PERCEPTIONS OF NURSES REGARDING THEIR WORK IN THE FAMILY HEALTH STRATEGY[1]

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ABSTRACT: This study aimed to analyze the perceptions of nurses regarding their work in the Family Health Strategy. It consists of a qualitative descriptive study based on the socio-historical foundations and intersubjective aspects of the nursing work. Data were collected in 11 Family Health Units in Cuiabá, Mato Grosso, Brazil, by means of semi-structured interviews with 11 nurses, and submitted to thematic analysis. The nursing work is perceived as based on strategic and preventive actions, on the participation in the delivery of care, in contrast to the administrative participation, and on embracing interactions with patients. The nurses demonstrated compliance with the axes proposed for the work in the Family Health Strategy and a certain lack of knowledge and unchallenged acceptance of these, especially with respect to the promotion of health and the renewal of the local administrative practice. This study reveals the importance of reflecting regarding the nursing work and the perceptions of nursing professionals as for the construction of the Family Health Strategy model.

DESCRIPTORS: Family Health Program. Nursing. Work. Social values.

PERCEPÇÕES DE ENFERMEIROS SOBRE SEU TRABALHO NA ESTRATÉGIA SAÚDE DA FAMÍLIA

RESUMO: Pesquisa com objetivo de analisar percepções de enfermeiros sobre o seu trabalho na Estratégia Saúde da Família. Estudo descritivo, qualitativo, baseado em fundamentos sócio-históricos e aspectos intersubjetivos do trabalho de enfermagem. Foram coletados dados em 11 unidades de Saúde da Família de Cuiabá, Mato Grosso, com 11 enfermeiros, via entrevista semiestruturada. Realizou-se análise temática dos dados. O trabalho do enfermeiro é concebido a partir de ações estratégicas e da prevenção, da atuação assistencial em contraponto à atuação gerencial, e da interação acolhedora com usuários. Localiza-se aderência a eixos propostos para o trabalho na Estratégia Saúde da Família e certo desconhecimento ou absorção acrítica destes, sobretudo no que diz respeito à promoção da saúde e à renovação da prática gerencial local. O estudo remete à importância da reflexão sobre o trabalho do enfermeiro e acerca das percepções em torno deste à construção do modelo da Estratégia Saúde da Família.

DESCRITORES: Programa Saúde da Família. Enfermagem. Trabalho. Valores sociais.

CONCEPCIONES DE ENFERMEROS SOBRE SU TRABAJO EN LA ESTRATEGIA DE SALUD FAMILIAR

RESUMEN: Investigación con el objetivo de analizar las percepciones de las enfermeras sobre su trabajo en la Estrategia de Salud de la Familia. Estudio descriptivo, cualitativo, basado en fundamentos socio-históricos y aspectos subjetivos del trabajo de Enfermería. Los datos fueron recolectados en 11 unidades de la Salud Familiar de Cuiabá, Mato Grosso, Brasil, con 11 enfermeras, a través de una entrevista con preguntas abiertas y cerradas, se utilizó análisis temático. Las enfermeras escogen las acciones preventivas como centrales en su trabajo, priorizan la asistencia en contrapunto a la función gerencial y señalaron como importante la innovación en su práctica, la producción de interacción humanizada con los usuarios. Presentan adhesión a ejes propuestos para el trabajo en la salud de la familia y cierto desconocimiento en la absorción crítica de éstos, en especial en lo que dice respecto a la promoción de la salud y a las prácticas de gestión local. El estudio se refiere a la importancia de la reflexión sobre el trabajo de las enfermeras y las percepciones alrededor de esta para construcción del modelo de la Estrategia de Salud de la Familia.

DESCRIPTORES: Programa de Salud Familiar. Enfermería. Trabajo. Valores sociales.

INTRODUCTION

The nursing work has a socio-historical nature, shaped by characteristics of the health care model that prevails in Brazil, in its specific configuration in the different locations, in the midst of national/local constructions and propositions of care reform. In addition, it is outlined with historical characteristics of the profession.[1-2]

Nurses promote productive technical political-ethical and interactive action, permeated by some self-government. This professional acts intersubjectively on the health needs of their patients, using different technologies, in a process guided by social purposes and assumed positions. In this productive act, the professional mobilizes his/her own knowing-doing as well as shared ones, comprising perceptions or ways of conceiving, valuing, feeling and projecting the practice in health and nursing.[1-3]

These perceptions compose the work and express, to a certain extent, the way the process of objectification is configured. They integrate it, configuring the knowledge that supports it, at the same time they allow a certain approach to the way it is developed.[3]

In this sense, it is important to learn how Family Health Strategy (FHS) nurses perceive their practice in this space, since the concepts, values and projections regarding it suggest the way it has been executed and indicate perspectives that guide it.

The FHS model proposes the renewal of the basic health care according to principles of universality, comprehensiveness, equity, participation and continuity, in a context of decentralization and social control, aimed at advancing from the control of diseases to the promotion of health, through humanized care with bonding, embracement and responsibility, towards the several local and specific needs of the families in their territory.

For the administrative work, this model proposes, among others, systematic actions of development for professionals, planning and evaluation of the local practices, based on the production and analysis of information in health and integrated to the policies established. It promotes educational-care and health promotion actions to be developed in the service, in the patients' houses and in the community. Health promotion is presented as one of the strategic areas for the operation of the FHS, increasing the value of the education in health, the social control and mobilization, and the establishment of partnerships.[4]

This area requires actions towards the determinants/conditioning factors of the disease process that go beyond the units and the health care system, aimed to provide conditions and ways of living for people and groups so as to reduce risks and vulnerabilities related to these ways of living, thinking and acting, conditions of work, dwelling, education, leisure, environment, culture, and social support to the families and individuals, including access to essential goods and services, such as health services, among other aspects.[5] Health promotion comprises the strengthening of the individual and collective capability of people and groups to deal with the diversity of health-disease causes, aimed at favoring the autonomy of the individual and strengthening the community action, by increasing its technical and political power.[6]

The construction of the FHS requires changes in the professional practices, ones which must be performed with commitment to its strategic propositions and precepts. Hence, the teams acting in the FHS are expected to conceive their work taking into consideration such references.

This is especially important for the nurse who occupies a position of leadership in the team, coordinating the work of Community Health Agents (CHA) and the nursing team, participating in the local administration and in the education of professionals, and developing specific and shared care actions.

It is fundamental, thus, to identify these perceptions and correlate them with the challenge of reconstructing basic health care practices, since these professionals express, through them, compliance and/or resistance, lack of knowledge and/or critical/unchallenged acceptance of the proposals of change towards the basic health care and its implications for their work.

Despite being important, this theme was insufficiently approached in national studies over the last five years.[7-8] This gap evidences, thus, the importance of the present study, which aims to answer the question: How does the nurse associate his/her work with the changes proposed in the FHS model?

The purpose of this study was to analyze how nurses who act in the basic health care network of Cuiabá, Mato Grosso, conceive their practice, considering their co-participation in the configuration of the FHS and their approach and distancing from the planned changes.

It is understood that the perceptions of the nurses regarding their own work relate with the

general context of their lives, with the institutional health and nursing context and the care models in conflict, as well as the critical or uncritical positions assumed regarding its reproduction-transformation,[9] which implicates in the adoption of political-ethical positions.

METHODOLOGY

This qualitative descriptive study was developed in Family Health Units (FHU) in the municipality of Cuiabá, Mato Grosso state.

In 2008, there were 37 FHU in Cuiabá, assisting 30% of the city population, namely 13 in the north region of the city, three in the south, 10 in the east and 11 in the west. In all of these units, the health teams are made of one physician, one nurse, two to three nursing assistants and/or technicians and five to six CHA.

The study involved the participation of 11 FHU in the north region of the city and 11 nurses working in these units. The other two units in this region were excluded because there was no nurse present at the occasion of data collection. This region was chosen because it was elected by the Federal University of Mato Grosso and the Municipal Health Department of Cuiabá for teaching-service integration activities, mediated by the researchers.

Data were collected between August and December of 2008, by means of a semi-structured interview with an average duration of one hour, which was performed at the unit and recorded. An instrument that had been previously tested was used, containing questions of identification and characterization of the sociodemographic profile, questions regarding the education and work of the participants, as well as regarding the practices performed by the FHS nurses and their perspectives towards these practices.

The empirical material was submitted to thematic analysis,[10] by means of: 1) exhaustive reading of the interviews and identification of the nuclei of meaning; 2) grouping of the related themes; and 3) construction of the empirical categories. The process was oriented by the study object, purposes and foundations. Three central categories were identified, elucidating the work aspects appreciated by the nurses: 1) its limitation on strategic actions, aimed at the prevention of diseases; 2) the care practice as per the FHS model; 3) and a more effective interaction with the patient as a differential in their care practice.

The research proposal was approved by the Research Ethics Committee, under the protocol 545/july2008, complying with all pertinent recommendations, the signature of the Free and Informed Consent Form, and the confidentiality and anonymity of the participants.

RESULTS AND DISCUSSION

The majority of the studied nurses were women (81.1%), aged between 40 and 49 years (77%); who had graduated in public institutions (72.7%) over 10 years ago (81.7%). Most of them had always worked in basic health care (81.8%), had between six and ten years of experience in the FHS (81.8%), were specialized in family health (54.5%) and/or in public health (72.7%), and part of them (27.2%) accumulated the two specializations. Most of the nurses also had an enacted employment bond (90%), being incorporated to the FHS by means of an internal selective process (64%), and some of them had another job (54%).

Limitation of the nurse's work on strategic actions towards the prevention of diseases

The nurses interviewed indicate the FHS as a "new" basic health care model, in replacement for the traditional model of the health care centers, which is broadly present in the care delivered to the population in the basic health care network of the municipality.

The Family Health Strategy proposes changes in the care, administrative practice and organization in the basic network,[4] projected in the context of the reforms in the health sector that resulted in the Unified Health System (*Sistema Único de Saúde* - SUS).

This strategy aims to develop integrated actions of prevention, cure and health promotion, by means of care to the demand, strategic actions, territorial health surveillance and actions planned according to the local socio-epidemiological reality.[4]

In this context, the nurses highlight the systematic development of the strategic actions, in agreement with the interpretation that the purpose of the care provided in this place is the prevention of diseases among the individuals, families and communities.

We work on the prevention here. Real prevention. There are many people who come here, feeling sick, and we tell them: 'This is just a FHU, we are going to refer you to the polyclinic. Because we only work on the prevention here' (E6).

I share all the weekdays with the programs. So on Mondays, I work with hypertensive and diabetic individuals; on Tuesdays, with pregnant women; on Wednesdays, with women's health; on Thursdays, with child health; and Fridays are reserved for meetings and discussions with the teams and the CHA (E3).

Therefore, the interpretations regarding the direction of their own work are coherent with this perspective. This work, as part of the collective practice, is conceived as having the ultimate purpose of "preventing diseases":

our greatest difficulty is making the population understand what the FHS means, what our purpose [nursing] *is, making them aware of what is best for their health and having them accept that our work aims at the prevention* (E7).

This understanding articulates with the way the FHS has been developed across the country and particularly in Cuiabá, organized mainly around the care to the existing demand and the strategic actions established in the National Basic Health Care Policy (NBCP)[4] towards the control of diabetes, hypertension, leprosy and tuberculosis; prenatal care; prevention of breast and cervix uteri cancer; and child development and growth follow-up.

These actions, developed and conceived with a preventive-curative character, are indicated by the nurses as an innovation in the basic health care work, since they substitute the organization of the supply of actions concentrated in the care of the demand, existing in the traditional health care centers, leading their activity towards specific groups.

This positioning, in a certain way, does not take into consideration the fact that the performance of the FHS team, including the nurse's, must also target the diversity and dynamism of the health needs in the local territories, by means of other specific actions with the same character of promoting health.

On the one hand, strategic actions must not be neglected, since they were established to broaden the comprehension and quality of the care provided to risk groups,[11] but on the other hand, the FHS work must consider the scope and specificities of health in their territories.

The NBCP, despite privileging strategic actions towards certain groups, from a risk perspective that is strongly incorporated in their technical-political propositions, proposes the planning of actions based on local health conditions and presents the promotion of health as an area to be developed.[4,11]

The axis of the territoriality proposed[4] allows to consider epidemiologically identified problems, their determinants and the subjectivity and individuality of the families involved in the health-disease process and in their care practices. This component is fundamental for the broad approach of the health needs and health promotion, enabling the preventive practice to be developed more comprehensively.

Given that the basic health care is configured so as to give order to the contact of the population with the health system,[4] the work in this setting must be organized based on the identification of the several existing health needs, so as to respond more appropriately to them and/or to articulate responses in other scopes, taking responsibility for other services whereas the agents assume its resolvability.

This is important, especially in the nursing practice, since this professional has, historically, taken the responsibility for the establishment of professional-institutional links, so that more effective responses to the health of their patients are provided.

Taking responsibility for the health of the population in its territory, the FHS must infer curative and preventive concerns of the traditional basic health care model, aimed at promoting access to better conditions and ways of living for the families, including their participation in defense of health, since this consists of an important foundation for the planned change.[4,11] The development of intersectorial actions is one of the purposes of the local teams, as well as the development of education in health, aimed at the production of participation as an exercise of citizenship.

The FHS, as well as other health professionals and sectors, are responsible for this task, and its execution depends on the concepts and values integrating it to the set of common social responsibilities of provision/development of health care. Hence, it is important for nurses to broaden the reading restricted to the preventive purposes of their practice and to the sufficiency of their participation in strategic actions, aimed at the political-ethical and shared construction of more comprehensive purposes and actions, coherent with the comprehensiveness in health.

Therefore, the perception that limits the nursing work to preventive and strategic actions must be the object of a critical review, recovering the relationships of the nursing work with the broad approach of health needs of the territories

and with the promotion of health, which constitute important axes of innovation planned for the basic health care, guided by the perspective of comprehensiveness.

The nursing care practice as per the FHS model

Nurses express their practice in the FHS through two historical components: care and administration, as both are legitimated as constituting their responsibilities:

the work of the nurse in the FHS, in my opinion, is divided into the care part, as we work in the programs, and the administrative part. In addition, we also have to work on the community (E7).

Care and administration integrate the work of the nurse in the FHS in Cuiabá, including actions related with their specific nucleus of competences and with the field shared with other professionals. Both these aspects are supported in the professional legislation and history, in the care models and national and local health policies, and in the experiences, knowledge and values that compose the daily work of the nurses.

The care actions highlighted follow the priority given to the purpose of preventing diseases and to the strategic actions. In this sense, nurses emphasize the appointments and more complex nursing procedures as part of their tasks, and report other actions shared with the team, such as home visits and education in health:

[...] *I make home visits, whenever I can and according to the schedule of the unit. I visit the families with the agents and technicians to talk and to bond with them. I give speeches in schools, in the communities, I perform more complex dressings and follow-up all of those performed in the unit. This is my responsibility* (E9).

the FHS nurse must give speeches, promote the education in health at schools, nurseries, community centers, prenatal meetings, STD/AIDS groups, groups for drug users, and perform appointments (E6).

In the care administration field, they recognize the organization and the supervision of the work of the nursing team and CHA as components of their practice:

[...] *I supervise the CHA and the nursing technicians, as they report to me all the actions they perform. We talk and exchange opinions to improve each case and each family* [...] (E9).

the nursing appointments are my responsibility, I am the only one who makes the preventive collection. The work organization is also my duty; I assign the functions and organize the dynamics of the team [nurses and CHA] (E2).

Although the work of the FHS nurse in Cuiabá comprises care and administrative functions, it is concentrated in the first scope, by means of appointments, activities of education in health, home visits and the development of nursing procedures.

In Brazil, this work does not have a uniform configuration, as it varies in different contexts. In general terms, the care activities of the FHS nurse are evidenced as: nursing appointments and procedures; educational activities; home visits; surveillance actions and other community actions. On the other hand, administrative actions include: activities for coordinating and administrating nursing actions and the local service, and the facilitation of the communication and interrelationships of the work.[12-15]

The NBCP defines the attributions of the local professionals, proposing their activity by means of "administrative and sanitary practices", in the form of team work.[4] This policy establishes that nurses must perform nursing appointments, develop the procedures and activities established in protocols, manage the actions of the CHA and the nurses, and manage the input of the therapeutic institution.

Together with the other team members, the nurse must deliver humanized care to the population, in the unit, in their houses and in the other community settings, and participate in the coordination of care in other health care units of the system. In the local administration, the nurse must participate in the territoriality, production of updated health information and diagnoses, planning, scheduling and evaluation of local actions, promotion of political participation, and social control of the community, and education of the workers.[4]

Historically, the practice of the nurse is characterized by some dichotomy between care and administrative actions and by the tension resulting from this division. It is possible to find certain idealization regarding the care, which nurses consider to grant identity to the profession, whereas the professional is engaged mainly in the administrative practice of the nursing work and in the generation of conditions so that the work of other professionals may be developed.[1]

This characteristic seems to be reproduced in the FHS of Cuiabá and in the way the nurses

conceive their work in this unit. It is through care that these nurses see themselves participating in its construction and assuming what is their responsibility. However, different from the historical idealization regarding the care practice, in which they mostly handle administrative functions, in the studied setting the nurses are mainly involved in care actions.

The tensions are transferred to the distribution of tasks in the administration of the collective work in the FHU, involving conflicts, especially, with physicians and with the central administration. The uneven assignment of responsibilities is seen as a problem that interferes in the result of what they understand to be the specific work of the nurse, particularly through the "overload it generates":

the entire bureaucratic part is left for the nurse to do. The FHS nurse has to do the paperwork, but not alone. We are a team. I have my duties and so does the physician. There are all those attributions assigned for the nurse: organizing, planning the nursing service, the nursing appointments. The nurse has to develop nursing care. This is the nurse's role in the FHS (E3).

If there is something to do, it is assigned to the nurse. If there is a planning meeting in the city health department, the nurse is the one to go. The physician does not go, he is not even requested. The Ministry of Health does not establish it is only the nurse's duty, but everyone's. The nurse accumulates functions. We even forget what we are really supposed to be doing or we do it in a hurry (E7).

These tensions existing around the fair distribution of local administrative assignments transfer the attention of the nurses from their importance in the construction of the model planned with the FHS, as well as from their intersections with the administration of the nursing care and the actions of the CHA, which is a specific attribution of the nurse. Administration is conceived as a bureaucratic function.

In Cuiabá, the inexistent integrated teamwork makes the articulation of the several professionals as for administrative tasks difficult, besides, the units work with a minimum staff, and there is not an administrator position or the figure of an administrator in the FHU. In addition, the central scope demands administrative responsibilities from the nurse, without the establishment of agreements involving the team and the provision of adequate conditions for their development.

The integrated teamwork is configured in the reciprocity among the several technical areas and in the interaction of the working agents, including the central administration. This modality of work aims to overcome the inequality existing between the tasks and the agents and to recover their interdependence. Communication is essential in this articulation, facilitating the negotiation of a common work project, cooperation and coping with difficulties.[2]

In the lack of a teamwork with these characteristics and conditions for the nursing exercise, the fragmentation, hierarchies and impositions existing in the local work, among other aspects, culminate in tensions and difficulties in work, leading nurses to disregard the way the local administration must be executed and their participation in the FHU.

In this setting, nurses are also expected to take responsibility for the production, analysis and use of information in health, for the systematic and participative planning and evaluation, execution of teamwork, permanent education, among other actions of the local administration practice, considering their contribution for the (re)organization of the work in the unit as well as their specific work. However, in fact, it is necessary to articulate and provide conditions to the team so that this reality is accomplished.

This aspect is also particularly important because the local administration is an essential means to trigger the reflection and revision of the practice, committed with the planned changes and the overcoming of the fragmentation and tensions permeating the daily collective work.[15]

Effective interaction with the patient as a differential in the FHS nursing work

As part of the changes in construction in their practice, coherent with the innovations planned for the FHS, nurses project what they nominate as humanization, sensitivity, embracement, dialogue, listening and bonding:

we have to change our old way of working the nursing appointment. We used to focus only on the complaint, and now we have to be more sensitive. There must be a greater bonding, we must know how to assist and embrace the family (E8).

something that must exist in our work is humanization, embracement. So I see the pregnant women and the children, talk to them, listen to what they have to tell me, and I always try to embrace them (E6).

The production of more effective interactions between the professional and the patient has been

confirmed as constituting a new way of leading practices in the FHS, which provides the subjects involved with joint constructions, countless possibilities of performance, the production of care and the satisfaction of health needs.

Embracement, as a way of relating with the patient, is considered a fundamental device for a good care performance. It consists of the constant search for a growing recognition of the health needs and the possible ways of satisfying them; and presupposes an attitude of commitment in receiving, treating and listening to this patient with humanization, through a relationship of mutual interest, structured as a professional "relationship of help".[16]

The broadening of the relational quality and its capability of strengthening the therapeutic process is favored by the bonding established between patients and professionals/services. Bonding is a tool for consolidating references in the professionals and for creating responsibility for the population of the health territories.[17]

Consistently, for nurses, the FHS innovates by targeting the delivery of health care based on the construction of bonding and responsibility for the assisted population, as the professional makes himself available, creates bonds with this population and embraces their suffering. This important task is seen as part of the innovations in their work in the FHS:

here in the FHU, the patients are used with me as I see in them the difficulties I experience in my own life, and our exchange of experiences contributes for us both, creates bonds between us. One day, a woman arrived here at the FHU and hugged me, crying. I brought her to my room and started talking to her. She told me that I was the only one that could help her at that point. I just thought: - my God! It is too much responsibility. Then she explained she was stopping breastfeeding her baby and that it was being very difficult for her, watching her baby crying. Her breast was hard and sore, and the family was complaining. She remembered me as the only person that could help her. It is the responsibility of a family professional. This is it, embracing, bonding, important things we try to do to promote and prevent. This exchange is very good (E7).

The nurses express a positive perspective regarding their practice in relation to the component interaction with the families and their members, considering the introduction/appreciation of soft technologies, seen as differentials in the model in construction.

These technologies have been historically appreciated by nurses, among other reasons, due to the fact that their specific work nucleus is the delivery of care, a process that is permeated by the close contact to patients and their different health needs.

This understanding is relevant and must be developed, especially given the characteristics of the interactions highlighted, since they indicate proximity to what is projected towards the relationships between patients and health professionals in the FHS, aimed at the production of care in the perspective of comprehensiveness and humanization.

FINAL CONSIDERATIONS

In the present study, the work of the nurse in the FHS is conceived based on strategic actions recommended by the NBCP, on the purpose of preventing diseases, on the care dimension in contrast with the administrative dimension, and on more effective forms of interaction with patients, outlined in the embracement, bonding and accountability.

It is possible to observe compliance with the propositions established for the FHS work and a certain lack of knowledge and unchallenged acceptance of these propositions, especially concerning their purposes, with the corresponding broadening of care actions, and the renewal of the projected administrative practice. This study evidences the need for reflection on the work of nurses and their perceptions as for this work in face of the construction of the FHS.

The way nurses conceive their own work in this model is permeated with characteristics of the basic health care in Cuiabá, as well as its limitations, contradictions and advances. The broadening of these perceptions demands the understanding of the complexity involved in the construction of the proposed strategy, including continuous joint investments in the production of new subjects and in changes in the local work organization. The practice of the nurse in the FHS is inserted in a model in transition, which explains the need for appreciating systematic critical-reflexive processes in its configuration, aimed at renewing the traditional ways of conceiving the practice and the appropriation and use of technologies coherent with the proposed changes.

The reflexive approach between the conceived and the daily work, through permanent education, is the path recommended to reconstruct the thinking and the practice. This practice requires, from nurses and other professionals, both

the access and the criticism towards what is proposed, so that it is taken as reference for the daily construction/reconstruction of the specific and shared work. It is criticizing, (re)signifying, (re) valuing, producing new knowledge and actions that the team may affect positively the conditions of the work in family health care.

New studies must be developed, given the dynamic character of the ideas apprehended, aimed to evidence singular aspects of the knowing-doing of nurses and to monitor the way their intersubjective participation is configured in the basic health care settings in the country.

REFERENCES

1. Almeida MCP, Rocha SM. Considerações sobre a enfermagem enquanto trabalho. In: Almeida MCP, Rocha SM, organizadores. O trabalho de enfermagem. São Paulo (SP): Cortez; 1997. p. 15-26.
2. Peduzzi M, Carvalho BG, Mandu ENT, Souza GC, Silva JAM. Trabalho em equipe na perspectiva da gerência de serviços de saúde: instrumentos para a construção da prática interprofissional. Physis. 2011 Abr-Jun; 21(2):629-46.
3. Mendes-Gonçalves RB. Práticas de saúde: processo de trabalho e necessidades. Cadernos CEFOR. São Paulo (SP): Prefeitura Municipal de São Paulo; 1992.
4. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política nacional de atenção básica. Brasília (DF): MS; 2012.
5. Ministério da Saúde (BR). Secretaria de Vigilância em Saúde. Secretaria de Atenção à Saúde. Política nacional de promoção da saúde. 3ª ed. Brasília (DF): MS; 2010.
6. Czeresnia D. O conceito de saúde e a diferença entre prevenção e promoção da saúde. In: Czeresnia D, Freitas CM. Promoção da saúde: conceitos, reflexões, tendências. Rio de Janeiro (RJ): Editora Fiocruz; 2003, p. 39-53.
7. Colomé ICS, Lima MADS, Davis R. Visão de enfermeiras sobre as articulações das ações de saúde entre profissionais de equipes de saúde da família. Rev Esc Enferm USP [online] 2008 [acesso 2012 Jan 20]; 42(2):256-61. Disponível em: http://www.scielo.br/pdf/reeusp/v42n2/a06.pdf
8. Pessanha RV, Cunha FTS. A aprendizagem-trabalho e as tecnologias de saúde na Estratégia Saúde da Família. Texto Contexto Enferm 2009 Abr-Jun; 18(2):233-40.
9. Chauí M. Convite à filosofia. São Paulo (SP): Ática; 2000.
10. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 9ª ed. São Paulo: Hucitec; Rio de Janeiro: Abrasco; 2006.
11. Freitas MLA, Mandu ENT. Promoção da saúde na Estratégia Saúde da Família: análise de políticas de saúde brasileiras. Acta Paul Enferm [online]. 2010 [acesso 2012 Jan 20]; 23(2):200-5. Disponível em: http://www.scielo.br/pdf/ape/v23n2/08.pdf
12. Costa RKS, Miranda FAN. O enfermeiro e a Estratégia Saúde da Família: contribuição para a mudança do modelo assistencial. Rev Rene. 2008 Abr-Jun; 9(2):120-8.
13. Schimith MD; Lima MADS. O enfermeiro na equipe de saúde da família: estudo de caso. Rev Enferm UERJ. 2009 Abr-Jun; 17(2):252-6.
14. Silva VG, Motta MCS, Zeitoune RCG. A prática do enfermeiro na Estratégia Saúde da Família: o caso do município de Vitória/ES. Rev Eletr Enf [online]. 2010 [acesso 2012 Jan 20]; 12(3):441-8. Disponível em: http://www.fen.ufg.br/revista/v12/n3/v12n3a04.htm
15. Kawata LS, Mishima SM, Chirelli MQ, Pereira MJB. O trabalho cotidiano da enfermeira na saúde da família: utilização de ferramentas da gestão. Texto Contexto Enferm 2009 Abr-Jun; 18(2):313-20.
16. Teixeira RR. O acolhimento num serviço de saúde entendido como uma rede de conversações. In: Pinheiro R, Mattos RA. Construção da integralidade: cotidiano, saberes e práticas em saúde. Rio de Janeiro (RJ): Instituto de Medicina Social, Universidade do Estado do Rio de Janeiro/ABRASCO; 2003. p. 49-61.
17. Silva JAG, Mascarenhas MTM. Avaliação da atenção básica em saúde sob a ótica da integralidade: aspectos conceituais e metodológicos. In: Pinheiro R, Mattos RA, organizadores. Cuidado: as fronteiras da integralidade. Rio de Janeiro (RJ): CEPESC/UERJ/ABRASCO; 2005. p. 241-57.

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