PET).

REFERENCES

1. Brasil. Secretaria de Atenção à Saúde. Núcleo Técnico da Política Nacional de Humanização. Acolhimento nas Práticas de Produção de Saúde. Brasília: Ministério da Saúde; 2010.

2. Souza ECF, Rosana RLA, Rocha NSPD, Uchoa AC, Rocha PM. Acesso e acolhimento na atenção básica: uma análise da percepção dos usuários e profissionais de saúde. Cad saúde pública [Internet]. 2008 [cited 2013 Oct 15];24(supl.1):100-10. Available from: http://www.scielo.br/pdf/csp/v24s1/15.pdf

3. Brasil. Secretaria Executiva. Núcleo Técnico da Política Nacional de Humanização. Humaniza SUS: Politica Nacional de Humanização: documento base para gestores e trabalhadores do SUS. Brasília: Ministério da Saúde; 2004.

4. Falk MRL, Falk JW, Oliveira FA, Motta MS. Acolhimento como dispositivo de humanização: percepção do usuário e do trabalhador em saúde. Rev APS [Internet]. 2010 Jan/Mar [cited 2013 Oct 17];13(1):4-9. Available from: http://www.aps.ufjf.br/index.php/aps/article/view/350/291

5. Malta DC, Ferreira LM, Reis AT, Merhy EE. Acolhimento: uma reconfiguração do processo de trabalho em saúde usuário-centrada. In: Campos RC, Malta DC, Reis AT, Santos AF, Merhy EE. Sistema Único de Saúde em Belo Horizonte: reescrevendo o público. São Paulo: Xamã; 1998. p. 121-42.

6. Takemoto MLS, Silva EM. Acolhimento e transformações no processo de trabalho de enfermagem em unidades básicas de saúde de Campinas, São Paulo, Brasil. Cad saúde pública [Internet]. 2007 Feb [cited 2013 Aug 11]; 23(2):331-40. Available from: http://www.scielo.br/pdf/csp/v23n2/09.pdf

7. Moura GMSS, Magalhães AMM, Souza DB, Dall'Agnol CM. The social representations of the process of choosing leaders in the perspective of the nursing team. Rev esc enferm USP [Internet]. 2012 [cited 2013 July 21];46(5):1155-61.Available from: http://www.scielo.br/pdf/reeusp/v46n5/en_17.pdf

8. Cardoso ASF, Dall'Agnol CM. Group Process: reflections of a nursing team. Rev esc enferm USP [Internet]. 2011 [cited 2013 July 21]; 45(6):1406-12. Available from: http://www.lume.ufrgs.br/bitstream/handle/10183/69691/000819074-02.pdf?sequence=2

9. Schimith MD, Lima MADS. Acolhimento e vínculo em uma equipe do Programa Saúde da Família. Cad saúde pública [Internet]. 2004 Nov/Dec [cited 2013 Sept 12];20(6):1487-94. Available from: http://www.scielo.br/pdf/csp/v20n6/05.pdf

10. Matumoto S. Encontros e desencontros entre trabalhadores e usuários na Saúde em transformação: um ensaio cartográfico do acolhimento Interface comun saúde educ [Internet]. 2005 Mar/Aug [cited 2013 Sept 30];9(17):419-24. Available from: http://www.redalyc.org/articulo.oa?id=180114100027

11. Schoze AS, Duarte Junior CF, Silva YF. Trabalho em saúde e a implantação do acolhimento na atenção primária à saúde: afeto, empatia ou alteridade? Interface comun

saúde educ [Internet]. 2009 Oct/Dec [cited 2013 Sept 10];13(31):303-14. Available from: http://www.scielo.br/pdf/icse/v13n31/a06v1331.pdf

12. Merhy EE. O ato de governar as tensões constitutivas do agir em saúde como desafio permanente de algumas estratégias gerenciais. Ciênc saúde coletiva [Internet]. 1999 Mar/Apr [cited 2013 June 19];4(2):305-14. Available from: http://www.scielo.br/pdf/csc/v4n2/7114.pdf

13. Maciel-Lima SM. Acolhimento solidário ou atropelamento? A qualidade na relação profissional de saúde e paciente face à tecnologia informacional. Cad saúde pública [Internet]. 2004 Mar/Apr [cited 2013 july 10]; 20(2):502-11. Available from: http://www.scielo.br/pdf/csp/v20n2/18.pdf

14. Bernardes A, Cummings G, Évora, YDM, Gabriel CS. Framing the difficulties resulting from implementing a Participatory Management Model in a public hospital. Rev latinoam enferm [Internet]. 2012 Nov/Dec [cited 2013 Sept 21];20(6):1142-51. Available from: http://www.scielo.br/pdf/rlae/v20n6/17.pdf

15. Oliveira A, Silva Neto JC, Machado MLT, Souza MBB, Feliciano AB, Ogata MN. A comunicação no contexto do acolhimento em uma unidade de saúde da família de São Carlos, SP. Interface comun saúde educ [Internet]. 2008 Oct/Dec [cited 2013 Sept 19];27(12):749-62. Available from: http://www.scielo.br/pdf/icse/v12n27/a06v1227.pdf

16. Uberaba. Secretaria Municipal de Desenvolvimento Econômico e Turismo. Uberaba em Dados: ano base 2008. Uberaba (MG): SMDET; 2009.

17. Uberaba. Secretaria Municipal de Saúde. Sistema de Informação da Atenção Básica: SIAB/2008. Uberaba (MG): SMS; 2008.

18. Fontanella BJB, Luchesi BM, Saidel MGB, Ricas J, Turato ER, Melo DG. Amostragem em pesquisas qualitativas: proposta de procedimentos para constatar saturação teórica. Cad saúde pública [Internet]. 2011 Feb [cited 2013 June 23];27(2):389-94. Available from: http://www.scielo.br/pdf/csp/v27n2/20.pdf

19. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 12th ed. São Paulo: Hucitec; 2010.

20. Brasil. Ministério da Saúde. Conselho Nacional de Saúde. Resolução Nº 466, de 12 de dezembro de 2012. Brasília: Ministério da Saúde; 2012.

21. Silva CRA, Lunardi Filho WD, Backes DS, Silveira RS, Lunardi VL, Silva APA. Acolhimento do Programa Nacional de Humanização. Cienc cuid saúde [Internet]. 2011 Jan/Mar [cited 2013 July 15];10(1):35-43. Available from: http://periodicos.uem.br/ojs/index.php/CiencCuidSaude/article/view/8901/pdf

22. Coelho MO, Jorge MSB. Tecnologia das relações como dispositivo do atendimento humanizado na atenção básica à saúde na perspectiva do acesso, do acolhimento e do vínculo. Ciênc saúde coletiva [Internet]. 2009 Sept/Oct [cited 2013 Mar 18];14(supl.1):1523-31. Available from: http://www.scielo.br/pdf/csc/v14s1/a26v14s1.pdf

23. Backes DS, Lunardi Filho WD, Lunardi VLA. A construção de um processo interdisciplinar de humanização à luz de Freire. Texto contexto enferm. [Internet]. 2005 July/Sept [cited 2013 Mar 28]; 14(3):427-34. Available from: http://www.scielo.br/pdf/tce/v14n3/v14n3a15.pdf

24. Oro J, Matos E. Organização do trabalho da enfermagem e assistência integral em saúde. Enferm. foco(Brasília) [Internet]. 2011 Nov [cited 2013 Mar 18]; 2(2):137-40. Available from: http://revista.portalcofen.gov.br/index.php/enfermagem/article/view/113/95

25. Ferreira J. O programa de humanização da saúde: dilemas entre o relacional e o técnico. Saúde Soc [Internet]. 2005 Sept/Dec [cited 2013 Mar 18];14(3):111-8. Available from: http://www.scielo.br/pdf/sausoc/v14n3/07.pdf

26. Brehmer LCF, Verdi M. Acolhimento na Atenção Básica: reflexões éticas sobre a Atenção à Saúde dos usuários. Ciênc saúde coletiva [Internet]. 2010 Nov [cited 2013 Mar 18];15(supl.3):3569-78. Available from: http://www.scielo.br/pdf/csc/v15s3/v15s3a32.pdf

27. Sá CMCP, Moura SG, Braga LAV, Dias MD, Ferreira Filha MO. Experiência da implantação do acolhimento em uma unidade de saúde da família. J Nurs UFPE on line [Internet]. 2013 July [cited 2013 Aug 10];7(spe):5029-35. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/2867/pdf_3098

28. Rosa SM, Souza AC, Araújo FCA, Marques D. Acolhimento e vínculo: percepções a partir de uma equipe de saúde da família. J Nurs UFPE on line [Internet]. 2012 Sept [cited 2013 June 20];6(9):2071-6. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/viewFile/2711/pdf_1432

29. Carvalho SR, Gastald D. Promoção à saúde e empoderamento: uma reflexão a partir das

perspectivas crítico-social pós-estruturalista. Ciênc saúde coletiva [Internet]. 2008 Dec [cited 2013 Mar 18];13(supl.2):2029-40. Available from: http://www.scielosp.org/pdf/csc/v13s2/v13s2a07

30. Chiesa AN, Fracolli LA, Veríssimo MDLOR, Zoboli ELCP, Ávila LK, Oliveira AAP. A construção de tecnologias de atenção em saúde com base na promoção da saúde. Rev esc enferm USP [Internet]. 2013 Oct [cited 2013 Aug 15];43(2):1352-7. Available from: http://www.scielo.br/pdf/reeusp/v43nspe2/a36v43s2.pdf

Submission: 2013/11/03
Accepted: 2014/01/15
Publishing: 2014/05/01

Corresponding Address

Bethania Ferreira Goulart
Universidade Federal do Triângulo Mineiro
Departamento de Enfermagem
Praça Manoel Terra, 330
Bairro Abadia
CEP: 38025-015 — Uberaba(MG), Brazil